Working with the Second Generation of Holocaust Survivors

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There is a wealth of literature on the psychological after-effects on Holocaust survivors as seen from a psychoanalytic or psychodynamic approach. It provides substantive evidence that some psychoanalysts are unable to deal with Holocaust-related material, and that there have been many therapeutic failures with those survivors and children of survivors who have sought psychoanalytic psychotherapy. Criticisms centre around the failure of the therapist to adapt or modify their approach to the client. There are also reports of offspring feeling critically assaulted by their therapist in ways that they have experienced from their parents.

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Interpretations have been seen as punitive weapons. In addition, evidence suggests that tolerating the rigours of the classical psychoanalytic approach, particularly regarding the anonymity of the therapist, has been especially difficult.

There is a distinct absence of humanistic research and clinical writing on the subject. This may be explained by the fact that the view of humanistic psychotherapies as academic and clinical entities in their own right is comparatively recent. Research was therefore conducted in London in 1997 to ascertain whether humanistic psychotherapists were working with the offspring of Holocaust survivors (known as the second generation); whether, in that case, they had an understanding and awareness of the complexities of the work; and what training, if any, was necessary. Over 100 humanistic, integrative and psychodynamic psychotherapists in North London were surveyed. This area was chosen because the number of Jewish people living there maximised the possibility of second-generation clients presenting for therapy.

The findings of the research were that a few therapists did not know whether they were working with the second generation, but that 46% of those surveyed had worked with or were working with a client or clients in this group. These psychotherapists were found to have awareness of many issues of the after-effects of the Holocaust on the second generation, but also some lack of a deeper understanding of issues specifically related to this group of clients. The research showed that they were unaware of the group's cultural needs for continuity and identity, as a result of their parents' losses. Another important omission was the problem of intergenerational transmission of trauma, which has been studied and written about at length in relation to the children of Holocaust survivors. (I shall explain this phenomenon more fully below.) The findings further showed that therapists were not aware of the ways in which Holocaust trauma-related work could affect both themselves and the therapeutic process — of the countertransference reactions that are a part of such work. The research report therefore recommended specific training.

Cultural and identity problems: linking the parents' past to the client

An entire East European Jewish way of life was destroyed during the Holocaust, leaving a severed link in the chain of continuity for the children of survivors. Identity confusion, understandably, often features in therapeutic work with this second generation. A background of Eastern European Jewish culture is always an important consideration to explore with a client, as they are likely to have been brought up with conflicting values and traditions, caught between their parents' culture and that of the host country.

Therapists may have difficulty helping their clients confront issues of Jewish identity. Questions of self-definition, or of Jewish culture, such as faith in God, or involvement in organised religion, or intermarriage (which is an issue of cultural extinction) are particularly painful for both survivors and the second generation to work through. Some clinicians feel that even the basic unconscious motiva-

tion for children to identify with their parents' Jewishness is problematic, as it so often arouses feelings of pain and confusion. Children link Jewish identity to their parents' victimisation, which adds to any existing feeling they may have of 'not belonging'. On the one hand, being Jewish is what caused the problems in the first place; on the other, belonging to an identifiable group is essential for a personal sense of identity.

Where there is a gap in one's past there is discontinuity and disconnection. This is exacerbated when therapists themselves have unresolved conflicts and blind spots about their own Jewish or non-Jewish identity

A potential weakness of the humanistic approach with this client group lies in exploring only the here-and-now of social influences, while ignoring the link with parental trauma. Enabling clients to make the link with their parents' traumatic experiences requires an exploration of their parents' past as well as their own.

Parents' unresolved losses

An aspect of the training should be to encourage therapists to try to understand as much as possible about the parental background, in order to understand how a client's parenting was affected, and what was transmitted to the child as a result of the parents' unresolved traumata. To understand the effects of survivor parenting on the second generation it is now widely believed that it is essential for therapists to have a knowledge of the survivor parents' pre-Holocaust context, their traumatic experiences during the Holocaust and their experiences following liberation, as refugees. This knowledge gives an understanding of the Holocaust as an historic, genocidal and cultural trauma for the Jewish people. At least one writer stresses that such knowledge is an absolute requirement for all post-Holocaust therapists.

Multiple losses under extreme circumstances were severe and overwhelming for Holocaust survivors: family, community, culture, identity, language, home and possessions, country, childhood or youth, education, jobs, trust in humanity and beliefs about goodness, and, in survivor mothers, the sense that they could not protect their children under any circumstances.

There is a paradox that complicates the lives of survivors and their children. The parents cannot mourn, yet are continuously preoccupied with the dead. This preoccupation profoundly affects their ability to be emotionally available to their living children. One child in the family may therefore grieve on behalf of their parents. The child who is thus designated is known as a 'memorial candle' (memorial candles are lit on the anniversary of a person's death to keep their memory alive). In addition, mental health professionals stress the intensity of survivors' expectations of their children. Throughout their childhood, the second generation have been exposed to their parents' painful moods.

Most studies from the 1960s–1980s suggest that it is the genocidal context that impairs the survivors' capacity for parental functioning. Children are seen as replacements for their parents' numerous losses, while also expected to give meaning to their parents' lives. These are the kinds of issues that lead to the parents' trauma being transmitted to the second generation.

Intergenerational transmission of trauma

A chapter in *Primate Behaviour* describing the instinctual transmission of trauma in primates illustrates how the intensity of collective trauma may also be transmitted in humans. 'In the Nairobi Park there are many groups of baboons that are accustomed to cars. A parasitologist shot two of these baboons from a car and eight months later it was still impossible to approach the group in a car. It is most unlikely that even a majority of the animals saw what happened and the behaviour of the group was based on the fear of a few individuals. It is highly adaptive for animals to learn what to fear without having to experience events directly themselves.'

In Auschwitz Jews must have believed that every Jew was going to be annihilated. How could this death threat not be passed through every survivor to the Jewish people in general, and to their children in particular? There is strong evidence from the literature to support a theory of intergenerational transmission of trauma. Although the mechanisms are not agreed upon, there are nevertheless many hypotheses that try to explain the phenomenon. Some clinicians believe that children take upon themselves the mental conflicts belonging to the reality of their parents. They may even manifest similar symptoms to those of parents still suffering from the effects of massive psychic traumata. In extreme examples the children live as if in two realities: their own present lives, and their parents' past, Nazi horrors. Some children have recurring Holocaust-related nightmares. Others act as if they are the dead sibling whom they have been named after, whilst at the same time suffering the guilt of rage towards parents who cannot recognise their separate, real identity. Many feel that their own problems are minimised, shunned or ignored, because nothing they themselves suffer can compare to the magnitude of their parents' experiences; they can only feel helpless, and guilty for it.

From a humanistic approach, the second generation's need to live in their parent's past and to change it is purposeful. Their purpose is perhaps to transform their parents' humiliations, shame and guilt into victory over the Nazis, thus undoing the threat of genocide and resurrecting those who died.

Research into intergenerational transmission of trauma is problematic because of the complexity and number of demographic and biographical variables involved. The phenomenon has been so extensively documented, however, that it does require exploration where appropriate. Nevertheless it is important to avoid simplistic generalisation. Holocaust survivors and their offspring are a heterogeneous group of unique individuals. Whilst there is undoubtedly some impact on family members, these may not be psychopathological, and all influences need to be assessed. Parental traumatisation is not the only significant aspect. Factors relating to the child determine the character and intensity of intergenerational transmission: the child's own character, birth order, whom they were named after, their relationship to their parents and the intra-gender and inter-gender parent-child relationship, as well as the child's psychological strengths.

Implications for the therapist

In order to protect their children, parents may not have spoken at home about their experiences at all. Conversely, they may have spoken too much, and at a stage in their children's lives when it was impossible for the children to cope with such knowledge. If there has been a denial and a 'conspiracy of silence', this can be repeated within the psychotherapeutic relationship. Second-generation clients may thus present with problems that are not related to their parents' Holocaust past. If they avoid the subject or deflect the therapist away from such material, and the therapist is unaware of colluding, empathy for the client is temporarily lost. If the collusion continues, the loss of empathy can cause a breakdown in the therapeutic alliance and a failure of therapy.

Countertransference reactions by the therapist

In the 1997 London research one therapist realised that she was working with a second generation only after she received the questionnaire. Her experience is not uncommon. A large-scale study was carried out in the USA in the 1970s. Three hundred questionnaires were sent to psychoanalytic psychotherapists in several countries who were working with the children of Holocaust survivors. The conclusion reached was that the psychoanalysts, like the children of survivors themselves, resisted uncovering the frightening impact of Nazi persecution. Many of them showed an amazing indifference and had never linked their patients' dynamics to the history of their parents' persecutions.

Other studies of therapeutic failures show two polarised tendencies: either a persistent emphasis by the mental health worker on the role of the Shoah (the Hebrew term for the Holocaust), or else a total ignoring of that role. My own personal experiences in two therapies illustrates an over-identification by one therapist and a denial reaction by another. In the early 1980s when I began my counselling training, I was aware that I needed to speak about the loss of my own family in a Holocaust-related context. The need to speak was strong, but the actual speaking filled me with dread and shame, as well as fear. These feelings had undoubtedly been transmitted to me by my mother, who never spoke about the murder of her entire family in Auschwitz.

My first therapist was non-Jewish, and when I finally spoke the dreaded words, she wept. She then apologised, and told me that she felt distress and guilt. I understand now that she was being both authentic and transparent, but at the time her reaction confirmed to me precisely the painful guilt I would have feared had I mentioned the losses to my mother and seen *her* distress. At that stage of my therapy, however, I could not upset my therapist. She apologised again the following week. I knew I could not speak of the Holocaust again. She may have been relieved, because she did not raise it again either. Shortly afterwards I terminated therapy with her.

Later, I was in therapy with a Jewish therapist. I told him that I wanted to speak of the Shoah. His response was silence. I interpreted his silence as either a reluctance, or a fear of what might be raised. In my fantasy I believed that he too could

have Shoah-related suffering which he might not have worked through. Out of self-protection, I chose not to speak of it further. He never referred to the subject again, and so it is possible that my fantasy could have had some foundation. Therapy again terminated abruptly, without exploration of the unspoken issue between us.

There is a growing awareness emerging of the importance of therapists' attitudes, reactions and countertransference processes in the treatment of trauma and post-traumatic stress disorder (PTSD). Working with clients who have grown up with traumatised parents is distressing. The client may experience disequilibrium from their upbringing; the therapist from his/her efforts to sustain empathic atunement with the distressed client. Therapeutic success contains the sustaining of empathy for the client. If empathy is blocked by the therapist's countertransferences, this leads to a failure of empathy and a possible therapeutic failure. The client will either withdraw, mistrust the therapist or leave. Countertransference reactions are obstacles to successful psychotherapeutic treatment of trauma if they are not understood, recognised and worked with.

An American psychotherapist has listed no fewer than 49 countertransference reactions in mental health workers and therapists working with survivors and their families. Some of these are: loss of boundaries, psychic numbing or emotional constriction, depression, disdain towards the client, bystanders' guilt, dread, rage, shame, disgust and loathing, grief, inability to listen, viewing the client as victim or hero, conflicting feelings about the client's Jewish identity, stressing the death rather than the murder of lost relatives, feeling like a privileged voyeur, and clinging to a professional role. Some therapists, who were not themselves second generation, reported envying clients who were. Some even condemned clients for using their parents' suffering to claim special status.

Countertransference reactions are integral to therapy. They are ubiquitous and expected. Lack of awareness and understanding of countertransference interferes with the therapeutic process, preventing the acquisition of knowledge of the client's trauma and resulting in a lack of empathy.

Children of Holocaust survivors may already have an over-protective, guilt-ridden attitude towards their parents. Therapists should be warned not to identify with the parents' depressions and losses, and not to transmit more 'understanding' to the second-generation client. Some humanistic therapies ignore the presence of the countertransference. In the 1997 London research, there were therapists who stated that they did not 'feel troubled' by countertransference reactions. They believed that their therapeutic approach would cover all possibilities and steer them safely through any difficulties. However no one approach is more effective than any other, and it is not the approach that prevents the empathic failure of the therapist.

Supervision

Therapists who work with this client group need very supportive supervision. Supervisors also need to have an understanding and awareness of the problems related to extreme trauma. Studies on senior supervising psychotherapists have

shown that they too were frequently unable to tolerate the content of trauma-related material from their supervisees' clients. Some supervisors attempted to rationalise the client's emotions, and like Freud, suggested that memories of such events were primarily the product of fantasy, not reality. This attitude diminishes and disrespects both the client and the therapist.

Specific training needs

Specialised training is required for working with clients who have other specific issues: trauma, alcohol and other substance abuse, domestic violence, bereavement and eating disorders. Second-generation clients have been brought up in the shadow of the Holocaust, and have very particular issues. Therapists working with the children of Holocaust survivors, or indeed with any children of survivors of extreme trauma, are less effective if they do not understand the specific identity and cultural trauma issues of that client group. There are both collective and personal issues of identity and culture that figure when dealing with the massive psychic trauma of a group with whom the client identifies.

Training needs to include an understanding of PTSD, although there is more to working with survivors and their offspring than PTSD alone: multiple bereavement, relationship difficulties, identity confusion, and difficulties in separation and individuation. The work is stressful and difficult for both client and therapist, and working through therapists' countertransference difficulties is a major part of the training. Knowledge of the historic context of the Holocaust survivor parents' experiences also informs the therapist and forms a vital part of the process of working with the second generation.

Conclusion

The symptomatology for the second generation is still unresolved and is now transmitted to the third generation. The longevity of suffering and the after-effects of massive psychic trauma are thus perpetuated. Traumas that occur from human-caused events, as opposed to natural disasters, are experienced as more incomprehensible and difficult. The impacts of traumata on the children of victims in Bosnia and Rwanda are other examples. The Holocaust is a paradigm for the study of universal phenomena related to trauma.

Further reading

Martin S. Bergmann and Milton E. Jucovy (eds), *Generations of the Holocaust*, Columbia, 1982

Haim Dasberg, *Child Survivors of the Holocaust Reach Middle Age: Psychotherapy of late grief reactions*, Bar-Ilan University Press, 1992

Irven DeVore (ed), *Primate Behaviour*, Holt, Rinehart & Winston, 1965

Dina Wardi, *Memorial Candles: Children of the Holocaust*, Routledge, 1992

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