ILLNESS IN THE ANALYST AND ITS IMPACT ON THE PSYCHOANALYTIC PROCESS

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It is nothing short of amazing that so little has been written about illness in the analyst and its effect upon the psychoanalytic process. With a treatment modality involving three, four or five sessions per week over the course of several years, inevitably some analysts had to have fallen ill. Although Freud suffered severely from an incapacitating illness for most of his professional analytic life, and in his teachings emphasized the importance of the transference, he never wrote of the effect of his illness on his patients. In 1990, Schwartz noted that there were fewer than 10 reports on the subject in the psychiatric and psychoanalytic literature. "In the first 50 years of psychoanalysis, there are no specific reports...of the impact of doctors' illness on the analytic situation. The one possible exception is what the Wolfman had to say to Ruth ~~Black~~ Mack Brunswick about his encounter with the ailing Freud" (Schwartz, 1990, p. 119).

One difficulty in writing about the subject devolves from the fact that there is no common ground of experience that is easily comparable and that can be used to substantiate generalizations or conclusions about how the analyst responds to his illness and its effect upon the therapeutic process. "Illness" is too general and too broad a term when considered in the context of its impact on the psychoanalyst and psychoanalytic therapy.

Sickness comes in many forms and an identical disease will manifest itself in different ways in particular individuals. Even leaving to a side the analyst's earlier relationship to illness in general and the precise life situation that he finds himself in at the time that he falls ill, there are variations in the situation that defy categorizing from one practitioner to another. For example, was the onset of the illness sudden or gradual? Was it immediately incapacitating or not? Was it life threatening or just severely incapacitating? Was there anything in the analyst's physical appearance to suggest to the analysand the possibility of sickness? This list could, of course, be extended at great length.

Loyal to the Hippocratic tradition and in keeping with his psychoanalytic principles, the analyst who falls ill asks, "What do I do now? What is in the best interest of the patient?", i.e., what will least compromise the psychoanalytic process? Lasky (1990) has clearly delineated the many dilemmas that face the analyst at that time. The individual circumstances either permit or deny leisure of forethought. Circumstances vary widely. In Dr. DeWald's case ( ), the illness appeared at first as a mild infection that did not seem to be threatening at all. He cancelled the sessions as one would with an ordinary upper respiratory infection and promised the patients that he would see them in a few days when he had recovered. As his condition grew progressively worse and more complicated, it became necessary for him to transmit to his patients, through his wife or secretary, a version different

from the original reason he had given for cancelling the sessions. In the case of Dr. Abend ( ), he had foreknowledge of the surgery that he was to undergo and he was able to interrupt the course of the treatment in a manner not unlike that when an analyst takes a vacation or goes to a meeting. When he resumed his practice, he bore a visible operative scar but revealed nothing to any of the patients of the nature of his difficulty. In my own case, having suffered a period of cardiac arrest in the interval between patients, I told a patient who had been in the waiting room that there was a medical emergency and that I would have to cancel the sesssion. The patient, a physician, knew immediately from my ashen complexion that I was the medical emergency and, in fact, her father had suffered a cardiac arrest under circumstances similar to mine, i.e., while talking on the telephone. She waited long enough in front of my office building to see me taken away in an ambulance.

The common element in these three vignettes is that, in each of them, there was a violation of the psychoanalytic principle concerning complete candor and honesty. Rationalized as being in the patient's interest, each analyst told either a half-truth or a white lie. Whether the explanation for the analyst's absence because of illness is transmitted to the patient before the interruption of sessions or during the course of the interruption or upon resuming sessions, both parties are aware that some degree of prevarication has entered the relationship and, no matter how

the analysis proceeds from that point, both analyst and analysand have to some degree participated in an exercise of denial. Under such circumstances, all analysts who have commented on the situation suggest that one continues as best as one can, preserving the integrity of the analytic process.

From my own experience and on reflecting on the reports that have appeared in the literature, I have been impressed by how powerful a role denial plays when the analyst falls ill. Reflecting anew on my experience, I have come to some further conclusions on the matter. These thoughts come from reconsidering the ideas I expressed in the 1990 paper on "The Psychoanalytic Attitude in the Service of Denial." In that contribution, I stressed the importance of the mechanism of denial. Tonight I would like to emphasize the defensive function of the psychoanalytic attitude as such, of a split in the analyst's self-representation. To do full justice to the ideas that I want to present it would be necessary for me to repeat my earlier contribution and to elaborate on those elements that I wish to emphasize tonight. This, of course, is impossible. What I shall do instead is to present a few highlights describing how I employed the analytic attitude, in effect, how I became my own analyst in order to control anxiety over the danger of death by mentioning a few of the aspects of the experience to illustrate my thesis.

While standing, talking to my wife on the telephone, I lost consciousness and fell to the floor. I felt I was dreaming; I was very tired and I wanted to rest, so I decided to sleep on the carpet on the floor of my office. In the dream I thought, "This is a strange place to sleep," and as I had this thought, I began to wake up, realizing that I was on the floor, phone in hand, experiencing a waking dream. "A hypnopompic phenomenon," I observed to myself. I also recalled a most profound sense of peacefulness and I had the thought, "If this is death, then I'm not afraid of dying any more."

My wife managed to get Dr. Clyne, who had his office in the same building, to come to my rescue. I was having repeated bouts of loss of consciousness and I began to study the sequence of events in a rather objective way. First I noticed the intrusion of darkness into the peripheral field of vision, followed by an interval of four or five seconds before I lost consciousness. During that interval, I noticed that I began to feel numbness at the tip of my nose, the tip of my penis, and the tip of my toes but not my fingers. I told Dr. Clyne that the difficulty must be circulatory because of the numbness I experienced at the extremities of the circulatory system.

The next experience I want to report took place as I left the Emergency Room and was being taken up to the Intensive Care Unit. My wife was next to me. It seemed to me that I had been in the Emergency Room for about 15 minutes. I was surprised when

my wife informed me that I had been there for 2-1/2 hours while the doctors were struggling to get my heart to beat regularly again and to restore consciousness. The information she gave me about the discrepancy of my time experience made me feel very good. "So it was 2-1/2 hours, not 15 minutes!" I told myself. "Because I was unconscious, my sense of time had been disrupted. The discontinuity of the self experience had caused me to feel that time had been compressed." I was pleased to learn that my own experience was in keeping with observations that I had made on some of my patients, namely, that a discontinuity in the sense of self-awareness resulted in a feeling that time had been compressed. In other words, to the list of my patients who had been supplying me with analytic data concerning the sense of time, I could now add myself and my own experience.

While I was in the Intensive Care Unit, I began to experience premonitory symptoms of losing consciousness. I told the nurse either "I am about to pass out" or "I am about to go under." After a considerable number of the house staff succeeded in resuscitating me, I continued the process of self-observation and self-analysis. First I thought, "If I used the expression I am about to go under, I must have regressed to childhood because that's the way one would describe the process of fainting in Yiddish, which was my first language." Next I was concerned about how long I had been unconscious. Perhaps there had been some brain damage. I decided to test myself as one would test a patient.

"What's the longest poem you know by heart?" I asked. "Can you recite it now?" I did it quite satisfactorily so I decided that I had passed the test.

As one can observe, throughout all of this I had been observing myself clinically and reaching various conclusions and interpretations to myself. But this process was most dramatically actualized when I was a participant/observer of the process of having a temporary pacemaker inserted into my heart. I was seated in a semi-reclining position so that I, like the surgeon, could watch the progress of the catheter upwards inside my body on a nearby fluorescent screen. The catheter was to be inserted into the femoral vein and passed through the inferior vena cava into the right auricle and then into the ventricle. The doctor was calm and efficient as he explained the procedure to me. I found the operation most fascinating, and I watched the screen as if I were observing somebody else's operation. "Now we are passing the point where the renal vein enters," the doctor said. "One can almost see the outline of the renal artery." Straining at the fluorescent screen, I felt I could make out the faint trace of a line of an increased opacity. "When we get to the auricle," the doctor said, "you'll notice how the catheter takes a slight turn and goes a bit downward." And indeed it did! At this point he stopped and explained to me that the catheter had to be passed into the ventricle during the phase of diastole because then the valves were open and would permit passage of the catheter. On his third

attempt the doctor was able to pass the catheter from the auricle into the ventricle. "Well done!" I said approvingly and with enthusiasm. Throughout the operation I had been engrossed by what was going on. I had experienced the entire procedure as if it were happening to someone else, to some other person whose inner workings I had been observing in a darkened room on a fluorescent screen.

In acting as my own analyst, I had in fact effected a split in my sense of self. One self-representation was experiencing serious trouble while another self-representation, with which I felt comfortably identified, was safely and calmly observing a medical procedure being performed with admirable skill. This split, or divergence, of the observing self-representation from the experiencing self-representation is analogous, even identical, with the situation that pertains to states of depersonalization. The split in the sense of self buttresses the denial of danger, thereby alleviating anxiety and, in this instance, fostering the use of adaptive modes of response.

A parallel set of conditions immediately comes to mind, namely, what happens in the psychoanalytic situation. In that setting the analyst plays the role of the comfortable observer while the analysand is the uncomfortable sufferer. But the relationship has even deeper implications, as Sterba ( ), Brierly ( ), Beres and Arlow ( ), Lewin ( ) and others have indicated. In the course of analytic work, the analyst

repetitively identifies with the analysand, i.e., temporarily he becomes, if not the patient, then a patient. But sooner or later the analyst breaks off his identification and reverts to the role of observer and interpreter of the patient's articulated experience. All of the analysts who discussed their experience of illness in the course of their work gave testimony to their identification as patients with their analysands. On the more positive side of the situation, if we can refer to it as such, is the fact that in the role as analyst there is a certain comfort exploring other people's problems rather than one's own. One would suspect that analysis as a profession must be particularly appealing as a way of getting free of the pressure of one's own unconscious conflicts by concentrating on the conflicts of others. As we all know, this factor presents many challenges to the analyst in handling transferences and countertransferences. Most striking are those instances of overidentification with the patient or, on the other hand, an inability to empathize.

One obvious conclusion that we can draw from this split in the self as a patient, one that is confirmed by all the reports contained in these varying accounts of illness in the analyst, is that, whatever the analysts revealed and said to their patients was just as much directed to themselves as it was to their analysands.

Although it may be somewhat tangential to our considerations, there were other elements in my experience of being ill that may be considered relative to the discussion of the nature

of the analytic situation. When I called out to the nurse to help me and said that I was going under, I was talking in English but I was thinking in Yiddish. It was a regressive appeal for rescue by the mother. Also, during the 2-1/2 hour period when I was in the Emergency Room, while the medical staff was trying to restore my heartbeat to regularity, I was totally unaware of the nature of my surroundings. There were a few moments of minimal consciousness during which I was aware of overwhelming darkness, of a black cloud with brownish tones and an irregular rift in the clouds through which there appeared once again the pale green color of the dream I had earlier in my office. I felt perplexed and confused. "Where am I? What has happened?" And I answered myself as a reassuring mother would respond to a child: "You are very sick and these people are trying to help you." These observations also constitute a split in the sense of self between the self-representation and a mother figure, considerations which lend support to Stone's view ( ) that the analytic situation regressively recapitulates elements of the mother/child relationship.