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A Remembrance of War. Past and Present Traumatic Fragments in a Case of an I.D.F Soldier Suffering from Anxiety Disorder

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Abstract

The paper focuses upon a nodal moment in the psychotherapy of Shmuel, a young I.D.F. soldier who suffered from an anxiety attack during his military service. His treatment revealed a complex story of a young man who took refuge as a boy from his parents' arguing in his grandmother's home where he was exposed to her tales of surviving the Holocaust. Those stories imprinted themselves upon him and were affectively repeated throughout his life. The undigested memory of those times created a vulnerability which was exposed and erupted during his military service. Through dream-work and repetition in the transference, he was able to digest these fragments. The clinical information in this case is fictitious. The author describes his ethical dilemma regarding the exposure of clinical data and offers a novel option to dealing with the dilemma.

Keywords

Trauma, Anxiety, Transference, Dreams

...Come you masters of war…
… You fasten all the triggers
For the others to fire
Then you set back and watch
When the death count gets higher
You hide in your mansion
As young people's blood
Flows out of their bodies
And is buried in the mud.
You've thrown the worst fear
That can ever be hurled
Fear to bring children
Into the world…

Bob Dylan, *Masters of War,* 1963

Introduction

This paper will describe the treatment of a young Israeli man, Shmuel, who turned to psychotherapy due to an anxiety attack during his Israeli Defense Forces (I.D.F.) military service. Part of the presenting pathological picture included a strong abhorrence of any activity which was he thought of as being associated with military activity. I will show how those symptoms, though triggered by an acute mental distress, were exaggerated and formed in their particular shape and content as a result of underlying, older unconscious layers in his past, pertaining to undigested events involving his parents on the one hand and his Holocaust survivor grandmother on the other hand. The re-surfacing of those deeply-buried recollections was achieved through transference-countertransference work, focused around a particular dream and its interpretation during the four-year long once-weekly treatment.

In order to couch the clinical picture on a theoretical basis, I refer to three key psychoanalytic concepts which I will outline briefly. These concepts serve as guiding posts, outlining the basic assumption of psychoanalytic psychotherapy: the work of the unconscious, the specific attention required and the importance of witnessing.

The first key concept is Freud's Return of the Repressed. This is one of Freud's earliest ideas which he first introduced in 1896, repeated in his seminal book on dreams (Freud, 1900), and later somewhat revised and developed in one of his case studies (Freud, 1907), his letters to Ferenczi (1910) and finally in his work on repression in 1915. What remained constant in his appreciation of the phenomena is the general outline stating that repressed material will always seek a conscious expression and that it is indestructible, i.e. is never lost to oblivion but only hidden from awareness until such time and event occurs which prompts its emergence as a symptom, dream or artistic expression. This concept is pertinent to this clinical illustration in the sense that it offers one possible interpretation to the question as to how events in the patient's childhood, which at the time seemed unrelated to his direct sensory experience (and therefore minor in their impact), have left such a strong and potent trace as to contribute to his present day

predilection. Furthermore, as will be shown later, the repressed but intact contents of undigested and perhaps indigestible mental content were only able to return and re-appear through such subsidiary forms as dreams as well as disturbing forms as the symptom of anxiety and artistic expressions. To put it in the Bard's own words: "Such stuff as dreams are made on" (Shakespeare, 1968, p. 120). Through the interpretation and linking of the three elements, dreams (and their impact upon the transference), symptoms and artistic expression, it was possible to release the undigested content from the repressive hold, flex and integrate it into the patient's awareness.

The second key concept refers to a particular clinical approach that was lately described by Ogden and Ogden (2013) in their work on literature and psychoanalysis. Relying upon language as the key element bridging between literature and psychoanalysis, Ogden and Ogden write that: "Language is not simply a medium for the expression of the self; it is integral to the creation of the self (which is a continuing, moment-to-moment process). In the analytic setting, with its focus on talking as the **principal** (my emphasis – R.A.) means of communication, voice and language usage are among the principal ways in which individuals bring themselves into being, 'come to life '"(Ogden and Ogden, 2013, p. 9). This is particular relevant to listening with the utmost attention to the complexities of the human voice of the patient and the therapist. The onus of this attention is placed upon the therapist who has to master a very complex attention span which stretches like a web almost infinitely. The main source is of course the voice of the patient. But the voice is never one-dimensional. Another possible dimension is the particular cultural and national accent which the therapist has to recognize and become familiar with. This may be true to every culture, but working in Israel, the therapist has to differentiate between not only several nationalities, but also widely differing ethnic backgrounds, place of residence and varying degrees of religiosity (including the professed absence of any). Another dimension would be the subtleties of the patient's voice as they alter from one session to another and within each session in relation to his affective state and transference position. Interlinked with this last dimension is the therapist's own multi-layered voice. The links between the two voices create yet another dimension which extends the web of attention deep into the unconscious realm where both voices form a new and yet-undiscovered territory. The exploration of this unknown territory is conducted, according to Ogden and Ogden, with the same minute and careful approaches that one adopts when reading a literary text which contains unfamiliar vocabulary and syntax. "The therapist treats the literary work as a creation, in the medium of writing, of a state of mind that the author has experienced in the past or is experiencing (perhaps for the first time) in the very act of writing" (Ogden and Ogden, 2013, p. 13). Thus, the therapist listens to the patient's words, and his own, as to a text being written during the session. This text is a live event, linked to past occurrence. Furthermore, this live event is in fact a performance of souls where the patient's whole being interacts, consciously and unconsciously, with the therapist's. The text analyzed, therefore, is not only what the therapist or the patient say, but the whole web, or matrix that evolves during their time together. And in this web are caught words, images, memories, objects and introjects.

The third key concept refers to Dori Laub's work on the subject of testimony in history and psychoanalysis (Laub, 1992). Laub, himelf a Holocaust survivor and psychoanalyst who worked with Holocaust survivors, writes about the tension that is required of the listener in the cases of trauma. Without using the term explicitly, Laub describe the clinical phenomenon usually associated with countertransference. He states that the listener to the story of extreme human suffering is himself required to deal with an unprecedented situation. By listening to the story of the survivor, the listener is acting both as a witness to the story itself and, perhaps more importantly, to the feeling associated with it, belonging both to the listener and the survivor. What he listens to most, at least initially, is to the experience of the absence of language in the trauma. The story, as it has not been told until then, is a mental gap. Without a human witness, it does not exist in tangible human and verbal dimensions and therefore acts as a force of nature, as a storm does. The listener is a participant in the traumatic event and is a partner in creating the emotional and cognitive space required for its verbal witnessing. In order to not let the forces of the trauma (the storm) transform the listener into being a survivor himself, he needs to be able to re-

main somewhat separate. Laub suggests that this position is attained by two paths: the first is a prior knowledge by the listener of the "territory" into which he is travelling and the second is his own ability to bear witness to his own process. Thus, the therapist who wishes to create a therapeutic environment which will facilitate the witnessing of an unforetold trauma, needs to sharpen his listening so that he can become attuned both to the multiplicity and diversity of the patient's narrative, conscious and unconscious, as well as to his own passage through the patient's tale.

To write or not to write – is that the question? Ethical dilemmas in clinical presentation

Before continuing with the clinical description, I need to address a major ethical issue I have been dealing ever since I began practicing psychoanalytic psychotherapy more than twenty years ago. As well as doing that, I have also since an early age been writing as an expression for personal and professional processes. Quite often, my writing deal with clinical issues. I have been considering the ways my writing practice, which is a central part of who I am, have been affecting, and affected by, my clinical work.

A careful estimate shows that I have conducted nearly ten thousand therapy sessions during these years. I keep a close account of my work, both as is formally required by law and as a way of observing and self-supervising my work. I see that practice of writing as an integral part of my therapeutic process. As Adam Philips wrote, writing and therapy have in common the desire for introspection on the quest for meaning (Philips, 2002).

Making notes of my work is not just for formal reasons or for keeping tracks of my work. As Michels wrote, writing clinical notes, whether for further publication as part of writing essays or for keeping a record, only contain conscious and unconscious aspects of the writer's mind. Over the years, especially with longer treatments, I recognize the way that the practice of writing constructs and deepens the therapeutic process. The therapeutic dialogue becomes a textual entity. More than once I have found myself thinking that what I am listening to could make a good story. Since I also publish prose and poetry, I have often wondered whether those clinical materials find their way into my writing. Even though I have consciously been very diligent in keeping the two realms apart, I have wondered whether some of my non-clinical writing is unconsciously influenced by my clinical work. Whenever I published clinical work, I have felt uncomfortable, even though I have always made a conscious effort of disguising my clinical data to such an extent that it was more fictional than descriptive (Alfandary, 2014; 2015; 2016).

Poland wrote in 2009 about the complex issue of sharing clinical data (Poland 2009). It is not always done just in order to receive guidance or to deal with clinical impasses. In latter cases, I felt it was justified to temporarily expose clinical data and violate the professional secrecy. I felt that such a violation was done in the interests of the therapeutic process. But at other times I had felt that I was also seeking something else. At those times, I felt that sharing clinical data was a response to the same creative urge I was familiar with which I associated with my non-clinical writing. At other times I felt the urge to show off the therapeutic successes I enjoyed. At the same time, being anxious for my patients' privacy, my blurring of the details has become so creative and elaborate, I felt I was in fact retelling their story and creating a different narrative than the clinical one. It was a practice such as Goldberg warned against when he wrote that a too good camouflage will make the clinical data into a work of fiction. As I will demonstrate later, I suggest that his warning is exaggerated (Goldberg, 1997).

To be clear, I share Stoller's warning that any direct mention of clinical data without the patient's clear agreement and involvement is a grave violation of the fundamental rules of psychotherapy and is detrimental to therapy (Stoller, 1988). No one seeks therapy so that the therapist publicize their predicament. Gabbard exposed many wrong practices that exist in this area (Gabbard, 2000). In his opinion, there is no guaranteed way to keep the patient's privacy on the one hand and to create the necessary training environment so central to our profession. He suggests a strict blurring of details, focusing on the process in the room and even fictionalizing cases, as Yalom and Yuval have been doing.

Kantrowitz suggests involving the patient in the process of writing up a case (Kantrowitz 2004). Bernstein suggests using a mentor in the process of writing to facilitate the transference process involved (Bernstein, 2008).

I find these answers unsatisfactory for me, though I have no criticism towards anyone using them. I suggest another option. And for that, I need to digress slightly. I suggest looking at a certain aspect of writing shared by psychoanalysis and literature. It was Freud of course who showed the affinity between the two fields when he used many literary examples to elucidate and support his clinical findings (Freud, 1908). He used a supposedly scientific and objective analysis of the literary subject to demonstrate his ideas. Shoshana Felman suggested that the two disciplines should be seen as equal subject sharing similar interests in the human psyche (Felman 1997). Both disciplines use language as the main path to seek meaning in life. Later thinkers, such as Hanly, suggested that even when a clinician presents "real" clinical data, it is still constructed based upon his experience of what took place and his memory of what took place. Therefore, the question of veracity becomes acute (Hanly, 2009). What is presented as true may well be just an aspect what is true and in fact represents the mind of the therapist more than anything else. The clinical picture we present is solely based upon our description of it. Therefore, as Collins suggests, we should replace truth with authenticity when we come to judge the reliability of our clinical data. I want to further suggest that distinction between what is hard data and fiction as far as the clinical picture is concerned is not so easy to make. Each fiction contains a subjective truth and each truth is subjectively told.

What I will present shortly is a therapeutic tale which I have written to illustrate certain issues I wish to share with you. None of what is presented belong to any one patient. It is all made up. But as it is made up by me, having had thousands and thousands of clinical hours, it is saturated with clinical material. Thus, not one of my patients is revealed in any way and I can stay true to my promise of secrecy. I do not believe a therapist can obtain permission from a patient to expose his secrets as this is a violation of the power relation between them. What I do reveal to you is the contents of my mind. I invite you to play with me in the Winnicottian sense, and hope that what I will tell you will feel authentic enough to be worthy of your attention.

Shmuel – Clinical Notes

Shmuel was 25 years old when he was called up for his three week reserve force assignment as a paratrooper in an elite unit of the I.D.F. At that time, he was still single though fairly active socially and quite pleased with the way his life was going. He was in his second year at university studying law which pleased his family but was considered by him only as a stepping stone towards a professional future he was not yet sure about.

Shmuel was referred to me a by a psychiatrist in the I.D.F. with whom I had worked in the past both in and outside the army. He thought that Shmuel needed to see a civilian therapist though one who was familiar with current military mental health practices in the army as I was. The Mental Health Department in the I.D.F. has grown both numerically and qualitatively over the last decades and in particular after the first Lebanon war in the early Eighties. The scope of this chapter does not permit expanding further on this point, but it is significant to affirm that soldiers suffering from shell shock and other mental disorders caused by and/or appearing during their military service, were taken more seriously than in the past and treated adequately accordingly.

When Shmuel made the first contact with me, it was by an email. The email arrived with nothing appearing in the subject heading and its content was very brief. Without addressing me directly, he wrote that F., the military psychiatrist, has given him my number and asked whether he could contact me. I sensed that this man had difficulty in approaching me directly and needed the virtual letter form to let me know of his need. He did possess my phone number but chose to make contact from afar. So, I was surprised that when he did ring, a few hours later, his voice sounded firm and resonated with self-confidence. He wanted to make an appointment straight away, as if the email brief exchange has established enough contact. I sensed that he was delaying and perhaps avoiding contact but doing so in an elaborate and confusing way. the association which I found myself

contemplating after putting the receiver down (he did ring a land line number), was that he had to prepare me for seeing him and this he chose to do by employing a variety of communication methods, as if to make double sure that I could be reached. A slight sensation of being toyed with and perhaps even manipulated lingered on and evoked a mixed sense of curiosity and a slight dread towards our first appointment.

So, when meeting him for the first time, I was very aware of the fact that it was not "*without memory and without desire*." I felt that I was asked to be a witness to some unconscious mental communication and this was already taking place between us prior to the meeting itself. When Shmuel entered the room, the affect that surrounded him was in stark contrast to all that I have described above. He seemed calm and collected, spoke with fluency and self-confidence, and related his complaint in a very leisurely manner. I felt ill at ease with my own pre-conceived judgment and almost paralyzed by the sense that I have been wrong in my initial assessment. Later on, I came to think about this, as result of his splitting-off defense mechanism. He could never be sure that where he would be is safe, so he had to play it both ways, both wary and confident.

He told me that during the last time he was called up for military service, the small unit he was a part of, ran into some trouble in one of the West Bank refugee camps. During a routine patrol, stones were thrown on the armored vehicle that they were driving in. One of the soldiers spotted a group of youngsters he thought were responsible who stood near-by, and the driver of the vehicle made an abrupt turn and sped forward in such a way which caused the vehicle to run down three of the youngsters. When other Palestinians who were in the area noticed that, hell broke loose. It was only a couple of hours later that they were able to pull out of the camp, aided by other armored vehicles that were called in. During that time, once he had realized that they had run over the youngsters, he felt paralyzed and sat in the corner of the vehicle almost without being able to participate in the actions. His fellow soldiers of course noticed his predicament but were too busy dealing with the situation themselves to do anything about it. Upon returning to base and following a briefing, he was immediately referred to the military psychiatrist who then referred him to me after a few consultation sessions.

The story was indeed a harrowing story and yet he told it as if he was reporting something that happened to someone else. I thought to myself that a dissociative defense mechanism was playing a part in the clinical picture to allow his affect to be so calm and so cut off from the content of his story. He carried on to say that since that event, he was in fact in serious doubt as whether he would ever want to go back to serve in the I.D.F. He then said that he thought that his reaction at the time was an expression of something he had felt deeply long time ago. He had always considered himself of a Dovish inclination as far as Israeli politics were concerned. Serving as part of elite military unit as he did, was justified by him as a necessity in face of the political situation Israel was in. But after that incident, which he thought was the fault of the driver of the armored vehicle, he was no longer able to justify to himself being part of military actions whose sole purpose seem to police and oppress the occupied Palestinian population. What he wanted from me, he said, was not so much therapeutic help, but help in getting him off the register so that he could be dismissed from further military service.

At that point, my heart sank. Not so much because I thought that dismissing Shmuel from further military service was a bad idea but since I was afraid that his retreat into a concrete solution, which was based upon even heavier repression, it was a sad move. As he was not the first soldier I have treated in such circumstances, I thought of suggesting that we meet a few times for me to get able to assess his condition and see how I can respond to his request. He responded very calmly that this was fine by him but wanted me to know that even if I did not provide him with the necessary documentation, he would nevertheless refuse to go back to the military service, even if it meant going to jail.

I described in some detail the content and atmosphere of the first session as it had a strong impact upon me. I make a short digression to describe the situation in Israel at that time which will both perhaps illuminate my own agitation, as well as, lay the basis for understanding what transpired in the therapeutic relationship that did

develop well beyond those initial sessions. This was in early 1996, a couple of months after the assassination of the Israeli PM, Mr. Yitzhak Rabin, by a Jewish right-wing activist. Again, the scope of this chapter does not allow for much further elaboration, but it is important to mention that the public atmosphere was laden with strong emotions, ranging from rage to deep mourning, following the actual assassination and its obvious Oedipal and patricide implications for Israeli society, regardless of one's political leanings.

Shmuel had never been to therapy before, and yet, I discovered during the following weekly sessions that he used it in a very sophisticated way. I expected resistance from him to the process based upon his initial declaration as to what he wanted from me. He seemed to have forgotten about it and proceeded to fill the hours with rich associations, both relating to his daily routines, including his rich social life, as well as his dreams. He remembered his dreams well and seemed almost thrilled when I had suggested to him, towards the end of the second session, that he began recording his dreams so that we could talk about them together.

Shmuel has been raised by his parents in a loving and attentive way, judging from his initial stories. Though they were both professionals very busy with their careers and they had been able to manipulate their work schedules so that he and his older sister were always in their focus. They also had substantial support from their own grand-parents who were still active. Shmuel had a very close and warm relationship with his grand-parents as a child. He felt lucky enough to have them around when he was a child. In particular, he enjoyed the company of his paternal grand-mother whom he described as an eccentric character. He said that most people found her hard to be around as she was too direct and confrontational. His own experience with her was different. With him, she spent many hours telling him tales of her early childhood in a central European country. It was a happy childhood which was cruelly disturbed by the rise of the Nazi regime in Germany and her own country's occupation almost immediately after the beginning of the Second World War.

Since the scope of this chapter does not permit expanding further and describing in details the path that the therapy took, I shall focus upon one particular moment in Shmuel's psychotherapy which occurred six months into the treatment. This particular moment which revolved around dream work and its impact upon the transference paradigm, serves as a demonstration of my initial claim that the pathological condition that Shmuel suffered from was not only a result of his own current experience, but was also a repetition of a past event which has returned to haunt him and claim recognition. By bearing a witness to the multi-layering of the dream and his affective reaction to it, the therapeutic space thus created enabled Shmuel to deal with very painful and previously unthought-of aspects of his self.

Shmuel – Dream work

Shmuel's dreams were abundant. Even though he said he had never tried to remember his dreams or make sense of them in the past, thinking dreams were a preoccupation only for psychologists and dreamy school girls, once he began writing them down, there was no stopping him.

Dream work is a key element in my concept and practice of psychoanalytic psychotherapy. I invite dreams both from my patients and from myself as I invite other unconscious communication. Working with dreams is both using symbolic interpretations of dreams as well as relying upon dream-work to do its silent job of elaborating and constructing aspects of the multi-layered self (Ogden, 1997, pp. 1-21). Thus, the ensuing dialogue about the contents of the dreams and the arising association, both by the patient and by the therapist, are a lot more than trying to piece missing unconscious information together. It is primarily about weaving a web of connotations and meanings which facilitate and enable the transformative thrust of the therapeutic process (Spero, 2010).

One particular dream which Shmuel dreamt and related to me after about six months of therapy signaled a move forward which I will describe in some detail. Important to mention that Shmuel's anxious symptoms seemed to have diminished significantly at that point and though he still felt strongly that going back to military service was against his principals, he no longer insisted that I en-

sured that his temporary sick leave would be made permanent. And here is the dream.

> *"I am flying or falling down from a great height, away above the earth's atmosphere but also from the 8th floor of my parents' house. The fall down takes a long time and I wonder when will I hit the ground. At the same time, I am also down below on the ground, preparing the surface for my eventual fall. I try to make the ground soft. While falling, I pass through the clouds and feel relieved because it means the fall will soon be over. It seems that the clouds also soften the forthcoming clash with the ground by slowing me down. I reach the ground and it is soft, like sand. My parents observe the whole time and are indifferent to my plight. I roll on the ground and then get up, unharmed"* (sic).

The dream was told in an excited manner, revealing that something important was being communicated, though what it was he did not know. He just felt that it was an important dream. I waited for him to bring up more associations, but he remained silent and looked at me with expectation. "Now it was your turn," he said. As far as he was concerned, he had delivered the goods and now I had to perform my share by deciphering the contents of his dream and relieve him of his anxiety. I felt the pressure of his attention and attributed it to his anxiety. Whatever I would say constitute a response to his anxiety, and this caused further anxiety. I decided to interpret that before trying to engage with the symbolic content of the dream. I had an idea or two in relation to the content but first applied my attention to interpreting the resistance. I suggested that the speed with which he wanted me to resolve the dream was akin to the speed with which he was falling down in the dream. He grimaced but remained silent for a minute or so. Then he said: "You know, what you just said is so disappointing. It means nothing. It is like throwing it back to my face. Why can't you just talk to me like an ordinary human being?"

His anger and disappointment were very clear. I felt a desire to respond to it by placating him and reassuring him but was able to restrain myself from such a sentimental outburst. Only just. His emotional expression was very strong and I knew that something profound had been touched. Despite my resolve to maintain my stance, obviously my face and body movement showed something else. He looked at me with a mixture of pain and anger and I felt moved by a sense of helplessness which permeated the room. I commented upon this and said that it seems that the dream, his emotional response to it and my words had created a powerful situation here and now that we should try and understand. To my surprise, Shmuel conceded and said that that I was probably right. But he remained quite sullen until the end of the session. After he left, I wondered whether I would see him again. I had a feeling that that might have been his way of parting, without spending any time or emotional energy to deal with his feelings.

From what I knew of his childhood, I should not have been surprised. By that time, he had already told me more about his parents' marital status which was not as rosy as it had appeared at first. They had remained a couple to that day and exhibited a stable enough parenting throughout his childhood, but as he grew up to become a teenager, he noticed that in fact they hardly spoke to one another in general, let alone in any affectionate or warm way. Nor did they seem to argue or fight much. They were just together, being there, with not much going on between them. Once he became aware of that during his adolescence, he also became more sensitive to minute changes in their mood. He began watching their behavior, monitoring their conversations and observing their faces while they were not watching. This has caused him a lot of distress, which went on unspoken and without any outlet. It became so that at some point, he had found it hard to stay in their presence for more than a few minutes and so would leave the room. His parents put it down to adolescence, but the truth was that he could not stand being in the same room with his parents, whom he loved, and who seem to be growing more and more apart. He could not bear to be a witness to an emotional reality that needed to be witnessed by someone but could not be him. What was needed to be witnessed, the reality of his parents' relationship was just too unbearable for him. It was beyond words. He would leave the room and often went to visit his grandmother, who lived in the building next door.

When Shmuel did turn up for the next session, it felt like a break-through. He was able to come back to a scene which felt to him to be full of the same emotional fragments that were so hard to bear witness too. He said that he only came back to tell me something. After leaving the previous week, something dawned on him. He realized that he was disappointed with the intervention about the dream because it reminded him that therapy was just words and words meant nothing in the real world. He then directed his gaze at me and said: "*Just as my grandmother always used to say. All the good words are useless. What's the point of talking when death is out there?*" These were strong words. I asked him to elaborate. He said that my interpretation of the dream reminded him of what he had always thought of therapy – that it was futile in the face of reality of war. "*Sometimes there is nothing you can say. And that's the worst times*." This feeling corresponded to his position while crouching down inside the armored vehicle while out there children were being killed because of a careless move his comrade has made.

He then looked at the bookshelf above his head and pointed to a particular book – "*The White Hotel*" by D.M. Thomas. "*Do you know this book? My grandmother let me read it when I used to hide in her apartment from my parents. I think she meant well, but that book destroyed me. It was in that book that I found out how pointless talking really was. Only actions matter. It does not matter what you say, only what you do and what other people do to you that matter. That's what my grandmother used to say. And she should know. She survived the worst of humankind*."

Patients referring to books in my library are something I have gotten used to over the years and yet each time it happened I deal with it differently depending on the varying circumstances. The book in question was a fictional account of a psychoanalytic treatment of a patient of Freud's and all that happened to her in and after the treatment. In the first half, the book describes in detail her treatment, focusing mainly on the love transference that transpired. The treatment is described as inconclusive. The patient then marries a young Jewish opera singer. They have a child together and move to Kiev in 1920. The husband runs away and she and her child are captured by the Nazis in 1941 and massacred in Babi Yar in September 1941. The second half of the book describes with the same acute attention to details, her time in the camp where she finally perishes from hunger. It is a grim book. Shmuel recounted its narrative to me and summed its impression upon him: "*What's the point of all this psychoanalytic babble? At the end, after Freud treated her, she died by the Nazis! So what good all her insights are? What does it matter that she understood how she was brought up this or that way? At the end she died of hunger by those animals! Psychotherapy is pointless when there's a war going on, and we are at war now and need to be at war forever so that they don't do this to us again.*"

There was silence. Shmuel was upset in a way I have never seen him before. I had the feeling that it was not just his own words that he was speaking. I felt I was allowed to witness a part of him that was in conversation with his grandmother. Her presence was often described by him as the one person whom he could relate to in his family during his adolescence. He would sit in her kitchen, watch her cook and listen to her stories about time past. Some of those stories were very pleasant stories and described the life style she and her family enjoyed in the pre-Holocaust Europe. But quite often, a bitter note crawled into her story and she told him of her struggles, her plight in the camps, the many losses she suffered. She almost always made a point of ending those stories in such a way as to show him the greatness of the Jewish people that survived the Holocaust.

More than once, he was left with a horror he could hardly digest. It was then he felt paralyzed, contemplating what he could not witness, trying to think and picture what could not be pictured. There was a big lull in his talk. He looked down at the carpet and then looked up at me and said: "*You know, you were right, it was like that in the armored vehicle. I was sitting there on the floor, knowing we have just killed innocent civilians, and I felt I could do nothing. It was the same feeling of horror. I was a witness to something I did not want, did not need, to be a witness to. I only wish I could erase it from my mind. I only wish I could go back to a time when all this did not happen. But I can't. It keeps coming back, again and again.*"

Discussion

That session was the nodal point of the process (Spero, 2014). The realization that he had reached was pivotal in helping Shmuel deal with his anxiety. Clear as it was then, it required much working-through and going over in his mind and in the therapy sessions. It was not an easy admission for him to make. In time, he was able to see how his parents' quarrels and slight neglect pushed him to spending more time with his grandmother. Her influence in him was stupendous but there was a price to pay. She served him as a haven but within that haven he got exposed to tales of a world that frightened him. Hearing her mourn her dead relatives, hearing her tell of her time in the concentration camps and her survival, filled him with admiration and horror. But mostly it filled him with a sense of helplessness. That sense had become lodged within him as an entity that felt suffocating but one he could not expel. Trying to get rid of that would amount to a betrayal of an integral part of his being. He had to keep it inside. It felt like a memory which did not belong to him but which he formed a strong attachment to. During the following sessions, he recalled more and more time he tried to understand what she had told him. He tried to make sense of it but could not. In later years, he was able to comprehend it more successfully on a cognitive level, but on a deeper level it remained an obstinate piece of experience he could not process but which kept coming back to him.

Shmuel's therapy lasted four years. The brief segment described was a part of a journey that stretched along a circuitous path, trailing sign-posts past and present. It was a journey into the psyche of one Israeli citizen and soldier who suffered what would have been described in the past as"shell shock" but which turned out to be the impact of a cluster of injurious events, all unique to the his time and that of his immediate ancestors. During the third year off the treatment, his grandmother died. It was she with whom he had spent many hours in his childhood and adolescence, trying to find refuge from his parents' tormented relationship. But he found himself caught up in the web of her memories, some pleasant but most involving her survival of the concentration camp. He was fortunate enough to have been able to spend meaningful time in her presence almost up to her death. Having realized the ambivalent impact she had upon him as an adolescent, he was able to both listen to her in a way which comforted her and remain at a safe distance. He no longer felt like a trapped soldier sitting defenseless inside an armored vehicle, fearing to witness what was going on in the outside world. He no longer sought to be dismissed from military service. He did ask to be transferred to another unit so that he would be less exposed to such actions. There was an avoidant touch to this tactic, but it seemed like a reasonable solution to an insoluble situation. He was able to admit to himself and to others his weakness, but chose not to hide behind it. It was his way of acknowledging that some memories cannot be forgotten or overcome. But it is possible to live with them, as long as they are kept at a safe distance. He formed a stronger social activism approach and even spent a year of his life working with teenagers at a local youth club, where they read popular texts together. He said that his favorite text was Dylan's Master of War.

Epilogue

Several years ago, long after the therapy was completed, I happened to see a TV report which described the work of a non-voluntary organization Israel called The Road to Recovery. It was established by Yuval Roth, whose brother was killed by a Hamas terrorist attack in 1993. Rather than surrender to grief and revenge, Roth decided to dedicate his life to try and make a difference and established the organization which now is responsible for the driving hundreds of Palestinian children and adults from the check points around Israel to receive life-saving medical treatments in Israeli hospitals. They are driven there by hundreds Israeli volunteers who drive them in their private cars. Roth describes each such drive as *"little peace"*. I was pleased to see Shmuel's face, smiling profusely, in the TV report, as one of those drivers.

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For more information about The Road to Recovery
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