

# FACING MORTALITY WHILE TREATING PATIENTS: A PLEA FOR A MEASURE OF AUTHENTICITY

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This article revisits aspects of a life-threatening illness I endured over twenty years ago, reviews responses to my paper on this topic, and offers personal recommendations to currently sick analysts and to our analytic institutes and societies. It emphasizes the ineffable, undocumentable, non-verbal aspects of my work with psychotic patients, and the profound empathy I found in them, which seemed to exceed that of less disordered patients. They were not strangers to chronic terror. I became a fellow traveler. Paradoxically, I felt that they were not so encumbered with denial and avoidance of death as are more functional people.

My teacher and friend, Jerome Frank (1961), in his classic text *Persuasion and Healing* discussed the universal features of psychotherapy. While he wrote about those members of a community designated as healers, I was impressed by my patients' efforts to heal me, to act as my shamans or therapists. Frank says, "The success of a psychotherapist depends in part on his really caring about the patient's welfare, and the odds are that he can invest more of himself, other things being equal, in patients he can like and respect, if not for what they are, then for what they can become" (p.130). Joan Halifax (1982), in her book *Shamans: The Wounded Healer* says, "I [will focus] on the inner journey shamans take during a life crisis and the ways in which they order the chaos and confusion of the voyage into Cosmos. The extraordinary consistency of the shamanic complex emerges in the study of this ordering process. That this commonality cuts across seemingly irreconcilable ethnic and cul-

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tural lines attests to the mystery and power lying at the source of myth, the human psyche" (p. 5). "The opening of vision for the shaman unfolds in a transpersonal realization resulting from a crisis of death and rebirth . . ." (p. 16). "Order is imposed on chaos; form is given to psychic confusion; the journey finds its direction" (pp. 17-18). My patients treated me *by* rededicating themselves to our shared task of their recovery from mental illness. They wanted to get better for *our* sakes.

In July 1978, I was diagnosed with a Stage III, Grade II ovarian cancer: a pound or so of tumor and countless cancer cells floating in ascitic abdominal fluid. After a 3-week hospitalization that included radical surgery, radiation treatment, and the beginning of a 14-month course of chemotherapy, I left the hospital feeling unremitting panic and despair. I knew that in a year I would undergo exploratory surgery to see if the treatments worked. Soon after I got home, I read in my then outdated gynecologic text that the author knew of studies reporting a 25% five-year survival, but he suspected that the pathologists at those hospitals were misdiagnosing many benign conditions as malignant. My surgeon had urged me to return to my pre-illness schedule as quickly as possible for the best possibility of recovery. I came back to Chestnut Lodge after Labor Day, having been away for two months. I resumed my private practice over the following weeks. I was in analysis but had not yet begun formal institute analytic training.

Thus my work became a forcefully prescribed occupational therapy. I needed my patients probably more than my patients needed me. We all were confronting life-threatening illnesses, theirs manifesting in mental and mine in somatic aberrations. They struggled with overt suicidality. I wondered whether my suicidality was unconscious, manifested through dismemberment of my immune system, as I had endured the stress of caring for my mother as she died of aplastic uterine cancer a little over a year before my cancer was diagnosed.

Bob Cohen, MD, a former Chestnut Lodge Director of Psychotherapy, often said that while there may be questions about the effectiveness of psychotherapy in severe illness, one thing is clear: if your back is to the wall, it's good to have company. While I stopped working with three patients (one of whom I'd met with for only one session, another who was leaving the hospital, and another who had been chronically raging and assaultive), only one patient announced she was leaving me. She was a doctor's wife who had asked her husband and his colleagues to find out where I was being treated, review my hospital chart and report their findings to her, which they did. She told me that because her mother was then ill, she couldn't be burdened with caring for both her actual and surrogate mothers. She seemed to feel entitled to the information she had obtained,

as if this were some variant of professional courtesy. She had intruded into my safe space, metaphorically, as the cancer had intruded into my healthy body. I hope she left dreading my potential revenge.

My patients and I resumed our work, saying little about my dilemma. I told them that I was frightened and why, and I told them that if I received bad news, I would share it with them so they could be sure that no news was good news. They returned to talking about their own issues, such that a transcript of our sessions probably would not have seemed much different from our earlier days, were one not alert to the ongoing drama of my struggle. And yet the atmosphere was obviously charged with unspeakable tension, and the gestures and manner of speaking of each of my patients carried profound tenderness and nurturing. I could distract myself from my own preoccupations during the span of the sessions, and was able to organize around the patients' material. I organized around their associations and felt profoundly empowered, even momentarily healthy, when I could make a meaningful interpretation. My patients fed me a certain reality of connection that I could not sustain alone. Alone, I was utterly preoccupied with apprehension, focusing on my peritoneum, working at not imagining tumor cells. In revisiting that phase of horror, as I wrote this article, echoes of that terror returned and with it a feeling of despair and outrage. I had dreams of having a recurrence or leukemia.

I had presented my paper "Resuming the Work with a Life-threatening Illness" at the 1979 Chestnut Lodge Symposium to an audience of about 500 local mental health professionals. I expressed my gratitude to my patients, my colleagues, and the Lodge itself, both its staff and its non-human environment, for being there with me through my ordeal. While I thanked my analyst, I did not name him. But his, Harold Searles's, influence is evident not only in the fact of my survival but in the substance of that paper and all my work. He was tough and consistent but also tender. After many months during which I flooded the sessions with my tears, he said, "Why don't you talk and I'll cry." My retort—"But how do I know that you *can* cry"—made explicit my pride that I could cry so much and so easily. Previously, I had just considered my uncontrollable crying a problem not a talent. Over the ensuing almost two decades, I now cry rather rarely, but this seems both handicap and strength because I have more difficulty accessing normal grief responses.

As I prepared my 1979 paper, I was astounded in reviewing texts on psychoanalysis and psychotherapy to find no mention of illness in the analyst. Even Fromm-Reichmann's *Principles of Intensive Psychotherapy* merely glossed over this topic. Did these writers assume that illnesses only occurred in elderly, seasoned clinicians who no longer

needed textbook guidance? Did they consider each person's illness too unique to permit generalities? Were they in "healthy denial," unthinkingly proceeding as if this topic were not relevant to them? Did they consciously avoid the topic in deferential loyalty to Freud, who avoided discussing his squamous cell oral mucosal cancer? Was the fact that Freud both suffered an obvious and eventually fatal illness and yet chose to continue working so problematic for those carrying forth the banner of classical analysis that the very topic of illness in the analyst became taboo? Why had there been such silence over the preceding century?

In July 1982, four articles appeared in three different psychoanalytic journals, each dealing with illness in the analyst. Simultaneously, they all became almost the first articles in the entire history of psychoanalysis to focus on this topic (Little, 1967; Chermin, 1976; Dahlberg, 1980). These articles formally and officially brought the sick analyst into the consulting room as an identified category of analyst. Illness became not just an unfortunate facet of an individual's life but a theoretical feature of analysis, broadening the topic of termination (Cristy, 1995; Durban, Lazer, and Offer, 1993; Feinsilver, 1998; Kitayama, 1991). Some analytic institutes now include these and related articles in their required readings. Perhaps institute policies have modified as well, and analytic societies more fully accept the ill analyst as a functioning group member. Disclosure of one's plight is not so dangerous. Formerly, we totally neglected the dark side of the oedipal triangle: we still gloss over the painful and universal truth that the older generation ultimately loses its strength and primacy, and increasingly relies on the now-grown children. We still do not grapple adequately with the transference implications.

The two articles in the July 1982 issue of the *Journal of the American Psychoanalytic Association* by Paul DeWald and by Sander Abend, respectively, received the most attention. Over the next three years, they and Eugene Halpert, whose article appeared in the *Psychoanalytic Quarterly*, organized six well-attended workshops on this topic at the meetings of the American Psychoanalytic Association.

In my paper, I described countertransference and transference aspects of my analytically oriented work, which took place in a hospital community in which everyone knew of my plight before my return to work. Chestnut Lodge still split tasks along a therapist-administrator divide. The psychiatrist-administrators of the units where my six patients resided met individually with each of my patients, telling them I had a serious illness that would leave me sick and uncertain of outcome for some time. Some strongly urged these patients to continue with their interim therapists, saying they ought to have a healthy doctor to help them work through their own illnesses. Interestingly, more than one

administrator was confused about what he had actually said. Had he uttered the word "cancer" or not? But the community sentiment was most clearly expressed by one of the psych techs, who called out to me from the tennis court as he saw me getting out of my car on my first day back, "Oh, Dr. Silver! Are you coming back to work again for a while?" We all believed I would soon be too sick to work.

What change in the atmosphere of psychoanalysis suddenly permitted these four publications and the general interest that followed? Were we following the example of the confessional poets and published diarists? Did the near-panic over the emergence of HIV necessitate open acknowledgment of the analyst's mortality; and did AIDS become the lightning rod of most dreaded disease, making cancer less dire! Did the Kernberg-Kohut debates shift psychoanalysis toward a more mutually empathic endeavor?

And why did my patients choose to stay with me? The late David Feinsilver, my long-time friend and Lodge colleague, struggled with metastatic colon cancer. He presented the 1997 Frieda Fromm-Reichmann lecture, discussing aspects of his then current clinical work. His patients, too, were informed and stayed with him. Likewise, Barbara Cristy, who has spoken on working while struggling with severe multiple sclerosis, maintains a thriving practice. Do our patients stay out of loyalty or to avoid beginning with someone new? Do they dread magical retaliation for abandoning someone in distress? Perhaps our patients stay because they think, "Good. Now she is no longer just the doctor, the one with authority. Now we both are sick together. It isn't just me putting anxiety into the atmosphere. Maybe finally we can help each other." This "we" is not merely the two of us, but each of us as transference figures for the other. Mom or Dad is hurting, and my presence can finally be clearly comforting; I'm not just the one causing them pain.

My patients' response runs counter to the general response of shying away from those who may be dying (as Leo Tolstoy's novella *The Death of Ivan Ilych* reminds us). Perhaps as communal animals we are hard wired, for self-preservation, to abandon a weakened members of the group, reacting as if they will attract predators. We tend to avoid our sick and dying colleagues or neighbors or friends or family members. Suddenly, we are too busy with the issues of successful living: earning money, and tending to home and family.

Considering the roots of this avoidant pattern, I see that we send our children a complex message when we simply tell them to cover their mouths when they sneeze, to wash their hands before meals and after using the bathroom, and not to look at a disabled people, explaining that they don't like to be stared at. These rules of hygiene and behavior form

the larger patterns in which we wash our hands of and avert our gaze from the sick or dying. We dread contamination; we feel deeply confused by our avoidance, experiencing an intense clash of guilt and recititude of having earned both punishment and praise.

When I read Harvey Schwartz's 1987 article on the impact of his illness on his analytic work, I contacted him to see if we might co-edit a book on this topic. International Universities Press published our book, *Illness in the Analyst: Implications for the Treatment Relationship*, in 1990, which set a model for other books on this topic. We considered a second volume, to include not only other physical illnesses, but mental illnesses as well, and articles not only by the doctors but by patients whose analysts have been ill. Ultimately, companion pieces could delineate the truths as seen by participants on both sides of the process. I would be interested in learning of potential contributors.

Intriguingly, in the various contributions to *Illness in the Analyst*, a gendered difference emerged. Women discussed their open acknowledgement of their situations and delineated the positive as well as destructive aspects of their patients' responses. Men tended to emphasize technical considerations and the need for anonymity. Because the meeting at which I presented this article focused on women and psychoanalysis, I develop this theme and its historical aspects. I believe that we are undergoing a powerful paradigm shift (Kuhn, 1970), moving from a centuries-long era in which combatant war was considered inevitable, in which boys were raised to be soldiers and girls to be mothers who raised future soldiers and mothers. The pyramidal structure of all institutions echoed that of the army. Debates over the territory of ideas, of scientific advances, were formulated as battle fronts. Freud's delineation of the human mind, with its defenses and inner conflicts, illustrates this pattern. World War II confirmed his pessimism. Even his refuted notions of activity as masculine and passivity as feminine echo a culture that barred women from educational advancement. Women were over-protected in their role of caring for home and young, sheltered from the harsh supposed realities of a cruel and combative male society. Not until 1908 could women enter German universities.

In the United States in the era of world wars and the Korean War, men were drafted, and the evening news was filled with casualty statistics. Boys played war games: cowboys and Indians, cops and robbers, allies and enemies. They were brought up to be the "strong silent type," and not to cry or be sissies. Women did not yet wear slacks and wouldn't until the birth of the National Organization for Women in 1972. The culture idealized the stay-at-home mom who managed the home and was allowed to cry. The kids depended on her, and she depended on her man.

The fundamental confusion between the ejaculating phallus and the discharging gun or canon, and the supposed petulant envy by women for lacking both sorts of equipment, bedeviled our profession until the 1970s.

Now, roles are more flexible, more blended. Men urge each other to have emotions other than anger. Women urge each other to lead. In this era of relative peace, we value tenderness and maternity, autonomy and assertiveness, in both men and women. The ideal analyst, rather than the strong silent type, is more empathic, more "classically" maternal. Countertransference is a clinical tool, not something we guard against. Perhaps these historical transitions permitted exploration of the topic of illness in the analyst. We no longer needed to be strong and silent soldiers, dying quietly and thus with honor. Both women and men now seem more free from cultural bondage to the supposed facts of the inevitability of war and nationalism.

This paradigm shift has led to a rediscovery of the works of Sándor Ferenczi, sometimes referred to as "The Mother of Psychoanalysis." His friend and colleague Otto Rank, who introduced the concept of object relations in the 1920s and whose work inspired the Pulitzer Prize-winning work *The Denial of Death* by Ernest Becker, I believe will soon receive renewed attention as well. Ferenczi and Rank were among the analytic pioneers suffering ostracism. They wrote on the centrality of the mother-infant bond and its place in the analytic experience as the primary dependency in transference and countertransference. Each lost in their attempts to integrate into American psychoanalysis when they began training lay analysts, nearly all of them women, when women had enormous difficulty gaining a place in medical school classes.

Intriguingly, Ferenczi wrote much of his now-famous *Clinical Diary* (Dupont, 1988) while he was both treating patients and grappling with not yet diagnosed pernicious anemia. Clara Thompson, the first president of the Washington Psychoanalytic Society and the longtime head of the William Alanson White Institute in New York City, was among them. Ferenczi began the diary in January 1932, and was diagnosed the following September, having suffered increasing fatigue. (Stanton, 1991) His final entry on October 2 is the only one in which he directly refers to the illness that killed him about eight months later. He begins by referring to Freud's abandoning him following his presentation of his best-remembered paper, "Confusion of tongues." Referring to Freud as the "higher power," Ferenczi begins:

Further regression to being dead. (Not yet being born is *the danger*. Is a new kind of solution to the personality problem possible after such *sinking* into the traumatic?)

In my case the blood-crisis arose when I realized that not only can I not rely on the protection of a "higher power" but *on the contrary* I shall be trampled under foot by this indifferent power as soon as I go my own way and not his.

The insight this experience has helped me to attain is that I was brave (and productive) only as long as I (unconsciously) relied for support on another power, that is, I had never really become "grown up." Scientific achievements, marriage, battles with formidable colleagues—all this was possible only under the protection of the idea that *in all circumstances* I can count on the father-surrogate. Are the "identification" with the higher power, the most sudden "formation of the superego," the support that once preserved me from final disintegration? Is the only possibility for my continued existence the renunciation of the largest part of one's own self, in order to carry out the will of that higher power to the end (as though it were my own)?

And now, just as I must build new red corpuscles, must I (if I can) create a new basis for my personality, if I have to abandon as false and untrustworthy the one I have had up to now? Is the choice here one between dying and "rearranging myself"—and this at the age of fifty-nine? On the other hand, is it worth it always to live the life (will) of another person—is such a life not almost death? Do I lose too much if I risk this life? *Chi lo sa?*

In his diary, Ferenczi details his experiment with mutual analysis, in which he and some of his patients (including Clara Thompson) reversed roles. He does not comment directly on his patients' responses to the real trauma of his own illness. Only on March 31, 1932 he does, slipping into passive voice, describe his own symptoms:

Two days in a row of only being analyzed: depressing feeling of having handed over the control, the reins. Disquieting idea that the patient has succeeded in escaping from analysis entirely, and in taking me into analysis instead. . . . Thus the customary superiority of the analyst became first mutuality, being on equal terms, then total subordination. In spite of this decision, no feeling of well-being, but in fact even symptoms: headache, sleep disturbances; the feeling of fatigue and sleepiness during analytic sessions, also during lengthy theater performances. A practical experience provided the solution. The patient's two-day abstinence made it impossible to delay her analysis any longer, and mutuality was again restored. (p. 73)

From the time of Ferenczi's article, the topics of mutuality and empathy have drawn intense criticism as psychoanalysis has fought for an identity as a science. My article was challenged by Richard Lasky (1990) and his discussant, Theodore Jacob, on these grounds. Lasky described me as resuming work with those patients who gratified my narcissistic needs (p. 162). He remarked on my "choice to cry with a patient over her illness" as if this were a planned decision, like deciding to water the

lawn. Jacobs (who criticized my work without having read my article) assumed it illustrated enactments.

My fundamental argument is that analysts who think they are effectively keeping their own precarious physical (and, by extension, mental) incapacities and uncertainties secret from the patients are operating with considerable denial. Denial, a primitive defense mechanism, keeps close company with projection and projective identification, all of which are weighty baggage as we try to hover evenly. When we return to work knowing our survival is in jeopardy, and act as if nothing out of the usual has happened, that very "as-if-ness" removes us from our valid place as analyst, and creates a situation in which we, the analysts, are relying on splitting and related borderline defense mechanisms. These are the fundamental conditions for enactment.

A highly esteemed classical analyst and close friend of mine kept working while he knew he was dying of metastatic cancer unresponsive to chemotherapy. Some of his colleagues, myself included, knew of his plight and his wish that the information remain confidential. Each time I arrived at his office door, he reminded me of Eduard Munch's "The Scream." After that instant, once he realized he was not alone, he reflexively assumed a look of bland neutrality, or pleasure at greeting me. His patients, too, must have seen this look of terror. I thought, from his presentations of the ongoing clinical work, that his patients were unconsciously but absolutely aware of the situation. By their specific regressive actions they seemed to try desperately to get the situation out in the open, or to have their own efforts on his behalf somehow acknowledged. I regret I never confronted him, telling him his secretiveness was not effective.

Jacobs' point of attack, however, is at the center of the debate: if we make explicit to our patients something they probably already sense, that we are in personal distress, are we thereby abusing, harming, cheating them? Is this disclosure an enactment? We then enter the realm of attitudes, not only about proper analytic technique of activity and passivity, but also about doctoring and patienthood, analyzability of the patient, and credentialing of the analyst, and by extension parenthood and childhood, masculinity and femininity, strength and weakness.

As I explored the literature on enactments, I was fascinated to learn from McLaughlin (1991) that,

Although the word enactment has surely been in our analytic vocabulary and use for a long time, it does not appear in the subject index of the Standard Edition of Freud's works or in Fenichel's compendium. Guttman's Concordance has only one citation [in which the word does not carry its current

meaning]. I could not find the word as a primary entry in the indexes of three [major analytic] journals up to and including 1986. This nonfinding tallies with Mosher's larger sweep of five periodicals from 1920 to 1986. The single title reference to enactment was to Jacobs (1986). (p. 596)

I especially liked McLaughlin's definition of analytic enactment: "to refer to events occurring within the dyad that both parties experience as being the consequence of behavior in the other. It is obvious that the sources in the analyst of his needs to enact, i.e., to retreat from or assert some pressure on the patient, can come from any combination of dumb, hard, or blind spots, touched by the contributions of the patient" (p. 600). Enactments thus exemplify projective identification. In contrast, I am referring to situations filled with the potential for mutual blaming, in which neither patients nor I regressed into this defense. Turning then to Jacobs' article on enactment, I found a work that, rather than authoritarian or prescriptive, gave cogent examples of the subtle enactments that infuse our daily work and give it meaning to the extent to which we are alert to them and value them. This reiterates the essence of Searles' (1975) article, "The patient as therapist to his analyst," which like most of his articles emphasizes the principle that our countertransference responses are our most powerful instruments of treatment, and that effective treatment benefits both patient and therapist. The therapist's resistance to change blocks growth in both parties.

All this is background for my position statement that the analyst can validly disclose to the patient her circumstance of patienthood as she confronts her mortality. The analyst cannot, however, desperately draft her patients to serve as if family members or friends or colleagues. When we pretend to spare our patients direct knowledge of these grim realities, we are like the wizard in L. Frank Baum's *The Wizard of Oz*, hiding behind our own blank screen, dreading Dorothy's discovering us and saying "But you are just a little old man!" By hiding, we cling to an *illusion* of an oedipal scenario in which the young are forever yearning to mate with the parent of the opposite sex, rather than leaving the older jilted or parented and looked after by the now competent adult children.

In reifying the oedipal phase, mentally converting it into a thing, we have erroneously pushed aside the earlier developmental phases and obscured a more basic relationship of parent and child. As Ferenczi taught, as we analyze our adult patients, we mistake the child's language of tenderness for the adult's language of passion (Ferenczi, 1931). We thereby avoid our patients' expressions of tenderness and of primary rage over imminent abandonment. We seem to dread the possibility of mu-

tuality in the analytic relationship, as if such an admission inevitably invites erotization of transference and countertransference. Do we maintain our privacy fundamentally to protect our private parts, seeing our patients as predators who will pounce on us sexually once we announce our weakened condition? To me, these dangers are in proportion to the analyst's denial of his or her yearning for tenderness. Ferenczi (1933) notes, "A great part of the repressed criticism felt by our patients is directed towards what might be called *professional hypocrisy*. . . . It is remarkable that . . . renunciation of the 'professional hypocrisy'—a hypocrisy hitherto regarded as unavoidable—instead of hurting the patient, led to a marked easing off in his condition" (pp. 158–59). He goes on, "The setting free of his critical feelings, the willingness on our part to admit our mistakes and the honest endeavour to avoid them in the future, all these go to create in the patient a confidence in the analyst. *It is this confidence that establishes the contrast between the present and the unbearable traumatogenic past . . .*" (1933, p. 160).

Illness makes the analyst no longer simply the observer of life's shifting patterns but an integral part, an emotional player, in clinical work. The kaleidoscope rotates and abruptly the scene changes, though still made of the same components. Suddenly or gradually, the analyst is different, lonely, in an individual struggle for survival. This is neither an enactment (which by definition refers to repetitious action echoing from childhood trauma) nor is it necessarily a reason to stop the analysis. Although many analysts do come to a decision to retire when they are severely ill, this is not the only right choice.

I am grateful to Zvi Lothane for calling my attention to an article he co-authored, paying tribute to Otto Isakower, "On the analyzing instrument" (Balter, Lothane, and Spencer, 1980). The authors quote unpublished remarks by Isakower (who, parenthetically, introduced the term "evenly-hovering"):

In describing the analyzing instrument, it is useful not to think of it as a permanently integrated, unitary system within the psychic structure of one person, the analyst. It seems more adequate to regard it, in its activated state, as being in rapport with its counterpart in the patient; or, better perhaps, to see it as a composite consisting of two complementary halves. It will be remembered that in Freud's description both halves function together as one unit, in continuous communication. The analyzing instrument represents a constellation of the psychic apparatus in which its constituent structures are tuned in a way that makes the apparatus optimally suited for functioning in a very specific manner. An essential characteristic is the unique and specific setting-in-relation to a near-identical or analogous constellation in a second

person. It represents an *ad hoc* assembly for a special task and it is of a transitory nature. Balter et. al., 1980, p. 475)

The analytic instrument is formed by the souls of two people analytically engaged. When the analyst is enduring profound uncertainty regarding physical health and survival, this instrument still functions but now produces melodies with a crackling dissonance—electric and modern—a deconstruction of routine tonalities. All defenses against anxiety ultimately develop to distract us from our knowledge that we each will die. We must differentiate analytic enactment from a change in the analyst that actively redirects the attention of patient and analyst. We should try shifting our standard of excellence from that of patriarchy, with its wise and strong leader, to a female-oriented model of the mother with young children. While the ideal military leader who has lost his equanimity cannot be trusted to lead his troupes into battle, a mother in anguish draws a different response. The military man would be reassigned and his career diminished or destroyed, but we would not recommend the mother's children be put in foster care because she is frightened, worried, and preoccupied.

When illness strikes us, we become actors in the drama of the patient's life, and they in ours, but this is not thereby enactment. Telling the patient is an active decision; *not* telling the patient is active as well. I believe we should not try to assess what a particular patient can handle. I find this as problematic as deciding who has the strength to endure analysis, and who is too weak. To the extent that we stand in judgment of them, we may find that in our times of need, we harshly judge ourselves to our own and our patients' detriment.

Finally, I will close with some practical suggestions. I would like to see institutes deal directly with the issue of illness in the analyst. I imagine three changes in our curriculum. (1) Perhaps we could introduce a procedure analogous to a fire drill in which midway through a continuing case presentation someone from the curriculum committee would call the presenter with the instruction to announce descriptors of a medical calamity: heart attack, cancer, infection. The class would discuss dealing with this crisis in the context of that particular treatment. (2) Later in the curriculum, in course work on termination, some of the articles on illness in the analyst could be read and discussed. (3) These discussions might encourage more formal planning for the inevitable events of our illnesses and deaths. We should periodically exchange a list of the initials of our patients, along with phone numbers and perhaps a suggestion for an interim or second therapist, with the person who takes call for us when we are away for fun or meetings.

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