Chapter 19
Wholeheartedness in the Treatment of Shared Trauma: Special Considerations During the COVID-19 Pandemic

Jill Zalayet

Introduction

I left my office on Thursday evening, March 12, 2020. Before crossing the threshold of my doorway, I stopped and took a long pause. Normally, I am rushing to leave at the end of my work day, trying to catch my train home, which only leaves twice each hour. On this evening, though, I felt the need to take in the contents of my office, the chair that I sit on, the couch that my patients sit or lay down on, the art on my walls, and the papers on my desk. I stood there for several minutes before turning off the light and closing the door. While it was not clear at that time how long I would be away from my professional home – the safe and cherished space where I see my patients – I had a visceral sense that it would be some time before I returned.

In the weeks leading up to this evening, news about the virus had been circulating. I supervise psychotherapy students in China over Zoom and had been aware of COVID-19 for several months and the impact that it was having there. People in my neighborhood had begun stocking up on cleaning supplies and dry foods, anticipating shortages. A highly charged debate about closing school buildings was brewing as stay-at-home orders were being issued in New York City. Many people were beginning to anticipate separation and loss, but it was not until that evening when I left my office that the magnitude of the loss began to set in and become real, the loss of the shared physical space with my patients.

Like many of my colleagues, I was tasked with rapidly transitioning to a telehealth platform from home, attempting to provide a holding environment (Winnicott 1960) for my patients in a climate wrought with tremendous uncertainty. As a clinician, in any environment, self-awareness, reflection, and insight into one’s areas of vulnerability are necessary, as a means of informing and mitigating
countertransference responses. However, in the context of this shared and unprecedented environment, my ability to discern and decipher my own blind spots and fears has been even more essential in order to provide the holding function that my patients desperately need. How do I manage the relational “disconnect” of not being with my patients physically, maintaining attunement, while also managing countertransference reactions that are inherent to navigating a shared trauma? In an effort to provide for my patients as well as for myself, I have found myself leaning into the work of Karen Horney, a formidable psychoanalyst and Neo-Freudian, whose theory and ideas have provided the holding and maternal function that I have so deeply needed during this uncertain time in our country and in our world. I am grateful for this space to share some of my thoughts and reflections related to Horney’s concepts of wholeheartedness and basic anxiety, as they relate to the vicissitudes of shared trauma (Saakvitne 2002; Altman and Davies 2002; Tosone et al. 2003).

Karen Horney’s relational theory and constructs have served as a guidepost throughout my psychoanalytic training and practice. Horney (1937) privileged the individual’s cultural environment in psychotherapy and believed that we cannot wholly understand another person’s plight and help relieve suffering unless we understand and attend to the full range of an individual’s environmental and cultural variables. This perspective was pioneering for her time as she dared to challenge drive theory, which largely disregarded environmental factors. Further, we are not blank slates as Freud contended, and we now understand how pivotal the relationship between the therapist and patient is in the effectiveness of the treatment. (Altman 1994). My focus and attention to Horney’s work in my doctoral studies have been an attempt to revitalize a groundbreaking theory within the social work community as I believe her theory and constructs to be as applicable today as they were over 100 years ago. Understanding the significance of historical trauma as well as the impact that environmental, social, and cultural factors have on an individual’s development is vital to understanding the whole person. Early trauma impacts an individual’s defensive structure. Recognizing the dynamic underpinnings connected to early trauma is essential to being able to respond to current trauma in a way that allows for greater insight, providing the opportunity for growth in the face of heightened anxiety and insecurity. The unfortunate and devastating impact of COVID-19 has served to further augment the relevance of Horney’s concepts of basic anxiety and wholeheartedness.

Wholeheartedness and Basic Anxiety

Defining wholeheartedness has proven to be a somewhat difficult and elusive project that I have grappled with. As it turns out, so have many before me. Ultimately, what I have come to understand is that wholeheartedness is experiential; you can only fully understand it by having the experience of being with a wholehearted other. There are many clinical concepts that share some similar aspects with wholeheartedness such as attunement (Stern 1985; Beebe and Lachman 2002), the
working alliance (Greenson 1965), genuineness/congruence (Rogers 1957), and empathic immersion (Kohut 1984). What I have sought to discern over the last several years in my doctoral studies is, what is unique and distinctive to wholeheartedness? What personal attributes of the therapist are important for the patient to feel safe and understood? Patients are better able to access their own constructive forces via their relationship with a therapist who has worked through their own inner conflicts and is able to draw upon all aspects of themselves and their emotions as a result. Cantor’s (1959) paper, “The Quality of the Analyst’s Attention,” based on various lectures Horney gave on technique before she died, states:

The whole-hearted aspect of the analyst’s attention involves observing with all one’s capacities and faculties. Here we are listening, seeing, and feeling with our intuition, undivided interest, reason, curiosity, and specialized knowledge. This knowledge involves awareness of our own selves, generalized professional knowledge and experience, and all that we are aware of in the particular patient. We are focusing ourselves as fully as we can on all the patient’s communications, verbal and non-verbal. It is the faculty of not being distracted, either by our own deeper problems or by situations which have upset us acutely. (p. 28).

How is one able to achieve this therapeutic state of wholeheartedness? As stated, we cannot always be wholehearted as we have our own blockages and countertransference. Wholeheartedness is a therapeutic ideal. Safran (2002) describes the attitude of openness and receptivity on the part of the therapist as being an idealized state and discusses the importance of the therapists’ ongoing and intuitive assessment of his/her own impact and countertransference in the therapeutic relationship. He explains that as humans we inevitably have desires, goals, and expectations and that “The task is not to rid ourselves of them, but to strive to the best of our ability to become aware of the impact they are having on the way we relate to the present moment in an ongoing fashion” (p. 237). What is essential is the therapists’ unwavering attention and commitment to understanding his/her own personal variables and inner conflicts as well as being continually mindful of times when we are unable to be wholehearted so that we may redirect ourselves. It is the therapist’s continual striving to be a “whole” presence when working with deeply traumatized people that embodies wholeheartedness.

Wholeheartedness is embedded in Horney’s concept of basic anxiety. She describes basic anxiety as the child’s experience of feeling alone and helpless in a potentially hostile world (Horney 1945). The infant is innocent, brought into the world with the potential for a full development. Horney (1950) describes the real self as the nucleus of one’s potential, explaining that it is the “alive, unique, personal center of ourselves” (p. 155). When trauma occurs, that potential and those early aspects get disregarded, and the demands of the environment become the focus. Horney describes how the person’s development under these circumstances becomes driven by the need to avoid or lessen basic anxiety so as not to feel alone and helpless in a hostile world. When the early environment is particularly inconsistent and/or abusive and neglectful, defensive solutions often become compulsive. Horney (1945) explains that the child will often split off from aspects of their real self, what she terms alienation, in an attempt to find safety. However, this sense of safety is precarious because it is not based upon shoring up the array of internal resources
and agency but rather it is based upon a shaky defensive system. This splitting off lends itself to the significance of wholeheartedness, as the child’s development is impacted and fractured. Gaining more access to the real self is one of the goals of treatment; alienation from the real self is viewed by Horney as a “psychic death” (p. 185). Psychotherapy becomes focused on healing these splits in the individual. The word heal means to make whole (“Heal,” 2020).

There are three defensive and unconscious solutions that Horney (1937) put forth. These solutions are utilized to circumvent and bind their experience of vulnerability and helplessness. They are moving toward (compliance), moving against (aggression), and a moving away (detached) solution. A compliant child is generally self-effacing and works hard to please and appease their caretaker(s); this child is most afraid of being alone. The moving against child feels that she/he needs to fight in order to be seen and heard and get what she/he needs. The moving away child is a more resigned child. Having attempted to move toward and move against, she/he learns that neither solution will allow them to get their needs met and so she/he detaches; hostility from friction with others increases this child’s basic anxiety. People cope with feeling unsafe, unloved, and undervalued by compulsively moving toward, against, and away from others. When the early environment is consistently unresponsive, the child feels particularly vulnerable, and he or she may adopt one mode of relating (one specific solution), more compulsively, and is usually to the exclusion of the other two solutions. In other words, the defenses that one uses to circumvent anxiety can become so rigid and compulsive that they interfere with the whole development of the individual. One of the goals of treatment is to help the individual utilize a less rigid, less compulsive solution, moving more fluidly among all three solutions as the current circumstances require.

**Horney’s Concepts and COVID-19**

Horney’s concepts and ideas are particularly vital and relevant now during the COVID-19 pandemic, as we are all experiencing the uncertainty and vulnerability of living in an unsafe world. The basic anxiety of feeling alone in a hostile world is being re-experienced by both patient and therapist – a shared trauma. How do we navigate this shared experience, helping our patients cope while managing our own reactions and responses? Horney (1945) shares with us that “Nobody divided within himself can be wholly sincere” (p. 163). In order to be able to provide for our patients, we need to be deeply reflective and introspective with regard to our own personal variables, well examined, in order to understand the ways in which we, too, are porous to responding to the current trauma and our own defensive structure and triggers.

The uncertainty in our current environment has thrust many patients back to the familiar experience of helplessness and vulnerability. Older defensive solutions are being utilized, often compulsively, in the face of tremendous insecurity. Many of my patients have questioned their reactions and anxieties related to the environmental
unrest, feeling that they are regressing and not handling their personal variables in a more constructive way. Some have shared feeling that the progress they have made and the flexibility they feel they have developed with regard to negotiating and managing their anxiety are at risk. Normalizing these feelings and reactions is critical. Basic anxiety helps us to understand the vulnerability that so many of our patients are re-experiencing. The current culture of social distancing lends itself to isolation, which for many patients is only serving to perpetuate and affirm their early experience of feeling alone and vulnerable in a hostile world. Deeply entrenched defensive solutions developed early on to mitigate helplessness have resurfaced in the face of this unprecedented environment, leaving many patients feeling particularly vulnerable and unsafe.

Helping patients understand that they do not have to be alone with their thoughts and fears is essential. Often as clinicians, we seek to cure or fix our patients’ pain and distress. We cannot fix the unimaginable pain and suffering that are taking place in the world and in our patients’ lives as a byproduct of the public health crisis and social/political climate we are navigating. In fact, affirming our patients’ subjective realities is essential. Their fears and anxieties are not all based in neurotic underpinnings – rather, they are based in the reality of the world in which we are living. What we can do is serve as a witness. As a wholehearted other, we can provide a safe and constructive space where the reality of the current environment and patients’ lived experiences are processed, while slowly deciphering derivatives and defenses from earlier traumas that may now be impacting current coping. As stated, wholeheartedness is a process of healing splits, the parts of oneself that were split off from early on, in the service of binding basic anxiety. It is a commitment to helping patients reconnect with their “whole” self and more of their capacity as a means of helping them to experience a deeper sense of their own agency. The therapist serves as a container and holds the patient in mind, an experience which is often unique for a person who was not acknowledged by their earliest caretaker(s) (Horney 1946). Through this process we can help transmute feelings of helplessness into a lived experience in which there exists greater possibility, hope, and meaning.

Toward the end of her life, Horney became interested in the principles of Zen Buddhism and the writings of Daisetz T. Suzuki (DeMartino 1991), further developing her concept of wholeheartedness and the idea of being able to operate with all of one’s faculties while remaining “oblivious to oneself” (Vida and Molad 2004, p. 338). Vida and Molad (2004) share that wholeheartedness is a concept that is very difficult to grasp because it is connected to having the “highest presence and the highest absence” (Horney 1987, p. 34 in Vida and Molad 2004). The idea of absence in this context is not suggestive of the therapist’s avoidance; rather, it is the Zen state of being completely present via a “self-less self” (DeMartino 1991, p. 277). It is only through deep, ongoing introspection and examination of our own inner lives that we can attempt to achieve such wholehearted moments. If as clinicians we are split and divided ourselves, we cannot serve as containers for the full range of our patients’ feelings and projections.
Final Thoughts

I have been back to my office once, since leaving in March, to gather a few things that I have needed. Standing once again in my space, alone, mask and surgical gloves on, it felt as if time had stood still. Everything was exactly where I left it, and yet everything had changed. Patients have asked me when and even “if” I will return to my office. I want nothing more than to be with my patients again, to return to the physical space that we seemingly lost overnight. Many of my patients have asked questions about my health, my overall well-being, as well as my plans regarding my practice and my office. At a previous time, I would have likely explored these questions for deeper meanings. Now, however, I feel the need to respond to these types of inquiries more directly. We have all been destabilized by the state of the world and the many real-life issues that we are attempting to negotiate. My patients need to know that I am able to be with them completely. Providing a safe space to authentically address their concerns and provide a mirror in which their fears are affirmed and not pathologized is my commitment to them. Safety in the therapeutic relationship is about attending to the well-being of the whole person, in every way that is needed, and that is what I will continue to strive to provide. For the time being, we all have to live with uncertainty. While we cannot forecast or know exactly what the future will look like, we can retain hope for better days ahead. For many of my patients, I am holding this hope for them, and I feel privileged to be able to provide this function.

References

Altman, N. (1994). A perspective on child psychoanalysis 1994: The recognition of relational theory and technique in child treatment. Psychoanalytic Psychology, 11(3), 383–395.
Altman, N., & Davies, J. M. (2002). Out of the blue: Reflections on shared trauma. Psychoanalytic Dialogues, 12(3), 359–360.
Beebe, B., & Lachman. (2002). Infancy research and adult treatment. Hillsdale: The Analytic Press.
Cantor, M. B. (1959). The quality of the analyst’s attention. The American Journal of Psychoanalysis, 19(1), 28–32.
DeMartino, R. J. (1991). Karen Horney, Daisetz T. Suzuki, and Zen Buddhism. The American Journal of Psychoanalysis, 51, 267–283.
Greenson, R. R. (1965). The working alliance and the transference neurosis. The Psychoanalytic Quarterly, 34, 155–181.
Heal. (2020). In Merriam-Webster.com dictionary. Retrieved July 19, 2020, from https://www.merriam-webster.com/dictionary/heal
Horney, K. (1937). The neurotic personality of our time. New York: W.W. Norton & Company.
Horney, K. (1945). Our inner conflicts. New York: W.W. Norton.
Horney, K. (1946). What does the analyst do? In K. Horney (Ed.), Are you considering psychoanalysis? New York: W.W. Norton.
Horney, K. (1950). Neurosis and human growth. New York: W.W. Norton.
Horney, K. (1987). Final lectures. New York: W.W. Norton.
Kohut, H. (1984). Chapter 6: The curative effect of analysis: The self psychological reassessment of the therapeutic. In A. Goldberg (Ed.), *How does analysis cure?* (pp. 300–307). Chicago: University of Chicago Press.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Counseling Psychology, 21*, 95–103.

Saakvitne, K. W. (2002). Shared trauma: The therapist’s increased vulnerability. *Psychoanalytic Dialogues, 12*(3), 443–449.

Safran, J. D. (2002). Reply to commentaries. *Psychoanalytic Dialogues, 12*(2), 235–258.

Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.

Tosone, C., et al. (2003). Shared trauma: Group reflections on the September 11th disaster. *Psychoanalytic Social Work, 10*(1), 57–77.

Vida, J. E., & Molad, G. J. (2004). The Ferenzian dialogue: Psychoanalysis as a way of life. *Free Associations, 11*(3), 338–352.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *International Journal of Psycho-Analysis, 41*, 585–595.