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The Longest Shadow
A Clinical Commentary On Moshe Lang's *Silence: Therapy with Holocaust Survivors and their Families*

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This commentary addresses one of the issues raised by Moshe Lang's Silence: Therapy with Holocaust Survivors and their Families, *namely the paucity of a psychotherapy literature about holocaust survivors and their families. Possible reasons for this phenomenon are discussed, with an emphasis on the implications for family therapy.*

> What, then, is truth? A mobile army of metaphors, metonyms, and anthropomorphisms ... truths are illusions about which one has forgotten that this is what they are.
>
> Friedrich Nietzsche

> There are no metaphors for Auschwitz and Auschwitz is not a metaphor for anything else.
>
> Alvin Rosenfeld

The Clinic and society reciprocally influence each other. For example, in the 1960's paediatricians first alerted an incredulous society to the widespread physical abuse of babies and young children at the hands of their parents, and psychiatrists described the looming epidemic of intelligent, outwardly-competent young women from privileged backgrounds who relentlessly starved themselves to the brink of death as a silent gesture of self-assertion.

Conversely, in the past decade, the Women's Movement has highlighted the silent suffering of women subjected to repeated violence and intimidation, whose plight was not recognised by their clinicians who treated them for an array of physical and psychological problems.

The past 25 years has seen an upsurge of interest in the Holocaust among Jewish communities in democratic societies. Autobiographical sketches, novels, philosophical reflections, plays, films, television mini-series, monuments, museums and university courses on this awesome subject have proliferated. Individuals and families have made "pilgrimages" to the former centres of Jewish communal life in pre-war Europe, and to the killing fields and sites of the death-camps.

To a degree, this growing societal interest has been reflected in the psychiatric and psychotherapy literature where a trickle of papers and occasional conference reports on the subject have appeared (e.g. Krystal and Niederland, 1971), and to which Moshe Lang's paper is a fine contribution. However, the number of papers published in the mainstream English psychiatric and psychotherapy literature is meagre and Moshe assures me that the picture is not much different in the Hebrew psychotherapy literature. In particular, there is little on the lives of Holocaust survivors during the first 20 or so years after the end of World War II, and even less discussion on how some enduring states of mind among the survivors may have influenced the mental health of their children and grandchildren.

In this paper I would like to address some of the reasons for this silence, and the implications for psychotherapists. We should, however, bear in mind the possibility that over the years skilled clinicians may have helped many survivors of the Holocaust but have been unable or unwilling to distil their therapy experience into a form that is deemed suitable for publication by the editors of a professional journal.

THE SURVIVOR GENERATION

The survivors who made their way to Western countries after the War found themselves in societies eager to forget. The imperative for the survivors was to find whomever else of their family and friends had survived, to rebuild their shattered lives and communities, and to participate in the promised prosperity of the new society in which they found themselves.

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In the first 20 years after the War, the majority of clinical papers dealing with the psychological experiences of survivors described single cases or at best a small number of patients treated by a psychotherapist, usually a psychoanalyst. Such case studies often are viewed with suspicion by academic psychiatrists and psychologists who consider them to be too "impressionistic" and "unscientific", with the result that this clinical literature has been ignored by the teachers of the helping professions. The few larger-scale clinical studies published in the first 25 years after the War were mostly conducted in the context of assessment for compensation and reparation claims against the (West) German Government; the language of such studies is the objectifying nomenclature of clinical psychiatry, and the aim of these investigations was not primarily therapeutic but to describe and assess the extent of psychopathology. The ignorance of clinicians mirrored the indifference of society.

This indifference may also have been reinforced by the survivors themselves. In 1961 the American psychoanalyst Niederland described the phenomenon of "survivor guilt". This concept has been much misunderstood. Niederland described a group of Holocaust survivors suffering from various forms of depression, anxiety, chronic aches and pains and other forms of physical and emotional distress; sometimes the patients described that a part of themselves felt emotionally dead. Niederland made use of the concept of identification as formulated by Sigmund Freud and elaborated by his daughter Anna Freud to suggest that the survivors carried with them "the ever present feeling of guilt, accompanied by the conscious or unconscious dread of punishment for having survived the very calamity to which their loved ones succumbed" (Niederland, 1961). It was as though, at least during those first two decades after the War, to be alive was an unconscious source of guilt and shame for having betrayed the dead. Such feelings caused the survivors to feel unworthy of help and to minimise the significance of the Holocaust experiences as a source of their current distress.

From a clinical perspective, this apparent collusion of silence between society, clinicians and the Holocaust survivor has a parallel in the experiences of some Australian soldiers who were taken prisoner by the Japanese during the second World War and who survived the forced labour camps in Burma. These survivors report how in the years following the end of the War they did not think that a war-weary society wanted to hear any more tales of horror, in addition to which the soldiers were silenced by their deep sense of shame at having been taken prisoner and at having survived when so many of their comrades did not. I have also treated some American veterans of the Vietnam War who had witnessed atrocities and who reported similar feelings a decade or more after their trauma.

If soldiers found it hard to speak and were not sure who could listen to them, the silence of the Holocaust survivor was deepened by yet another factor. In the 20 years following the end of the War, the dominant form of psychotherapy in the U.S.A., U.K. and Israel was psychoanalysis. The majority of psychoanalysts were Jewish. Most of them had escaped from Europe in the 1930's, leaving behind many family members and friends who subsequently perished in the Holocaust. A smaller number of analysts were from families who had lived in the U.S.A. or U.K. for one or more generations. While perhaps not grieving the deaths of their family members, as were their more recent migrant colleagues, therapists from these 'established families' may have had to face the painful question of whether they and their communities had done as much as was humanly possible to save their fellow Jews in Europe. A key element in psychoanalytic therapy is the therapist's ability to tolerate the powerful and at times provocative or destructive feelings that the patient feels towards him. If the analyst has unresolved guilt or anxieties, or if the patient senses that this is so, then patient and/or therapist may tacitly or unconsciously avoid those matters which may be too painful for either of them and which they fear may turn the hitherto benevolent therapeutic relationship into a sado-masochistic one.

We should also consider that the clinical techniques of psychoanalysis in the early post-war years were ill-suited for helping the survivors. Psychoanalysis was useful primarily for people suffering from various forms of neurosis, where the patient's 'inner' life distorts their perceptions of 'external' (i.e. social) reality, rendering the world more anxiety-provoking than it actually is. However, for the Holocaust survivor it was not the destructiveness or perversity of his/her 'inner' world that led him/her to experience their social world as problematic; rather it was the external world which had been totally, remorselessly and incomprehensibly brutal.

In time, psychoanalysis developed clinical models and therapeutic methods to deal with the overwhelming trauma of external reality, and some of the most insightful papers on healing the Holocaust survivor reflect these advances in psychoanalytic thinking (Pines, 1993). However, by that time (i.e. late 1960's) great changes were afoot in clinical psychiatry and psychology which muted the survivor's voice in therapy.

The so-called biological revolution in psychiatry had dawned, based on the hope that understanding the neurochemistry of the brain would lead to effective drug treatments rather than the psychoanalytic emphasis on tracing the symbolic meaning of subjective experiences. At the same time various forms of the Human Potential Movement became popular; these emphasised an individual's authentic choices and capacity for rapid change, and were disdainful of psychotherapy approaches that appeared to dwell on the past or which allowed a person to blame others for his or her current unhappiness.

All these factors contributed to the silence of the Holocaust survivor in the therapy context.

CHILDREN OF SURVIVORS

While the Holocaust survivor faced the problem of making sense of a civilised world transformed into a charnel-house, the children and grandchildren of survivors face a

different set of problems which, broadly-speaking, consist of two separate, though overlapping developmental difficulties.

The first is the child's experience of parents who are persistently emotionally absent from the child's life, because the parents are chronically depressed or are constantly preoccupied with thoughts and images of the trauma they endured and the loved ones they lost. If the parents' emotional absence is sufficiently prolonged and severe it may lead the child to construct an inner world so as to fill this gap. This may be done in many ways — some creative, others 'pathological', some which conform rigidly to family or societal values, others which defy such values.

The second aspect is the child's experience (which may not be fully accessible to conscious introspection), that he/she represents for the parent or grandparent a substitute and a consolation for what they lost during the War, most particularly siblings or other children. The child experiences his/her identity in terms of being an idealised replacement for the dead family members. Conformity to or rebellion against this identity, with consequent concerns for the welfare of the parents, may consume a great part of the child's emotional life, especially in the adolescent years, but often persisting into the child's adult and married life, as Moshe's cases poignantly show.

Although these formulations of the dilemmas of the child of Holocaust survivors were described by psychoanalysts in the late 1960's, the method of psychoanalytic therapy concentrates on the individual. Parents, siblings and grandparents do not participate in psychoanalytic therapy and their life experiences are not addressed except as perceived by the patient.

FAMILY THERAPY

Moshe Lang sensitively describes some of the ways family therapy has developed of promoting dialogue between the generations about disturbing topics and of addressing how some families become frozen in time in the face of massive trauma, to the extent that the grief and fear of the traumatised generation still grips the family two generations later.

It might have been expected that once these family therapy approaches won professional legitimacy by the late 1970's the traumatic experiences of the Holocaust survivors would at last gain a forum, albeit via the problems of their children and grandchildren. However, this did not happen. I think this reflects the ideology of the family therapy movement which, in its zeal to distance itself from psychoanalysis, minimised the unique subjective experiences of individual family members and their personal histories, and concentrated on the functioning of the family as a whole (i.e. as a system of behaviours). Furthermore, this neglect of the individual led to the growth of a cadre of family therapy professionals who were unskilled in handling the often powerful feelings that brutalised patients evoke in their therapist.

Instead, the language of cybernetics, the gamesmanship of paradoxical injunctions and double binds, the neglect of meaning, the reification of the concepts of systems and boundaries, and the insistence on rapid therapeutic change via perturbation of recursive patterns, silenced the voices of history. Even the transgenerational models of family therapy rarely ventured into the European childhood of the parental generation.

The narrative approaches in family therapy, especially when informed by feminist thinking, have provided bridges between subjective experiences and the social and historical contexts in which subjectivity is constructed. However, the Holocaust survivor is not just telling a story. He/she is also a witness, someone who is providing testimony. For the survivor there is not a plurality of readings or multiple perspectives of equivalent validity from which the story may be told. The survivors fear that if the empirical links between life experience and its narration are modified in any way their story will be lost.

> Their impossible task is to show somehow that their words are material fragments of experiences, that the current existence of their narrative is causal proof that its objects also existed in historical time (Young, 1990, page 23).

With what trepidation might the survivor view the deconstructionist claim that 'the Author' is merely a rhetorical device; that the narrative, once it is demystified or interpreted by the narrator, merely leads to another myth about the narrator, which is demystified in turn by another narrator, and so on, in an infinite egress?

Amidst the barely tolerable memories of limitless horror will the survivor find vindication or refutation in the post-modernist claim that the subject is a construction, a convention, a consensus, the product of a game played by those who know how to deploy the power to name? (Foucault, 1972).

CONCLUSION

Psychotherapy demands a synthesis of the perspectives of the individual, the family and the socio-cultural context. It also requires respectful attention to how the past may be alive in the present and distort the future in people's relationships, often in ways of which they are not fully aware. It is easy to write and lecture about this need for synthesis. It is much harder to practice it in the clinical context where societal myths and human frailties, including our capacity for self-deception and professional myopia, have led clinicians to neglect Holocaust survivors and their children.

Moshe Lang's paper redresses some of this neglect.

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