

Psychotherapy of Holocaust Survivors – Integration of Traumatic Experiences?

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ABSTRACT

The paper presents reflections on psychotherapy of Holocaust survivors based on nineteen years' experience in individual and group work. We describe the change of paradigm in thinking about psychotherapy for survivors. The way of perceiving survivors changes from terms of psychopathology or injury towards acknowledgement of adaptive mechanisms. The goals of therapy have also changed – during the healing process symptoms become less important, while priority is given to coping and ability to give meaning to life despite the presence of symptoms. We ask questions about conditions that help to integrate the traumatic experience. The term “aintenance” is used to describe having a sense of integration without necessarily integrating all of one's experiences and feelings. “Integration” of the Self requires taking into account the social context. The goal of working through in the social context is to make the Shoah present in the collective consciousness. The way patients attempt to integrate their personal experience reflects the way the society they live in integrates its own past experience of the Holocaust. The question remains open to what extent not only survivors but also the societies where the Shoah took place are affected by mourning, guilt and shame.

the Holocaust remains to a large extent a taboo subject, also for the community of professionals – psychologists and psychiatrists (1). The terms “Holocaust” and “Shoah” are used in the paper interchangeably. Shoah is a Hebrew word for holocaust, and when capitalized it refers to the Holocaust of European Jews at the time of Nazism in Germany. The original biblical word “holocaust” (meaning “burnt offerings”) for Shoah was first used by Elie Wiesel. The term is sometimes regarded as controversial due to its superficiality: the similarity is limited, since Jews were burned, but not offered.

The first reports dealing with psychological problems of Holocaust survivors date back to the 1960s (2-6), while the first studies concerning the survivors were conducted in the 1970s and 1980s (7-9). The long interval between the war and the first studies is due to a phenomenon referred to as a “conspiracy of silence” (10). The term describes the relationship of the post-Holocaust world to Holocaust experiences. The survivors did not talk because they felt humiliated by their experiences, while witnesses did not ask because they were ashamed of their indifference to or even participation in the crime of the Holocaust. Survivors' families were not exempt from the conspiracy of silence. Bar-On (11) called this the “double wall” phenomenon, since the wall was on both sides: of the survivor parents and their children. Occasional opening of a little “window” on either side made the children feel that their parents did not wish to return to their painful memories, at the same time making the parents feel that their children did not wish to listen to them.

Early attempts at psychological understanding of survivors originated from the classical psychoanalytic thinking. The first works, e.g., by Bettelheim (12), were strongly influenced by Anna Freud's (13) theory of identification

INTRODUCTION

Any society must take some time by necessity to come to grips with the subject of collective trauma and its consequences. Thus, despite relatively numerous studies,

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with the aggressor. At that time the focus was on the pathology of the so-called “survivor syndrome” (2-9, 14). Advocates of the “survivor syndrome” did not believe in the feasibility of psychoanalytic therapy, regarding trauma-related changes in survivors’ personality as irrevocable. Moreover, the psychoanalytic technique utilizing patient regression was considered doubtful since it involved the risk of recurrence of extremely traumatic situations (15).

Later works (16-18) employing other therapeutic approaches dealt with problems specifically related to the Holocaust and describe survivors in terms of their strengths, survival ability, and capability of returning to life after their trauma. Considering survivors in the framework of self psychology, perceiving them not as separate, “impaired” individuals, but in a broader familial and social context, acknowledging the role of “narration” – all these factors have changed the goals and expectations of their therapy. Group therapy regarded as a reversal of the situation of loneliness experienced in the face of trauma has played an increasingly important role (19).

GROUP PSYCHOTHERAPY OF HOLOCAUST SURVIVORS IN POLAND

A HISTORICAL BACKGROUND

A therapeutic program addressing the consequences of Holocaust trauma was launched in Poland in 1990. The program started with research conducted in Cracow under the direction of Professor Maria Orwid (20-22). At her initiative, since 1995 individual therapy has been provided to Holocaust survivors, and then group therapy (23, 24).

We offer therapy to persons constituting a specific group in terms of social identification. As a rule they come from assimilated Jewish families whose contacts with Poles enabled them to survive on the so-called “Aryan side.” Their double Polish identity prevented their emigration after the World War II and during the 1968 wave of emigration. The marathon group psychotherapy model is used: three-day workshops offering six hours of therapy daily are held twice or three times a year. We started with a group of about 80 participants. Each meeting was attended by 50-60 persons working in four groups. Since many participants have died during the past 19 years, and some are not well enough to participate, our therapeutic groups are presently attended by 7-8 persons. The groups were formed spontaneously, with no initial qualification process, and any member of the “Children of the Holocaust” Association was entitled to receive psychotherapy. “Selection” or “exclusion” of anybody from the survivor group seemed impossible after their war

experiences. The lack of qualification and no baseline assessment of the severity of the participants’ disorders have also a de-stigmatizing function: they are provided with group psychotherapy not due to their impairments or problems, but just because they survived extreme life experiences. The participants represent a full spectrum of disorder severity – from neurotic conditions through borderline disorders (frequent among traumatized persons) to psychotic disorders. Perhaps - as proposed by Quinodoz - it would be diagnostically most appropriate to accept “heterogeneity” of early traumatized patients, with concurrent neurotic and psychotic aspects of their disorder (25).

PROBLEMS SPECIFIC TO HOLOCAUST SURVIVORS IN POLAND

Survivors’ psychological problems we have encountered in our therapeutic work are consistent with those described by researchers and therapists dealing with psychological consequences of the Holocaust. Complaints reported by group members include loneliness, a sense of isolation and difficulty in interpersonal contacts, also with people closest to them.

An important issue is that of fears related to trauma re-activation. Sometimes seemingly trivial political events and public or private anti-Semitic statements or messages can evoke panic and deepen the therapy participants’ sense of isolation. Traumatic memories can also be activated by losses natural in their age group (such as death of a close person, retirement, ill health, disability).

Another important issue in Poland is the secret of survivors’ Jewish background and the secret of the Holocaust. Almost all therapy participants had hidden their Jewish ancestry from their children until they reached the “right” age (survivors believed the right age to be when the child is capable of “hiding” him/herself). Parents were afraid their child might feel “different” – humiliated and rejected; their own fears and apprehension were sometimes projected in an extreme form related to their wartime experiences. At the beginning of their therapy some participants continued to hide their Jewish ancestry from their already adult children. Other families talking among themselves about their Jewish roots still maintained silence as regards survivors’ experiences during the war. These families and their functioning can be classified using the Danieli’s (26) typology as “victim families,” where the family atmosphere is characterized by depression, worrying, distrustfulness and fear of the external world, as well as a symbiotic attachment to the family.

In the course of therapy a majority of the participants decided about their “coming out,” at the family forum at

least. This decision may have resulted from other group members' reports about how their children responded to their Jewish background disclosure. The children's responses varied, even though group participants' fears of being rejected within the family and persecuted by the external world turned out to be groundless.

Group members are not homogeneous in respect of age, and therefore also of their wartime experiences. Some of them survived the war consciously – being aware of dangers, and sometimes feeling responsible for others. Those who were little children during the war either had no or only fragmentary memories of that period. They learned about their family history at a later age, sometimes in adulthood.

A recurrent issue is a comparison of traumatic wartime experiences of those who do remember the Holocaust with another type of trauma suffered by those who miss their closest relatives but do not even have memories of them. At the initial stage of therapy a sort of competition in suffering could be seen among group participants born long enough before the war to remember that period and those born at the beginning or during the war and so have no wartime memories. Some participants of the latter group had lost all their family and were unable to recall either the circumstances of their own survival or their family's pre-war life. At the beginning of therapy they seemed to share a stereotypical belief that those who do not remember are "better off." With time they came to know the difficulty of living without multigenerational family memories, the difficulty of "being from nowhere." Another important issue is identity problems – the question "Who am I?" keeps returning in various contexts, most recently also in the final one: "In which cemetery will I be buried?"

THERAPEUTIC APPROACHES IN WORK WITH HOLOCAUST SURVIVORS

Various psychotherapeutic approaches are represented in our therapeutic team: psychodynamic, systemic and group-analytic. We do not try to "integrate" these approaches, but rather to use the different perspectives so as to enrich our perception of our patients' problems. Similarly, the diversity of our Holocaust-related experiences is regarded as an asset. At present half of the therapeutic team members come from families where both parents are Polish, while the other half are from mixed Polish-Jewish families, where one of the parents is a Holocaust survivor. The therapeutic team was created by

Maria Orwid, a Holocaust survivor herself, who worked as a co-therapist until 2000. Differences in Holocaust-related familial experiences result in differences concerning the transference/countertransference relationships, which is discussed at the therapeutic team meetings.

As mentioned earlier, both the perception of the survivors' "pathology" and goals of therapy change over time – from the maximalist approach of the classical psychoanalysis striving for personality reconstruction to more realistic ideas of self psychology. In the recovery process the ultimate goal is no longer construed as "being symptom free," but rather as coping successfully and making one's life meaningful despite the presence of symptoms. A similar way of thinking is represented by Lomranz (27) in his construct of "aintenance," i.e., a person's ability to have a sense of integration without necessarily integrating all his or her experiences and emotions. The concept of aaintenance assumes an ability to feel well without integration of various biopsychosocial levels, or of various dimensions (cognitive, affective, value-related) at a single level. Aaintenance enables the individual to accept inconsistencies, relativism, asynchronization, paradox, ambivalence, ambiguity and absurdity; to live a conscious life under conditions of such vagueness, feeling well and experiencing fulfillment or integration. In particular, the elderly can develop the skill of tolerating thoughts, emotions, events and behaviors that seem inconsistent in either personal or cultural dimensions, at the same time keeping their balance without a sense of discomfort or fragmentation. Aaintenance enables them to experience contradictions separately, without the necessity of their integration, and moreover does not involve any changes in their sense of self-continuity.

These theoretical concepts are supported by our observations of changes occurring in survivors. Survivors report their satisfaction with their present life and are involved in various types of activity – creative, social, or in self-education, which does not mean they are symptom-free or have a sense of complete integration. They call participation in group sessions their "battery charging," which perhaps can be interpreted as feeling more robust and getting a stronger sense of agency.

INTEGRATION OF TRAUMATIC EXPERIENCE AS EXEMPLIFIED BY INDIVIDUAL PSYCHOTHERAPY

A question remains to what extent integration of a traumatic experience itself is possible. To exemplify the problems we are trying to cope with in therapy of

survivors a case is presented of a female patient who decided to participate in group sessions after five years of individual therapy.

CASE REPORT: MS A

Ms A, born in 1942, had a Jewish father and Polish mother. Shortly after her birth she was left in the care of total strangers “on the Aryan side,” where she remained until the end of the war. Her mother left her in hiding so as to devote herself exclusively to rescuing her husband and his Jewish family. Since the people she was left with were reluctant to have her mother visit her, these visits were very rare. Ms A has single wartime memories, associated with fear. In infancy she was kept in hiding, isolated from other people, in a cubbyhole where some scary animals scurried over her. For a long time after the war she would have phobias connected with touching fur. Both her parents survived the war and took her back from the hideaway. In the patient’s family her wartime experiences were never talked about and the patient herself never mentioned the first two years of her life when describing her childhood. She was “born” on returning home after the war. Her Holocaust survivor father suffered from depression and insomnia after the war. Her mother used to sit up with him. The patient, hearing them at night, would also go to her parents’ bedroom to keep vigil by her father. During her therapy she came to the conclusion that she had been delegated to prevent her father’s suicide, since her father’s brother did commit suicide after the war. When talking about her family she used such terms as a “horde” or “clan” (which was meant as a positive description of family bonds), about herself – that she let them “drag her in headfirst,” about her brother, born after the war – that he “didn’t let them crush him,” “managed to avoid being sucked in”; about her father – “he was a vampire.” In another context the adjective she associated with the word “love” was “merciless.” This seems to accurately depict her emotional situation in the family – so very close-knit that there was no space for her and her feelings. Dependence can be seen as threatening to her, since one may become “a vampire,” just as her father, while closeness may lead to being swallowed up. The patient describes her distorted development as follows: “...it so happened in my life that I had to give support and against my nature shape myself into somebody else. I used to believe that if a figure were cut in half and then put together again, a shift (displacement) would remain.”

INDIVIDUAL PSYCHOTHERAPY OF MS A

When entering therapy the patient had a severe pain syndrome of unclear etiology that under certain circumstances difficult to specify was aggravated so much as to impair her functioning.

The most difficult periods in therapy were those of separation, when the patient’s somatic symptoms became more severe and she had a feeling of psychic disintegration with an inability to self-soothe. She experienced a lack of care as an attack of hostile objects, and described her feeling that reality was “pressing” on her. As emphasized by Kernberg et al. (28), the basic fear of borderline patients is that aggression will destroy love – accordingly, the patient “choses” disintegration, enabling her to deny her anger and avoid confrontation with her negative feelings for her parents and the therapist. In such situations she talked about her guilt feelings – as illustrated by her case, survivor guilt may be associated with a sense of guilt due to her anger at her parents for not taking care of her. This might recur when she felt neglected or not being taken care of by the therapist.

The first noticeable change in the course of therapy consisted in “getting back” her father as a positive object. The patient herself perceived this as a result of therapy where she could express her anger toward him for destroying their post-war life, but also describe how important he was for her in the development of her Jewish identity.

Another change occurred at the somatic level. Since the patient was unable to recall her wartime experiences, the therapist “described” to her how an abandoned, lonely baby could feel. It was an attempt to recover narration and integrate her fragmented experiences into a whole. After two years of therapy the patient reported two dreams that clearly differed from those she had had so far. Both depicted the world “after a disaster” and in both the patient wandering about could get no help. The dreams were accompanied by a considerable motor agitation; the patient said she had almost fallen off her bed. The dreams were interpreted as a picture of the world “after the Holocaust,” but also of early experiences of the abandoned child. At that time the patient’s pain syndrome disappeared, which seems to indicate her regaining integration at the body level.

While the patient was in hiding, her mother knitted mittens for her. One of the mittens outlasted the war and was regarded by the patient as her “good luck charm.” In the course of therapy the patient happened to lose her mitten and in order to cope with this loss she wrote a poem dedicated to the therapist:

Mittens 1942
 From wretched, rough, wartime wool
 beetroot colored,
 she fashioned a pair of mittens.
 Two pearly little buttons, to each she attached,
 from better times.
 Mittens, for my barely half-year-old hands,
 lest they freeze confined, in an alien land.
 Charmed by her, life-giving, for me:
 For a child with such mittens
 must surely survive.
 Such elegant mittens –

Both the form of the poem and the circumstances under which it was written suggest a possibility of integration of the patient's traumatic experiences. Assuming that trauma destroys the ability of symbolization, her capability of symbolizing a concrete object in the form of a poem – a memory of maternal care – may be regarded as a genuine process of restoration. We would like to add that the mitten was found....

Figure 1. *Lost mitten*



Another poem written by the patient after her close friend's death was sent to the therapist with the following comment: "I am coping, of course. But please accept the enclosed. Thanks to that I will be able to cope just a little less frantically." Despite the evident chaos and disintegration the patient was again able to symbolize and creatively transform her experience.

TRAUMATIC EXPERIENCE INTEGRATION IN THE SOCIAL CONTEXT IN POLAND

Memoir writing and other ways of commemorating the Holocaust turn out to be therapeutic experiences for many

survivors. An important problem is to find not only a language to describe their indescribable experiences, but also a possibility of narration. Therapy and informal talks with their close friends and family or in groups of survivors, as well as media interviews they give concerning their experiences lead to their recovering narration about that period of their lives (29). Research has confirmed that opening up of the traumatic past is associated with an improvement in mental and physical health – survivors are motivated by a sense of obligation and by the need for making their life experiences meaningful (30). It is important to them that their stories about their traumatic experiences are heard by others. We should not only hear about the Holocaust, but also perceive it in the context of a person's whole life experience.

An open question remains whether the mourning process can be completed in the case of survivors. Due to the extent of their trauma the mourning process termination is difficult, but possible. However, this needs more time and fulfillment of some additional conditions, particularly acknowledging a space for the Jewish Holocaust not only in the personal, but also in social narration. The completion of mourning for losses was not possible in real time during the war as people were struggling for their survival; then, in the post-war period survivors were trying to restore their lives, hoping to find their families and friends alive. The "conspiracy of silence" as well as the feelings reported by survivors – a sense of loneliness, being misunderstood and sometimes also accused – left no space for the mourning experience.

Two parallel processes can currently be seen in Poland. One is the presence of a "Shoah complex" in Polish society, i.e., difficulty in thinking and talking about the Holocaust due to guilt feelings. This was evidenced by reactions to books by Gross (31, 32) and other authors who write about participation of the Polish society in the Holocaust. The difficulty in facing this fragment of the Polish history may be related to a "conspiracy of silence" that exists also in Polish families: as same as survivors' children protect their parents from pain by means of silence, children of the Holocaust witnesses protect their parents from shame. The other process involves an increased interest of the Polish society in survivors' tales presented in books, films or their personal narratives, together with attempts to embed them into the whole history of Jewish life in Poland. Sometimes an impression may arise that the two processes are dissociated and that the Polish society tends to share mutually contradictory beliefs, thoughts and feelings. Difficulties with working through the "Shoah

complex” enhance the acting-out tendencies, towards either closure or appropriation of the Holocaust in the collective consciousness.

A good example of this process could be the establishment of the Museum of the History of Polish Jews. The Museum, erected on the site of the former Warsaw Ghetto, faces the Monument for the Warsaw Ghetto Heroes, in close proximity to the Umschlagplatz from where Warsaw’s Jews were deported to Treblinka gas chambers. In this place of absence the Museum shows the centuries-long presence of Jews in Poland. It is surrounded by monuments commemorating the Righteous, which again serves to deny the Jewish tragedy of not receiving effective help from Poles. This shows that integration of the Holocaust trauma is a difficult and painful process.

We might consider the meaning of the earlier-mentioned concept of “aintenance” (i.e., the possibility of having a sense of integration without integrating all of one’s experiences and emotions) in the social context. The assumption of such a perspective of ambiguity seems necessary to deconstruct national myths and to give up idealization of parents. Not identifying with the parents’ generation is the first step to share mourning for the wrongs of the past (33).

It may enable us to escape from the transference relationship to the Holocaust in which we define ourselves as survivors, persecutors, rescuers or observers (34).

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Traumatic memories of holocaust survivors and their effect on the experience of identity. Ruth Reches, Jolanta Sondait— Mykolas Romeris University. Introduction. Bearing in mind the fact that the victims of the Holocaust did not survive, there is incomparably less academic literature, not only in the realm of psychology, about their long lasting experiences. Those who managed to survive experienced severe, sustained traumas which haunted and will haunt them for the rest of their lives causing sustained psychological problems. This literature indicates that identity defects, that evolved after the Holocaust, are particularly severe and evoke enormous psycho-traumatic effects. He defines transpersonal experiences as the "experiential expansion or extension of consciousness beyond the usual boundaries of the body ego and beyond the limitations of time and space" (Grof, 1988, p. 38). Examples of transpersonal experiences include "past life" experiences, complete identification with an animal species, profound spiritual experiences, and so on. Transpersonal experiences appear to tap sources of information lying far outside the range of an individual's concrete knowledge base as well as outside of the range of ordinary human experience. Research on psychotherapy integration: Conclusions from an NIMH workshop. *Journal of Consulting and Clinical Psychology*, 5(3), 448-451. Genetic changes stemming from the trauma suffered by Holocaust survivors are capable of being passed on to their children, the clearest sign yet that one person's life experience can affect subsequent generations. The conclusion from a research team at New York's Mount Sinai hospital led by Rachel Yehuda stems from the genetic study of 32 Jewish men and women who had either been interned in a Nazi concentration camp, witnessed or experienced torture or who had had to hide during the second world war. Her team's work is the clearest example in humans of the transmission of trauma to a child via what is called "epigenetic inheritance" - the idea that environmental influences such as smoking, diet and stress can affect the genes of your children and possibly even grandchildren.