After the Holocaust
Therapy with Survivors and their Families

Moshe Lang
Williams Road Family Therapy Center,
Windsor, Vic., Australia

** I am deeply grateful to the many Holocaust survivors and their families who over the years trusted me with their pain and memories. My particular thanks to those families who gave their permission for their stories to be told. Some personal details have been altered to protect the identities of the people involved.*

To Tess, special thanks for writing this chapter with me.

An earlier version of this chapter with the commentary by Kaslow first appeared in Generation, 4 (1) in March 1994 entitled: "The Long Shadow of the Holocaust." The sections entitled Anorexia, Morbid, Jealousy, and the commentary by Harari first appeared in The Australian and New Zealand Journal of Family Therapy (Lang, 1995). They are reproduced here with their kind permission.

The stories in this article plus additional ones will be published in a book containing four sections: Children, couples, adults, and the Holocaust (Lang & Lang, 1996). Further exploration of the subject appeared in the Family Therapy Networker (Lang, 1995).

Introduction

In my 30 years of practice, I have seen many Holocaust survivors and their families. I have presented and published my work extensively yet, until 1988 when the Williams Road Family Therapy Center organized a conference on 'The Holocaust: Clinical Perspectives' (Lang & Stagoll, 1989), I had remained silent on this aspect of my work.

In preparation for this conference I began to confront the reasons for my silence. I was afraid of trivializing the enormity of the Holocaust and feared I would be unable to do justice to the experience of the people involved.

This chapter presents a number of stories of families who came with symptoms or complaints that seemed unusual, at times bizarre and devoid of meaning. Though all the families had seen other members of the helping professions, the Holocaust had never been mentioned. Only when it was explored, did their problems become comprehensible, providing the context for alleviating or resolving them.

In the Holocaust six million Jews, including one and a half million children, were systematically murdered. Those who survived experienced deportation, starvation, deliberate degradation and humiliation, as well as an organized attempt to destroy their personalities and identities. Daily they witnessed the Nazis' brutality and killing which often included members of their own families as victims. Some were forced to participate in the process of extermination.

Survival became the imperative in the death camps. How to avoid the next selection, how to avoid beatings, how to minimize the cold and hunger became the day-to-day aims. Concentration camp inmates tried not to be noticed, since being noticed was dangerous. They became like robots; memory, conversation, and affect were switched off. Many who saw their parents, siblings or children murdered coped by becoming mute for long periods.

After the war, survivors very often found that everything they had known had disappeared. Family, community, home, language and country. They were alone in an alien world.

Most emigrated to new countries, U.S.A., Canada, Israel, Australia, and countries in South America. Often when they attempted to talk about their experiences, they encountered disinterest and an unwillingness to be heard. They were blamed for their failure to fight or try to escape. They were often asked in an accusing manner, "How come you managed to survive when so many did not?" Many tried to avoid seeking psychiatric help.

Those who did seek help found, in the majority of cases, that their Holocaust experience was not discussed. Their own need to remain silent interacted with the attitudes of society around them and with the attitudes of the mental health professionals entrusted to care for them.

The psychological and psychiatric literature abounds with papers detailing the detrimental effects the Holocaust has had on survivors and their families (e.g., Braham, 1988; Chodoff, 1975; Ertinger & Krell, 1985; Krystal, 1968; Krystal & Niederland, 1971). Generally overlooked is the amazing resilience of the survivors, the strength and vitality that made it possible for many of them to overcome their pasts and build new lives for themselves and their families in a new country.

Shower Phobia

In my early days as a child psychologist, I was asked to see Shirley, an eight-year-old girl who had a very unusual problem. She refused to take a shower, reacting with extreme panic when her parents insisted.

She had seen a number of professional people, but none could explain her intense reaction. Discussions with her previous therapists and reading her file were not helpful. The basic information in the file was that the family was Jewish, the father in business and the mother a housewife. Born in Europe, her parents had come to Australia in 1946.

In the assessment interview with Shirley, I asked her to do a drawing. She drew houses and chimneys – big houses with lots of chimneys. I showed her cards of people in different situations and asked her to make up a story about each. A repetitive theme emerged of people going into a house to take a shower and never coming out.

My inquiries revealed that her parents were Holocaust survivors, and that talk about the Holocaust was a constant feature of family life. With this new information I was able to tell Shirley that I thought I understood why she was unwilling to have a shower, and explained it to her. She was able to talk more about her fears and told me she was not only afraid of the shower, but also of the soap. To her the soap was her grandparents. Further exploration with her parents revealed that they often spoke of how Jewish bodies were used to make soap, and how Jews were told to undress and enter the showers, after which they never returned. Probably she had overheard her parents saying that the smoke and ash of the burning bodies was constantly visible from the many large chimneys and could be smelled for miles.

Her parents were not aware that their conversations and their war experiences had affected Shirley, and Shirley's problem did not develop because of her parents talking about the Holocaust, but because they talked with total disregard of her. Once communication between daughter and parents took place, so did recovery. Perhaps her symptom was her unconscious way of incorporating and joining into the family discourse, insisting on being included in family communication.

This communication included the explanation that the Holocaust happened a long time ago and far away, and that showers are safe now and do not contain gas. Soap is made of palm oil and not, as happened then, of Jewish bodies such as those of her grandparents. Once her parents realized the impact of their conversations on Shirley, they were much more careful of what they said, and inquired regularly about her feelings.

Perhaps most people who went through the Holocaust cope by remaining silent, but in some families life is dominated by conversations about the past. Such a preoccupation may account for the failure of Shirley's parents

to see the connection between her fears and their recurring discussions. The helping professionals may have contributed to this by not involving the parents more directly in therapy. They did not inquire into the parents' history or ask about current family life.

It is likely that Shirley became symptomatic not because her parents talked but because they talked inappropriately in her presence.

Yet what is an appropriate manner for parents to tell their children that they had siblings who were murdered, and that their parents were unable to do anything to prevent it? What is the appropriate age at which a child is ready to receive such information? Do we professionals have either theoretical or empirical knowledge which qualifies us to advise parents on this problem? If the answer is no, what we can offer is to listen to their impossible dilemmas and try to confront the confusion and ambiguity that such questions inevitably generate.

Failing

Letters of referral from a school counselor and a child psychiatric clinic introduced me to the following family.

Anna, 14, was increasingly failing at school, although at times she performed brilliantly. This frustrated her teachers, since she was a very capable student. Though usually a friendly, chirpy girl, at times she was morose and withdrawn. A psychiatric evaluation confirmed that she was intelligent but periodically depressed. In the letter there was an agreement that the main culprit was her father who was described as excessively demanding. When she did well he would be overgenerous and indulgent, but at other times he would be dissatisfied and critical, insisting on more effort and better results.

Anna was seen by the clinic intermittently for about two years, while the parents were seen separately. She was preoccupied with her ambivalent relationship to her father, Isaac. Her failure to please him consistently made her feel depressed and worthless. Despite help from the school and the clinic, the family experienced no improvement and had asked to be referred to me.

The clinic file contained Anna's developmental history and details of her parents' marriage. It showed that mother had been born in Australia and that father arrived here in 1947 and was self-employed.

At our first session we discussed Anna's schooling and her general state. Nothing new was revealed about her. The mother remained in the background. In conversation with father, I casually asked if he spoke Yiddish. He did. I asked where he came from and where he had spent the war. He indicated that this was something he did not want to discuss in front of his wife and daughter. I persisted and asked if he had been in a concentration camp. He replied that he had been for about ten months before libera-

tion. I asked about his family and, once again, he indicated that he preferred me not to ask. Again I persisted, asking if they had all perished. He responded that Hitler had got them all.

This was the only new material that emerged in the interview, although the father also communicated with pride that he was a successful businessman. At the end of the session he asked what I thought; he was paying and he wanted an answer for his money. Because I had taken him further than he wished, and since he pressed me, I felt I should respond by sharing my preliminary thoughts, even though I was not yet ready to do so.

"You are proud of your achievements as a businessman and understandably so. I guess you had very little education and came to Australia without the language, without a profession or trade. To be so successful you must be very tough and demanding on yourself. Probably you are asking of your daughter not more but in fact, much less than you have asked of yourself. Also, if you lost every member of your family, your daughter must mean a great deal to you. Perhaps in some way she has to make up for the parents, brothers, and sisters you lost and possibly for your own youth too."

His wife and daughter were transfixed. He was very keen to respond, but I had to stop him since time was up. I said I was most interested to hear more but asked if we could leave it until next time.

To my surprise, Isaac came to the next session alone. He said he wanted to talk to me but did not wish his wife and daughter to hear. Since the war he had suffered from a recurrent nightmare from which he would wake up sweating and screaming. In the nightmare, he lost control and went on a rampage with a submachine gun, killing Germans. I said half in jest: "Is this a nightmare or sweet revenge? Sounds to me like a mitzvah (a good deed)." He laughed a bit and answered seriously that he was very afraid he would lose control, go insane or end up in jail.

I commented that surely his wife knew about his nightmares and he agreed, saying that she regularly helped him when he awoke, bringing him cold towels or whatever he needed. She never inquired, and he never told her of the content.

He insisted that his daughter knew nothing of his nightmares and that she never heard a thing. He responded to my doubts by claiming that because they lived in a big, double-brick house with good sound insulation, and because his daughter had her own room, she would not have heard. He was willing to continue to come, provided he could come alone; he did not wish to involve his wife and daughter. I expressed some misgivings but accepted his conditions. I was partially comforted by the knowledge that his daughter had a good working relationship with the school counselor, whom I knew.

I saw him regularly for a few months. He told me some details of his concentration camp, ghetto and war experiences; of his witnessing the murders of members of his family; and of his inordinate difficulty in controlling his rage. He talked of his guilt for surviving, his disturbing memories and profound shame, with occasional expressions of pride in his achievements.

He then decided to tell his wife about his nightmares. To his surprise she was much relieved. She had worried it was much worse, imagining that every night he was back in Auschwitz, rather than getting even with them. Her response meant a great deal to him.

He made it clear that coming back to see me felt wrong because there were things a man should keep to himself and problems he should sort out by himself. I responded that I supposed this attitude had served him well till now, but possibly at a great price. He was unwilling, or perhaps unable to share anything of his past experiences or current problems with his daughter.

When he decided to stop seeing me, his nightmares continued but their intensity was diminished. When he awoke, he would speak to his wife about them, and his fear of losing control abated.

Isaac and the school reported that Anna had changed significantly. She told the school counselor that her father's critical outbursts had lessened and that he was far less demanding. She was much happier and her academic performance became consistently good. As his fear of losing control diminished, so did his need to control his daughter.

Although I worked with this father alone, I would have preferred to work with the whole family. I wanted to maintain direct contact with his wife and daughter; but he chose otherwise. I communicated my anxiety to him but nevertheless decided to go along with his wishes. Therapy is and should be negotiated together. Although I thought therapy should continue in this case, Anna's father chose to terminate. Perhaps he could not permit himself to resolve more of his difficulties. The nightmares were his way of remembering and maintaining his rage. To feel even better may have evoked more guilt for surviving when the rest of his family had perished in the gas chambers.

Even though Isaac told me a great deal of his experiences, he intimated on occasions that there was much that he was unwilling or unable to reveal. I made this overt by saying I understood, and encouraged him to talk about what he chose to, and to remain silent on other things.

The decision to remain silent is not just to protect the person and those close to him, but is often a mark of profound respect for those who perished. As one Holocaust survivor said: "To talk is to desecrate the memory."

The children of survivors are often placed in an impossible position. They are expected to make up for all the losses of their parents. Exploring

Isaac's Holocaust experience gave a deeper meaning to the comment that he was "over-demanding." Therapy made this unrealistic and damaging expectation overt, and as a result less confusing and debilitating for his daughter.

Perhaps Isaac's willingness to break his silence and come alone to the second session was due to my persistent and vigorous interest in his story and my positive comments on his achievements. Survivors experienced much shame and degradation, so the more positive the therapist can be, the better, with a very significant qualification: to avoid denying or diminishing the guilt, rage and horror that they experienced.

Survivors are particularly sensitive to denial because the Nazis were assisted in their monstrous plan by the use of "official language." The systematic attempt to exterminate the Jews was "The Final Solution," the inmates of the concentration camps were not people, just "numbers," human corpses were referred to as "dolls," gassing human beings to death was "special treatment."

For Holocaust survivors today a major source of rage and pain is the current attempt to deny that it ever happened.

Survivors often say: "We have no words, what we have seen and experienced is unspeakable." According to Primo Levi (Levi, 1988a, p.6 & 1988b, p.129) "Auschwitz was another planet. Even if you were there, you still did not know what it was like for someone else there. Ordinary language cannot convey what happened there. Simple words like hunger and cold could not capture the sort of hunger and cold we experienced."

When survivors cannot find the words, the therapist needs to convey that language is often inadequate, that to fully understand is impossible, but that there should be a willingness to struggle to achieve as much understanding as possible.

Perhaps the most significant communication is in the silences - the non-verbal pauses, the mutual understanding. Writers such as Elie Wiesel suggest that the Holocaust can never be written or spoken about directly. It can only be evoked obliquely (Wiesel, 1970). Even if language were available and comprehension were possible, some things are too horrible to confront. Both therapist and patient need to be able to acknowledge that they are unable or unwilling, on a given day or altogether, to confront such horrors directly. Often we have to avert our gaze.

Anorexia

For about a week I was inundated with phone calls from friends, professionals, and strangers urging me to see a family whose only child, Becky, aged 17, was suffering from advanced anorexia.

The parents and Becky came to the first interview. Becky had been of normal weight three years ago, when she had decided she was too fat. She went on a diet and continued to lose weight; her periods stopped and she had little energy. Her parents became alarmed and took her to their doctor, who diagnosed anorexia and referred her to a psychiatrist. About two months earlier, her weight had been so low that she had been hospitalized.

In the hospital she was seen as difficult and uncooperative. She refused to join the patients' groups and was uncommunicative. She continued to lose weight, so her privileges were gradually withdrawn. First she was not allowed to get dressed, and then, she was prohibited from continuing her studies for the final high school examinations. This caused Becky the greatest consternation. Force feeding was now being considered.

One of the treatments offered by the hospital was family therapy, which she refused to attend. In order to see me she needed special permission to leave the hospital. Her psychiatrist and the hospital team were reluctant to grant her the privilege of getting dressed and going out, but finally, after much debate, they agreed.

Before her anorexia Becky had been an able and conscientious student, although she had always been fussy and easily upset. She had a few good friends, but her main interest was her studies, so her social life was minimal.

This information was given to me by Becky's parents. When I questioned Becky, she responded very reluctantly in monosyllables, though she had been listening intently.

The parents watched anxiously as they expected me to engage Becky. To their surprise I told her to feel free to talk or not, that I would assume, if she chose not to participate, that she had good reasons, and if she wanted to keep them to herself, I would understand. Since her parents had so much to tell me, if Becky was quiet they would have more time to talk. Though Becky remained relatively quiet and contributed minimally after that, she seemed more involved and relaxed from then on. Her wariness and hostility were diminished.

As we continued to meet it emerged that the parents, especially the father, were very critical of how Becky had been treated by the medical profession. He felt that he and his wife were being blamed for their daughter's condition, without at any time being consulted. He believed she was getting worse, particularly since her hospitalization, and could not see how the regime there could make her better. Only after expressing his anger and criticism of the treatment was he able to change focus and talk about himself.

Eventually he said that he felt he had deserted his daughter; he blamed himself and was full of remorse. Part of his life pattern was not being available to his daughter because he worked so hard to provide his family with material things. He also intimated that he had been through the Holocaust,

and it hovered like a dark cloud over our meetings. Nevertheless he told me little about it until he finally said that he could not help but see the hospital staff as "the Nazis," taking his daughter away to a "concentration camp" while he watched passively and allowed them to "torture" her. He saw this as a repetition of silently watching as his parents were taken away to the gas chambers.

The mother's assessment of Becky's treatment was similar to her husband's, though less intense. While she thought his way of thinking about it was extreme, she welcomed his increased involvement, which was something she had hoped and pleaded for over the years.

Eventually I said, "If that's how you see it, what are you going to do?"

Becky's father said, "What I really want to do is take her away."

I encouraged him to consider what the consequences would be if he did so. Eventually he made a plan to go to the hospital and discharge his daughter, then the two of them would go on a long vacation. He agonized over the risks involved, but after much anxiety he decided he had to mount a "rescue operation," regardless of the dangers. During these weeks of discussion and agonizing, Becky's weight stabilized but did not improve, and she remained quiet but attentive. I suggested that her silence was perhaps due to her not wishing to overtly endorse her father's plan, though she liked it. Perhaps she wanted him to relinquish his passivity and make the decision.

Becky's father did eventually carry out his plan. This proved to be a turning point for positive changes, both for Becky and her parents. Becky and her father went away together for six weeks. There were daily confrontations about: when to get up, where to eat, what to do, how much to tip, when to go to bed, and so on. Becky, however, gradually gained weight and on their return Becky resumed her studies and graduated with distinction. The long road to recovery continued for Becky and her family.

The treatment offered to Becky followed accepted medical practice; its private meaning for the family was not considered. For Becky and her mother, the treatment was another example of the father's passivity. For him, it was a repetition of helplessly standing by while his parents went to their deaths.

Stiff Neck

Arthur was a general practitioner who had a suburban practice. He had referred patients to me from time to time, and they spoke of him with affection, communicating how well he cared for them. We had spoken many times and met on occasions over the years, and the care and responsibility he took in his work always impressed me. He was knowledgeable, sensitive, and conscientious.

The phone rang and I heard a familiar voice. "The patient I want to refer to you today is me," Arthur said. "One of the main reasons is that I know you are interested in the Holocaust." I immediately agreed to see him.

In our first interview he told me that for the last thirteen years he had been plagued by a terrible problem which caused him shame and embarrassment. He had a very stiff neck and had difficulty in turning his head to the left. He felt that everyone was aware of his disability. All possible investigations and treatments had revealed no cause for his problem, and nothing had helped, including years of individual and marital therapy.

After his graduation and first year of residence thirteen years ago, Arthur had applied to be an assistant to an elderly country doctor. He had been both excited and apprehensive, since it was a busy practice and there was only a small country hospital – the doctor was expected to do everything. He went by train to the interview and it was then that he first experienced the stiff neck which had persisted ever since.

"You have said that this has caused you much social embarrassment. How come, what have people said to you?" I asked.

It seemed that no one had actually remarked on his disability and his wife was the only person he had mentioned it to, apart from the relevant professionals. He had not told her how much it bothered him, since he wanted to minimize the whole problem.

Early in my career I had difficulty in restraining myself from speaking out when I saw connections. After years of experience I had learned to listen and wait until the time was right. However, as I listened to Arthur the urge to indicate the connections in his story became almost irresistible. The themes of the stiff neck, the inability to turn to the left, the onset occurring on a train, the possibility of separating from his family, and the years of shame and secrecy all led me to the Holocaust. Nevertheless I managed not to share my thoughts at that time.

"I have known you for a number of years and we have met on many occasions, yet I have never noticed anything unusual about your neck," I said.

He was clearly relieved and reassured. He went on to tell me that he knew his father, Abe, was Jewish and had been in Auschwitz, where he had lost his family. He had come to Australia after the war, married a non-Jewish woman and lived in suburban Melbourne. Arthur's parents had cared for him and his two sisters lovingly, and family life was quiet and uneventful. His father had a small clothing shop in the suburbs, and was a careful and conscientious man who made a comfortable living.

Arthur had made up his mind to be a doctor when he was a young boy. His medical career meant a great deal to him, and he was the pride and joy of his father. He had worked very hard, both at his medical career and at helping his family. Arthur knew his father had been through the camps and

that his family had perished, but how he knew he was not quite sure, and the subject had not been discussed.

I decided to explore further and asked if he knew where his father had been born; if he had brothers and sisters; where he went to school; what he did before the war; whether he had photographs of his family; but there was nothing Arthur could add.

"Why did you feel that the Holocaust was relevant to your problem?" I asked.

"Well, I've tried everything I can think of, and thought that something from my father's past might somehow have affected me. So I decided to try and explore it," Arthur said.

"Up until now I have never thought much about the Holocaust. I was not brought up Jewish. My wife and my kids have no Jewish background – apart from my father, who never mentions it. So until now I didn't think of it. What do you think?" he asked.

"For now I will limit myself to a couple of comments, though there is a lot I could say. Are you aware how the Jewish people are described?" I asked.

He was surprised and shook his head. "The biblical description is that of a stiff-necked people," I said.

"You mean I am a stiff-necked Jew but I have kept quiet about both those things," Arthur said.

"I'd like to prescribe something," I said. "Would you be willing to tell your wife about the intensity of your problem – tell her as much as you can – and ask her to tell you as fully as possible what she knows and feels about it? Also think of who else you can trust and see if they are aware of your disability – but only if it makes sense to you. If not, leave it and we will talk about it next time."

When we next met, Arthur told me that it had been difficult for him to speak openly to his wife about his problem. Nevertheless he did it, since he realized that it was important for him. His wife had not been surprised by how much his disability dominated his life; she had been aware of it for some time. She was certain, though, that his stiff neck was not visible to her or to anyone else, but she had not felt able to say so until now. She had been distressed that he was so affected by it but, worse, she had been very hurt that he had excluded her and not let her share and help him with the problem. This had prevented her from talking about it, and she was very pleased that he had decided to bring it into the open.

Arthur had thought about talking to others and could see the wisdom of it, but first he wanted to explore his idea that there was a Holocaust connection.

I continued to see Arthur over the next two years and we explored his relationship with his father more fully. It became clear that Arthur's efforts to be a good doctor and a responsible and loving son were made mainly for his father's sake. Somehow he sensed the losses his father had suffered and this was his way of making up for them and attempting to heal his father's wounds. Though his parents had their own medical doctor, the person they trusted and consulted was Arthur. His mother always came to him when she was worried about her husband's high blood pressure and although Arthur was officially unable to prescribe and treat, he still carried the burden. His parents also shared with him their worries about his sisters and their families – they seemed to expect him to "cure" everything. So he found himself in the position of medical, emotional, and financial adviser to the whole family. He was always being supportive and reassuring but never expressing his own anxieties and problems, and how burdened he felt by all this responsibility. He remembered that, even as a schoolboy and medical student, he had felt anxiety and fear about not doing well enough and so disappointing his father – his sense of being burdened had started at a very early age. He did not wish to tell his parents about it because he believed this would make them worry even more.

He thought that knowing more about his father's past might help him, but was reluctant to ask because it might have a detrimental effect on his father.

"Consider the alternative," I said. "You've had thirteen years of suffering. You believe that your father's past may be relevant, yet until now you have decided not to tell him about your problem or ask about his past. Until now you've not given him any choice. So I suggest you consider telling him what you have been through. Also, perhaps tell your parents how you feel about being responsible for the whole family and how anxious and vulnerable it makes you feel, and how you have suffered with your neck for so long."

Though Arthur saw the veracity of what I said, he was still reluctant. He worried that his father might feel as if he were being blamed for Arthur's problem.

"That's the downside," I said, "but alternatively it may help you to resolve your problem, and your father would know that he had played an important part in helping you. Perhaps the best way to get your father to open up is for you to change and tell him how it has been over all the years. That would help your father to change too."

Though Arthur completely agreed with this, he could not bring himself to do it. I suggested that he invite his parents to the next session, or that he ask his wife to talk to them, but finally he agreed to approach his father indirectly by talking to his mother first.

His mother told him that his father suffered from a frequently recurring nightmare, waking in great distress, sweating and shaking. She would comfort him, but had never inquired about the content of the nightmare, and he had never told her about it.

It was clear that Arthur had to talk to his father, but it was still difficult for him. I asked what worried him the most about it. He said that, since his father had kept quiet for so many years and never spoken to anyone of his experiences, to speak of them now might open the floodgates of memories so terrible that they might push him over the edge into deep depression or even insanity.

"Perhaps you are right," I said, "but consider the alternative: that he is waiting for someone to indicate that they want to hear; that he wants to tell – he wants it to be known, and he might especially want you to know. It may be a great comfort to him in the same way as when you told your wife about your neck – that was a comfort to you and her. Further, it may be reassuring for him to know you are ready and willing to hear." Arthur was still fearful. I suggested that after he had told his father about himself, he should tell him that he knew about the nightmares and would like to hear about them, leaving it to his father to respond or not as he wished.

When Arthur did eventually pluck up the courage to ask his father about his past, his father welcomed the opportunity. He said that he and his parents had been taken in a cattle truck to Auschwitz. They were lined up, and he was sent to the right to work while his parents were sent to the left to the gas chambers. Since then, he had been unable to bear to look to the left.

His father told him of his life in Poland, of his brother and sisters and his experiences in Auschwitz and afterwards.

After this his father often talked of his visual memory of his parents walking to the left, his feelings of guilt and shame as he stood by, unable to watch. He spoke of many disturbing events and losses, but kept silent about others. However, he shared with Arthur happy memories of his family life before the war, and this was unexpected.

As we were all caught up in the intensity of the story and the gradual opening up of communication between Arthur, his parents, his wife and family, the problem of Arthur's stiff neck was forgotten, and it gradually faded away. When and how it disappeared Arthur did not know.

I asked Arthur how he understood the disappearance of his stiff neck after thirteen years of constant pain. The only thing Arthur, the well-trained physician, could say was: "Somehow everything loosened up, including my neck." Arthur's explanation is probably as good as any.

Physical complaints may develop as metaphors or exquisite symbols for what occurs in life. Particularly in families, the most powerful communications are often nonverbal. As Arthur grew up he was exposed to his father's nightmares, though perhaps he did not remember this. The mystery of how he developed a symptom so specifically relevant to his father's nightmare is difficult to explain. It seems that both Arthur's and his father's life parallelled the nightmare and the symptoms – when his parents were marched to the left he could not look. He was unable to share what happened, and allowed no one to see. His wife knew of his nightmares but did not look at them. Neither parent looked at Arthur's weaknesses, only his strengths. Arthur had to be strong and would not let anyone see his "soft spots."

Of the many traumatic and horrendous experiences Arthur's father had endured, the one that remained frozen in time, and had been revisited every night, was the point of separation from his parents.

Similarly for Arthur, the stiff neck which stayed with him constantly for thirteen years began at the point of separation from his family. This is a common experience in Holocaust families.

For Arthur and his father the healing started when each communicated and shared his private anguish. When they *connected* with each other by talking about the pain of separation, they began to overcome their torment.

Morbid Jealousy

Gary was the epitome of the successful businessman. He lived in a large house in an upper-class suburb and his children went to private schools. He wore an Italian suit and a gold ring and in a quiet way he let you know he drove a Mercedes.

Once he began to say why he had come, his easy confidence disappeared and he spoke with embarrassment and shame. The contrast was striking, particularly as he was a veteran of three years of individual, marital, and family therapy with three different therapists. His problem remained unaltered.

He said he had a good wife, a good marriage, good kids, good business, and a beautiful home. He had been married for about twenty years when, some four years ago, he began to worry that his wife had been unfaithful to him before their marriage. They had gone out together for some time before they married, and then decided to break up. During this short break she had gone out two or three times with another man, and it was with this man that he imagined she had betrayed him.

This thought took increasing hold of him until he was constantly and morbidly preoccupied with it. For a while, he managed to keep it to himself, but eventually he subjected his wife to nightly interrogations about what had happened between her and this man. He really knew that "she didn't do anything bad," and even if she had what was all the fuss about

now? He had broken it off – she had been free. Since their marriage, she had been a devoted wife and mother. Why could he not stop tormenting himself?

A careful exploration of any possible precipitating event seemed unhelpful. The most likely was that his daughter had left home. He was not altogether happy about this, but accepted it since she was sharing a flat with friends whom he knew to be from good homes.

During the next few meetings, the details of his business and family emerged. His Jewish mother had left Eastern Europe in her teens and worked in England, where she met her husband, a Scotsman. Gary's father died when he was four, and his mother emigrated to Australia. Here she worked in a factory on various shifts. As she was unable to care for Gary, she placed him with a family in the country, where she managed to visit him about once a month. Gary wondered whether his mother could have kept him or had no other choice.

After a few months, and despite occasional encouraging signs, we ended up getting nowhere. Neither of us had any understanding of the origin or meaning of his complaint. As a last resort, I suggested involving his mother. At first he was most reluctant, since it was important for him to continue to appear successful and competent to his mother, more than to anyone else. Letting her know of his problem was anathema to him, but we could not think of anything else to do. His wife was about to leave, driven to distraction by his unfounded jealousy. In desperation, he eventually agreed to involve his mother. Although he wanted to talk to her first, he could not bring himself to do so, but he did ask her to the next session.

When Gary told his mother his problem she went white and could not speak. I asked if she could tell us anything that would help us to understand Gary's problem.

She said, "It's all my fault, it's all my fault. I left home against my parents' wishes. I married out and so betrayed and shamed my parents, who disowned me. Then my whole family perished in the Holocaust. Since then, every night I have nightmares in which my mother comes and reproaches me. I always wake up crying and saying, `Leave me alone; it's enough!' I think God has punished me for marrying against my parents' wishes by having them killed, and by my husband dying. Then I was left with a little boy I couldn't look after, and now this."

In her nightmare, her conversation with her mother was in Yiddish, a language she had not used for nearly fifty years.

Gary was now also very pale, struck by the fact that his mother had used the identical words that he had when he talked about his wife's betrayal.

Gary's mother emphasized that this nightmare was a nightly event which she had never told a living soul.

To her surprise, I asked, "Did you send Gary away to protect him from your nightmares?" While her answer was a convoluted, "Yes, no or maybe," both Gary and I clearly understood her nonverbal response as "Yes."

Although she struggled with the idea emotionally, she seemed to accept and feel relieved by it.

Over the next few months, Gary and his mother came both separately and together. Many things were explored and resolved, but the unmistakable turning point in therapy was his mother's confession of her secret nightmare, and the striking similarity with Gary's own torment.

We can hypothesize that the trauma was transmitted from one generation to the next. There is no doubt that Gary's mother never told him about her past – her guilt, her shame, her nightmares, and her persecution. Yet he was profoundly and minutely influenced by her experience. The puzzling aspect is how such communications can take place from one generation to the next.

It seems clear that intense pain and trauma leads to extensive and severe denial and repression which in turn provide a fertile ground for maintaining family secrets, particularly in the context of an intense, ambivalent relationship in which one generation impacts strongly on the next. The healing occurs by lifting the veils of secrecy and making the covert unconscious communication overt and part of ordinary conversation.

All of Gary's previous three years of therapy, and his many hours of therapy with me, in which his marriage, his family relationships, his sexual history, and his business affairs were explored, failed to provide a context that explained or provided any understanding of his problems. The problem remained isolated in his life and defied comprehension.

This stood in marked contrast to the fateful session with his mother, when all three of us felt instant recognition like a bolt of lightning – at a level at which logic does not enter. This insight was experienced viscerally, in the heart and in the gut. It was the turning point in therapy, which eventually led to a smooth resolution of Gary's and his family's problems.

When I was seeing Gary, he was so dominated by his problem that he was immobilized by frequent bouts of depression lasting some days. His nightly interrogation of his wife made sleep almost impossible and his health was affected. His daughter was reluctant to visit, and his son's school performance had deteriorated.

Gary's attitude to life was rigorously anti-historical. He lived life in the here and now, being uninterested in and ignorant of his parents and their family history. Life began when he and his mother arrived in Australia: there was no pre-Australian past.

His mother's inner life, in contrast, was almost totally dominated by her pre-Australian past. The breaking of her silence helped her to reduce

the nightmares and become more involved in her present-day life, and also made Gary more interested in his own and his family's history. The healing process began when they both relinquished the rigid positions they had occupied.

Gary did not regard himself as Jewish and the Holocaust had no personal meaning for him. His mother had been in England when the Holocaust took place; it was her family who had perished. This made Gary a third-generation person affected by the Holocaust – indeed a very long shadow.

Gary accused his wife of betrayal in a manner similar to his mother's self-accusation of betrayal. Both experienced unending secret shame in relation to their problems. The only connection with the onset of Gary's problem was that his daughter left home at the same age as his mother had left her family. As we explored this connection, Gary acknowledged separation difficulties which he had previously denied.

I found it hard to believe that Gary's mother had never mentioned her nightmares to him, so over the next few months I explored this. In the end, I was satisfied that she had never told Gary about them. She and Gary were, however, together often enough for him to have been aware that she did have nightmares, since she frequently woke up screaming, in a sweat. They had apparently both forgotten this.

It is likely that the content of her nightmares was indirectly communicated. Gary knew that he had no family except his mother. From a very early age he knew that other children did have families. His mother never spoke of his father, her parents, her siblings, and so on. Her silence was exceedingly eloquent. Perhaps he even inquired as a child, but the response was only silent pain.

Constant Warfare

For some time I had known Ruth as a senior and responsible social worker. One day she rang and asked whether she and her brother, David, a prominent medical specialist, could come to discuss worries about their parents.

At the first session Ruth said that most of the burden of their parents fell on her. The constant phone calls from each of them had recently become too much for her and she had pleaded with her brother to become more involved. She was delighted that, for the past few months, he had done so. He agreed that she had carried much more of the burden than he had. His parents were in awe of his career and success and would do nothing to disturb him. Then he took over and presented "the case."

Since their mother had arrived from Europe, he said, she had bouts of depression. For the last forty years she had ongoing psychiatric care, including three administrations of electroconvulsive therapy (E.C.T.), medication, and frequent hospitalizations.

In recent years, particularly since their father's retirement, interaction between the parents had become increasingly hostile. Each would ring Ruth several times a day, complaining how impossible the other was. Over the years, the mother had often complained that her husband had threatened to kill her. Since discussing it more fully with Ruth and other colleagues, David felt it was time to seek psychotherapy. He believed that I might understand the situation better since I was Jewish and had a special interest in the Holocaust. Specifically, he asked me whether I would see both his parents together, because previously only his mother had undergone therapy.

I was not sure if I could help, as there had been a long history of depression and of marital problems, and the parents were in their late sixties. People at that age do not relish discussion of their problems. Both Ruth and David acknowledged that this was so but urged me to try nevertheless, saying there was nothing to lose. Eventually I agreed to an assessment interview, provided that both of them came too.

"Wouldn't it inhibit them?" David asked.

"I expect so," I replied. "That's one reason I'd like you both to be present."

All four came to the next session. Some of the "case history" was repeated.

"Yes, I do get very unhappy and agitated," the mother agreed. "I've told various doctors over the years that my husband is going to kill me, but they don't believe me; they think I'm *meshuga* (mad)."

I asked the father, "Do you tell your wife you are going to kill her?"

"Of course I do," he replied. "If the doctors had asked me, I would have told them so. She drives me crazy. If anything is moved an inch out of place in the kitchen the third world war starts. Every plate has a different towel. If I use the wrong towel I hear about it for days. If I go to the toilet and leave the light on, I hear about it for months. It's as if she is trying to drive me out of the house or out of my mind. So of course I say I'll kill her."

"How long have the two of you been fighting like this?" I asked.

This was a bombshell. Suddenly they both became quiet and pale. Until that moment, each had spoken eagerly, wanting to get in first and interrupt the other. Now neither wanted to speak.

Eventually it emerged that it had started when they were on the run and in hiding during the war. In the Lodz ghetto, with their families about to be rounded up, they were prevailed upon to escape if they could. They reluctantly agreed to go, and left the ghetto to go to a Christian family, their parents' partners before the war. They were hidden and then moved on, hiding again until the war ended. They were cooped up for months on end. Scared

of being discovered, they worried in silence about what had happened to their families, even though they knew what to expect. Perhaps even worse, the people who hid them quarrelled almost every night, not realizing that they could hear. The wife wanted to send them away, since they were risking their lives and the lives of their children for two Jews.

"In turn," they told me, "we were driving each other crazy just by our looks and whispers, but we just had to be quiet. Somehow we survived, only to discover that our families had been liquidated. Our guess is we've been fighting ever since. We've never stopped."

"Maybe your fighting is a celebration of victory, a triumph over Hitler," I suggested. "After having to be so quiet in hiding for so long, now that you are free, you can yell and scream to your hearts' content."

They became thoughtful and quiet, so I continued, "There is one other question I'm keen to ask and I hope you won't mind. What were the last words you remember your parents saying?"

Again they were taken aback. They became tearful as they remembered the words, "Look after each other."

Over the next few months, I usually saw the four of them together, but occasionally just the parents, when Ruth and David were too busy. They were happy for their children to come, but worried that it was interfering with David's practice. David, however, indicated that it was time very well spent, since for years he had worried about his mother and his parents' relationship. If he could help by coming, it was preferable to seeing more patients.

"To you, maybe, my career is the most important thing," David said. "But to me, you are more important than my career and my patients, and your protecting me gives me more worries than if I knew what was going on."

During these months, one comment I made stood out for them. One day, when the parents had come alone, they were sitting on a couch in the corridor rather than in the waiting room. I saw them sitting very close together and engaged in either an animated conversation or a fight. When they came to my room I asked whether they would give me permission to say something very personal which they might think was *meshuga*, and they nodded. I told them that I had noticed them in the corridor and didn't know whether they were fighting or whether two young lovers were having an animated conversation.

I wasn't sure which explanation they thought was more accurate, but I could see they clearly preferred the latter. I took it as an invitation to continue. I said that most couples at their stage in life were bored with one other, having no energy left, yet here they were, engaged in a lively exchange. Perhaps one of the secrets of the success of their marriage was the constant challenge to understand what was going on, what they were doing to each other, in the same way as they had puzzled me when I saw them in the corridor. Neither they nor I could work out how much of what I said was serious and how much in jest. But I was certain that they liked what I said, that it meant a lot to them.

My contact with this family still continues as the need arises. The mother still gets depressed from time to time, the father still threatens her occasionally, and sometimes they drive each other crazy. But the constant phone calls to Ruth have ceased, as has the need for E.C.T. and hospitalization.

In her years of psychiatric treatment, Ruth's mother's Holocaust past was never confronted; neither was her "paranoia" investigated by talking with Ruth's father. Her symptoms were explored, but silence reigned on her history.

Having the whole family attend was a major factor in achieving this relatively positive outcome, particularly the presence of David. His parents were exceedingly proud of him and, over the years, had attempted to spare him the worries of their predicament. He, in turn, had protected them from the knowledge of how deeply distressed and concerned he was. This arrangement of mutual protection had placed Ruth in an increasingly intolerable position which only began to change when she enlisted David's assistance and all came together to therapy. David's presence confronted his parents with the reality of his anxiety about them. More importantly, it confronted them with the achievement of having produced such a capable son. Their own life was constant warfare, dominated by the events of the past, even though they did not talk about them. They were preoccupied with sickness, death, guilt, and shame. David represented a successful present and a bright future: health, success, pride, and joy. Bringing them together to therapy made them confront these differences more fully and led to a new and healthier way of relating to each other and feeling about themselves.

Ruth's role could easily be overlooked. The children of migrants often become experts on local culture and spokesperson for their parents, who become dependent on them. At the age of 10, when Ruth went with her parents to a bank to ask for a loan, the manager said, "This is the first time I've approved a loan to a ten year old!"

Many survivors have lost parents, brothers and sisters, and their children often become all of these. David and Ruth assumed the role of parents to their own parents, as if they were a nuclear family, with a father much admired but distant and peripheral, and a mother overburdened, over-responsible, and under-appreciated. Ruth's professional achievements were not acknowledged by her family.

When I showed them this story, the father commented, "You know, we had no one to talk to. We lost everybody and we lost our faith, so we

couldn't talk to a Rabbi. We poured out our troubles to Ruth. Now we can talk to you, at last Ruth can live her own life a bit."

If a therapist is able to use humor in a positive way that touches his or her patients, it is evidence that the therapist understands them and speaks their language. Even in the death camps there were moments of humor, and when survivors get together they spend some time in humorous reminiscing.

Humor can play an important part in therapy and help to break the silence, to reduce tension and the awkwardness of a social situation. It also helps people to see connections in a new light. On the other hand it can be cruel and distancing if it is used to avoid and minimize the expression of pain by the patient. The crucial test of humor is how it is experienced. Either it is seen as accepting and warm, in which case it helps to break the silence, or as harsh and disrespectful, so reinforcing it.

A Time to Grieve

Mrs. Cohen did not want to come for family therapy at all. She only attended because her children had asked her to, and only for their sake. They were concerned that, since the death of her son-in-law, about eight months ago, she had not been the same. She had "dropped her bundle," staying at home, refusing to go back to work, and neglecting her housework. It seemed as if she had lost interest in living. Before her son-in-law's death, Mrs. Cohen had been a dedicated teacher, a proud housewife, and a concerned and conscientious mother.

Her widowed daughter, who was pregnant, and her son had been urging their mother to get out of the house, to resume her normal life and go back to work. They said they had never seen her like this and were very concerned. They hoped that I might be able to convince her to become her old self again.

When I inquired further I was told that the daughter was behaving as she wanted her mother to behave. She kept her chin up, put on a brave face, and got on with life. Their mother's behavior was a total puzzle to both children.

Mr. Cohen was in many ways similar to his wife. He was a respected school headmaster and a devoted father and husband. He agreed with his children, although without their intensity and conviction, that his wife should "snap out of it."

It was only in answer to specific questions that I was told that the Cohens had spent the war years in Europe. When I inquired further, they somehow intimated that they had been through the camps and had suffered a great deal, however they refused to give me any further detail. The children indicated that they had a good idea of what their parents had been through. They thought of them as people who could cope with anything.

They agreed that their mother should talk to me about what she had been through because that might help her to "come good again." Mrs. Cohen wasn't so sure. When I asked why, she indicated that it was not so simple.

When I gently asked whether she could perhaps tell me more, she responded by saying, "I have been carrying a lot; also they don't understand...Maybe I was strong, but that was only on the outside. Inside it has been a terrible turmoil and a great struggle."

The longer the conversation went, the more polarized the family became. The children insisted that their mother tell me everything and get on with it. The mother maintained her right to be the way she was. She was not so sure that talking was a good idea.

Eventually they all turned to me and insisted that I tell them what I thought. I replied that I found it very difficult to answer because I was also struggling with the same issues; how to work out which was the best way. To decide between the two alternatives was very difficult. On one hand, many people, and particularly psychologists, believe that talking about things that are painful is helpful. Mrs. Cohen said that she had been carrying a heavy burden for a very long time; perhaps, therefore, it was time for her to unburden. Further, she had said that she had been strong externally but internally in pain. Perhaps if she were to talk she would get some comfort and relief. In so doing, she would do something for her children that for some reason was very important to them: reveal an important part of their family history. Particularly now that Mrs. Cohen's daughter was expecting a baby, perhaps it was very important for her to know of her family history.

On the other hand, I said, there may have been very good reasons for Mrs. Cohen to maintain her silence. Perhaps she wished to remain silent because that was her way of showing respect to those who had not survived. She may also have felt that it was wrong for her to relinquish her suffering. She was entitled now, after so many years, to allow herself time out for grieving. Until now it had not been appropriate to grieve; it had been time to build, work, and plan for the future. Perhaps now she could afford the "luxury" of mourning and grieving – not just for her son-in-law but for all the others as well.

"I also recall," I told the children, "that you described your mother as weak or cowardly for behaving the way she has during the last few months. Perhaps she has been weak for giving in to the pain and suffering, but perhaps she is a hero for finding the courage to cry after all these years."

It was this last comment, more than anything else, that appealed to Mrs. Cohen and meant a great deal to her. She turned to her children and said, "You see, I am right. I am the hero. You know what I think? I need to think about that. Maybe I will talk to you, but then again, maybe I won't. I need to think about it."

"What do you think we should do?" the children asked me.

"Perhaps you can all go home and think about it," I replied. "But among other things, you could also think about whether you all come together next time or if only your mother should come. She may not want to burden you with her story. I will leave it to all of you."

Mrs. Cohen chose to come alone, indicating that my recognition of her ambivalence and struggle had made it easier for her to come again. My acceptance and praise of her silence made it easier for her to talk. Like many survivors, Mrs. Cohen had managed to keep her grief over all her losses inside, but when a new loss is experienced after so many years of silence and control, it reactivates the grief and intensifies the memories of the old losses. For most survivors at Mrs. Cohen's stage of life, the most common loss is the death of a spouse. Perhaps in her case, the loss of a young life was more painful and more congruent with her Holocaust experiences.

As a Holocaust survivor, Mrs. Cohen belongs to an aging population. Perhaps it could be said that they have now reached a stage in life in which it is normal to attempt to remember the past and try to integrate it with the present and the future. It is time to reflect on life. Perhaps this also made it impossible for her to retain her former way of functioning.

Families can become highly polarized or split around Holocaust experiences. In this family the children took the extreme position of pushing Mrs. Cohen to resume her former way of functioning – of being strong and not yielding to pain or weakness. Mrs. Cohen took the opposite view, believing that she was entitled to grieve and to remain silent. Such a public split often obscures the private and submerged ambivalence. Mrs. Cohen also wanted and needed to talk and remember, and eventually to share her memories with her family. Her daughter also needed to grieve and cry for the loss of her husband, but felt constrained from doing so. She had to concentrate on the future and the life growing inside her.

For the daughter, too, there may have been another aspect about which she remained silent. She indicated that she knew her mother's story. Since she described her mother as strong and able to cope with anything, it is probable that her mother had told her story by stating the bare facts in a matter-of-fact manner.

Children of survivors, particularly when they are expecting their first child, become acutely aware of the absence of grandparents and extended family and the lack of continuity in family life.

As Mrs. Cohen's daughter expected to become a mother, perhaps she became more closely identified with her own mother and more interested in her, not just as a mother but also as a daughter. For her own sake, and for the new life inside her, she needed a richer and more emotional description

of what had happened to her family, so that her physical loss would not be accompanied by silence about the dead.

Holocaust survivors experience intense conflict and ambivalence: about the urge to talk and bear witness and the opposite impulse to remain silent; between the wish and need to leave it all behind them and the intense commitment never to forget, to remember everything. Indeed some live with a *dread* of forgetting. They want to protect their children and keep them free of the horror, yet they are dismayed by the idea of the children not knowing. They often idealize their parents, yet at the same time feel rage towards them for leaving them "abandoned and unprotected," for relying on them, their children, in the death camps, and for making them witnesses to their degradation, shame, and death.

This kind of conflict is experienced by each individual, as well as between members of the family. Individuals take opposite positions and the family becomes polarized.

Under the Nazis there was one ideology and one truth – there were no choices. Life was dominated by terror and the effort to survive.

Against this background it is very useful to offer multiple descriptions of survivors' lives, symptoms, choices, and the meanings that can be attributed to them. The more sensitive these descriptions are to the reality of their experiences and the social and historical context in which they emerged, the more enabling and freeing it is to survivors and their families in lifting the veils of silence.

Reflection

Most of the families described here had sought psychiatric help, and in every case their Holocaust experiences had not been raised. The families did not mention the Holocaust and did not share their memories, and it can be assumed that their previous therapists did not inquire or communicate their willingness to listen. When these families were offered the opportunity to explore their Holocaust experiences they all took it, at least to some degree. Silence, like talking, is interactive.

The avoidance of the Holocaust in therapy used not to be the exception but the rule. Often the files in psychiatric institutions, whether in the U.S.A., Israel, or Australia, recorded only "born in Europe," "arrived U.S.A./Australia/Israel" and the year – nothing more. On the whole, the personal, ethnic, and professional background of the helper made little difference. Even when analyst and patient were both Holocaust survivors, it was still avoided (Danieli, 1988; Kestenberg, 1972). Yet on the whole the psychoanalytical literature has confronted the Holocaust whilst the Family Therapy literature has not. Migrants who come to a new country commonly

wish to leave their old life behind, and Holocaust survivors certainly hoped for this too. Those in the helping professions often acceded to this wish by ignoring the past.

Primo Levi described how a guard in Auschwitz taunted the inmates by saying, "None of you will be left to bear witness, but even if someone were to survive, the world would not believe him." (Levi, 1988a, p.1) The survivors often experienced even worse, generally, no one was interested; they didn't want to hear. Silence, to some degree, was often imposed by the social context and, to a large degree in therapy, by the therapist.

Not only were Holocaust survivors not heard, they were often blamed for the crimes committed against them. They had failed to resist, to run away, had been too passive, their families had gone to the gas chambers like lambs to the slaughter. Even their very survival was questioned. Did they survive at the expense of others by collaborating with the enemy, or by committing immoral acts?

On some occasions when I have presented my work on the Holocaust to mental health professionals, I have been asked why survivors could not simply forget and forgive: why were they so morbidly preoccupied? I often receive letters urging me to consider the merits of forgiving. Such an attitude in professionals working with survivors and their families must exacerbate their sufferings. Directly or subtly, the message is conveyed that there is something wrong, or even pathological, in not wishing to forget or forgive.

Even in the psychological literature written by therapists who have worked with survivors, the silence caused by mutual avoidance of the subject by the survivors themselves, their families, the therapists, and society in general, is usually referred to as a "*conspiracy* of silence" or as "collusion." (See for example, Danieli, 1984, 1988; Niederland, 1967.)

This is a regrettable use of language. "Conspiracy" is defined as "an evil, unlawful, illegal, reprehensible act or plot involving two or more persons;" "an agreement by two or more persons to commit a crime, fraud or other unlawful act." It involves, therefore, blaming and condemning victims, and places further demands on them to refrain. It is one thing to say that people choose to be silent and that their silence is detrimental to them and their families, and thus to encourage them to speak. It is quite another to use condemnatory language.

Silence or communication is never total. Often those who have not spoken have communicated in some other way. Those who speak of the Holocaust frequently remain silent about some aspects of it, usually those aspects most associated with their inner feelings.

When their children were young, parents naturally wished to protect them from their horrendous experiences, from the knowledge of how cruel, treacherous, and dangerous the world could be. For many, this tendency to protect continued, and often the parents waited for signs from the children that they were ready and willing to hear. In therapy it is often incumbent on the therapist to help the children convince their parents that they are able to cope with the unknown horrors that may unfold. This can be a long complex and painful process. More often, parents are willing to share their experiences if it is for their children's sake rather than to gain personal relief for themselves. Of course there are some survivors who talk compulsively and at times inappropriately in a manner that is damaging to their children (see Shower Phobia).

Holocaust survivors have the memory of what happened, and therefore a context for understanding their symptoms. Often their children experience the symptoms and the pain of their parents without the knowledge of the trauma that gave rise to them.

Usually the parents who are non-communicative about their Holocaust experiences are also silent about their lives and the lives of their families before. Thus the children grow up without a context in which to understand their own sufferings, without an extended family, and without any family stories. This may make them feel more alienated and confused about their suffering and cause self-recrimination such as "What right have we to suffer since our trauma is so insignificant compared to that of our parents?"

One task of therapy is to facilitate communication, enabling the parents to tell of their experiences and the children to discover more of their family history. This gives meaning and understanding to their suffering.

In psychotherapy talking is cure; silence is usually associated with defensiveness, resistance, negativism, and denial. The positive aspects of silence are often overlooked. The sufferer may experience silence as strength and courage. Silence can be a mark of respect. To remember, we stand together in silence; in silence we pray to honor the dead. As one survivor said, "When they walked into the gas chambers they were silent. Those who watched them watched in silence. The whole world remained silent. To talk about it now in order to gain personal relief is to desecrate their memory." Silent suffering and guilt is often a testimonial, a memorial to those who have perished. "They have no grave and no tombstones, my silence is their resting place, their memorial candle" another survivor said to me.

Many who survived say that what kept them going more than anything else was the wish to stay alive in order to tell, to bear witness. Many live in dread that when they die, their story will die with them. For most survivors there is a struggle between remaining silent or talking, and this is often parallelled within their families, where the children wish parents to communicate but the parents are reluctant to do so.

It is not the role of the therapist to promote either silence or communication, but rather to indicate a willingness to listen if the families choose to talk. The therapist needs to show a readiness to discuss the family's ambivalence about talking or not, and to elicit their fears and anxieties about it. The therapist may be helpful by offering indirect ways of communicating and thus provide a compromise solution. As has been observed, oblique methods are often the only ones appropriate when confronting the enormity of the Holocaust.

To the Nazis, all the camp inmates were the same – merely numbers. They had no identities and no choices. In therapy, therefore, giving the family the choice of whether to come or not, of who should come, how often, for how long and with what aim, is of paramount importance. The therapist should offer multiple descriptions of any event and allow the family to choose. The choices need to be informed, and so the therapist needs to be open about possible options. The family may then be invited to decide how they can work together.

Because these families have experienced unparalleled loss, the therapist should indicate a willingness to be permanently available to them, as a sort of psychological or emotional general practitioner, someone who they can call on regularly or from time to time as required, either jointly, in smaller groups, or individually.

Sometimes complete or significant recovery is achieved. Often, however, it is necessary to settle for less. Frequently members of the family, usually the children, need to accept the inability or unwillingness of their parents to change. Even if the children's acceptance and understanding of their parents is all that is achieved, this can be an important source of comfort and satisfaction to all.

The task of therapy is to explore the possible contexts that are relevant to the presenting problem. No psychological theory or empirical evidence can predict this with certainty.

In the families of survivors the Holocaust history may or may not be pertinent. Holocaust survivors can be depressed, or their children can have marital difficulties or fail at school, without it being in any way related to the Holocaust. It would be a tragedy if, whenever a Holocaust survivor or anyone of his or her family consulted a member of the helping professions, they were pressured into reliving the Holocaust.

It is common for many families to feel embarrassed or defeated when they seek psychiatric help. How much more so for survivors when their experience has taught them that to display vulnerability or weakness was exceedingly dangerous, often resulting in death. It is particularly important for the therapist to be conscious of this but also of the family's history of resilience in overcoming untold difficulties. The more the therapist highlights their strengths, the more willing and able they will be to acknowledge their difficulties and presumed weaknesses.

The ability of Holocaust survivors to rebuild their lives, to work, laugh, dance, marry, and raise their families, is evidence of vitality and resilience of extraordinary proportions. It should never be forgotten.

Bibliography

Braham, R.L. (Ed.). (1988). *The psychological perspectives of the Holocaust and its aftermath*. New York: Columbia University Press.

Chodoff, P. (1975). *Psychiatric aspects of the Nazi persecution*. In S. Arieti (Ed.), *American handbook of psychiatry* Vol. 6, 2nd ed. New York: Basic Books.

Danieli, Y. (1984). Psychotherapists' participation in the conspiracy of silence about the Holocaust. *Psychoanalytic Psychology, 1* (1), 23-42.

Danieli, Y. (1988). Confronting the unimaginable: Psychotherapists' reaction to victims of the Nazi Holocaust. In J.P. Wilson, Z. Harel, & B. Kahana (Eds.), *Human adaptation to extreme stress: From the Holocaust to Vietnam* (pp.219-238). New York: Plenum.

Eitinger, L., & Krell, R. (Eds.). (1985). *The psychological and medical effects of concentration camps and related persecutions on survivors of the Holocaust: A research bibliography*. Vancouver, BC: University of British Columbia Press.

Kestenberg, J.S. (1972). Psychoanalytic contributions to the problem of chidren of survivors from Nazi persecution. *Israeli Annals of Psychiatry, 10* (4).

Krystal, H. (1986). *Massive psychic trauma*. New York: International University Press.

Krystal, H., & Niederland, W.G. (Eds.). (1971). *Psychic traumatization. Aftereffects in individuals and communities*. Boston: Little, Brown.

Lang, M. (1994). The long shadow: Family therapy with Holocaust survivors and their families. *Generation, 4* (1), 22-49.

Lang, M. (1995). Silence - therapy with Holocaust survivors and their families. *The Australian and New Zealand Journal of Family Therapy, 16* (1), 1-10.

Lang, M. (1995). The shadow of evil. *The Family Therapy Networker*, September/October Edition, pp. 65-67.

Lang M., & Lang, T. (1996). *Resilience: Stories of a family therapist* (in press). Melbourne: Reed Books.

Lang, M., & Stagoll, B. (1989). Holocaust conference. *The Australian and New Zealand Journal of Family Therapy, 10* (1), 53-54.

Levi, P. (1988a). *The drowned and the saved*. Harmonsworth, U.K.: Penguin.

Levi, P. (1988b). *If this is a man*. Harmonsworth, U.K.: Penguin.

Niederland, W.G. (1964). Psychiatric disorders among persecution victims: A contribution to the understanding of concentration camp pathology and its aftereffects. *Journal of Nervous and Mental Disease, 139*, 458-474.

Wiesel, E. (1970). *One generation after*. New York: Simon and Schuster.

The Longest Shadow:
A Clinical Commentary on Moshe Lang's Paper

Edwin Harari
St. Vincent's Hospital, Fitzroy, Vic., Australia

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 one another. For example in the 1960s pediatricians 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 recognized 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 centers 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 & Niederland, 1971), and to which Moshe Lang's chapter is a fine contribution. However, the number of papers published in the mainstream English psychiatric and psychotherapy literature is meager 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.

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 objectifing nomenclature of clinical psychiatry, and the aims 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 survivor to feel unworthy of help and to minimize the significance of the Holocaust experiences as a source of his or her 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 labor 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 1930s 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 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 toward 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 sadomasochistic 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 his perceptions of his "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 "inner" world that led him to experience his 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 1960s) 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 emphasized 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 trau-

ma 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 his inner world so as to fill this gap. This may be done in many ways – some creative, others "pathological," some of 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 idealized 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 1960s, 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 to promote dialogue between the generations about disturbing topics and address how some families become frozen in time in the face of massive trauma, to the extent that the grief and fear of the traumatized 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 1970s 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, minimized 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 behaviors). 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 brutalized 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, p.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 postmodernist 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).

Psychotherapy demands a synthesis of the perspectives of the individual, the family, and the sociocultural 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 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.

Bibliography

Foucault, M. (1972). *The archeology of knowledge*. New York: Random House.

Krystal, H., & Niederland, W.G. (Eds.). (1971). *Psychic traumatization. International psychiatric clinics, 8* (1). Boston: Little, Brown.

Niederland, W.G. (1961). The problem of the survivor. *Journal of the Hillside Hospital, 10*, 223-247.
Pines, D. (1993). *A woman's unconscious use of her body - a psychoanalytical perspective*. London: Virago Press.
Young, J.E. (1990). *Writing and rewriting the holocaust*. Bloomington: Indiana University Press.

The Longest Shadow: Commentary on Moshe Lang's Paper

Florence Kaslow
Florida's Couples and Family Institute
West Palm Beach, FL, U.S.A.

While reading Moshe Lang's chapter, I was struck by the similarity of his patients to mine, although we reside and practice thousands of miles apart. Jewish Holocaust survivors who live in diaspora countries such as Australia, the USA, Canada, South Africa, Mexico, Argentina, and Chile have generally tried to acclimatize to their adopted homelands, and perhaps to compartmentalize the memories and fantasies about the personal/historical events that occurred in Germany, Poland, or Czechoslovakia. On the one hand, this has been necessary so that they can rebuild their lives, establish new families, and live in the present while planning for the future with a modicum of optimism. Yet, on the other hand, they know and are periodically reminded that they must not forget because to forget would be to fail to be vigilant.

Nonetheless, we know that when people suffer from post-traumatic stress disorder and its accompanying symptoms – anxiety, depression, pessimism, fear, obsessive-compulsive behavior patterns, and the inability to trust so that close interpersonal relationships elude them – they may take many years to recover. The recovery includes talking about the memories of the experience, often with much repetition. Ultimately, it is beneficial if some understanding and integration of the horrifying facts and experiences can take place. This may not be feasible for Holocaust survivors; some find that there is no way to accept and forgive this widescale inhumanity. In addition, therefore, to a legacy of being victims of incomprehensible cruelty, sadness and grief over multiple losses make healing and recovery quite dif-

ficult. This survivor experience is not akin to that of a traumatic disaster such as an earthquake or a hurricane. These are not deliberate or premeditated acts and are not initiated by a nation's desire to purge the world of certain groups of people it deems to be unworthy.

When survivors emigrated, they were often socialized not to talk about their tortured past. Few wanted to hear the horrendous stories, and certainly not repeatedly. Survivors tried to hide the numbers tattooed on their arms and to look and act like everyone else. They turned their time and attention to making a living; to learning new languages, customs, and lifestyles; to building a family and creating a new future. They tried to submerge the shame and guilt they felt for being tainted by such an era, from having lived in the world of the concentration camp and/or hiding out to escape capture and extermination. If their new spouses, children, and eventually grandchildren heard too little about their past, these latter often fantasied about situations and behaviors that were as bad or worse than any which might have actually befallen the victims. If the sufferers remained overtly preoccupied with the Holocaust and talked and cried about it often, the children frequently tried to take care of and protect their parents from further hurt and harm. Many became perfectionists, excessively devoted and enmeshed – realizing they could not break away as part of their own normal development because their parents could not tolerate additional losses or abandonments by cherished family members. Only in the past two decades have groups of Holocaust survivors and their families begun to get together in countries in the diaspora to share their experiences, form support networks, make it legitimate to speak out, and build Holocaust memorials so that "We Shall Not Forget."

It is against such an historical backdrop and internationally generic, yet Australian specific, context that Lang has written his compelling chapter, After the Holocaust: Therapy with survivors and their families. His willingness to accept silence as emanating from not only a desire to protect current relations, but as a sign of profound respect for those who perished, is quietly and profoundly illuminating.

Dr. Florence Kaslow was also asked to offer reflections on her experiences with the offspring of Nazis. While she was clear that no parallel was to be drawn between the suffering of the two, her experience offered a valuable, added insight into the long - and twisted - shadow of the Holocaust[1].

Survivors of Perpetrators: The Polar Opposite

An effort is made to explore the perpetrator legacy herein through the retelling of an unanticipated therapeutic encounter that recently took place when the author was in Germany.

In 1989, I was scheduled to do a four day workshop on theories of family therapy in Germany. The participants were a group of about 30 beginning second-year trainees in a postgraduate family therapy program. Their first year had focused predominately on the self of the therapist, and they had explored family of origin issues. Most had also been in individual therapy. The first morning I asked them to each share with me their goals for and from the workshop. When one of the men, Hans, who happened to be one of several participants rotating the translator role blurted out, "I'd like to finally find out – if I'm the son of a murderer – what am I?" I reacted with stunned silence and then an acknowledgement of the comment with a nod. Most of the others raised questions about the different schools of thought, and we breathed a collective sigh of relief.

On the third day, I did a demonstration session with a couple who periodically lived together. Each had been previously married to others, and had children from their earlier unions. Each seemed to have numerous unresolved loose ends with their families of origin and their inability to either let go of the relationship or to make a definite, permanent commitment. One of my suggestions to the couples' therapists was that they might consider conducting a multigenerational session with each of the parties and his/her parents. Some trainees said they had read about this approach (others had not), but none had seen it done or had used it. They requested that I include such a demonstration on the fourth day.

By then I had developed a good rapport with Hans, and some others in the group had gradually let me know that they harbored the same anxiety that he had expressed. Therefore, I asked if he would like me to illustrate how to prepare for and conduct a multigenerational session around the dilemma he had presented. This meant he would be the "identified (index) patient" and would select members of the group to represent his relatives. We went through the potential pros and cons of utilizing his real life story. He seized the opportunity saying he was desperate for relief from this lifelong nightmare and that he felt safe enough with the group to take the risk. The previous year they had all done a great deal of self-disclosing and he was comfortable doing so again.

First, I conducted an individual session with him to get a brief history and his view of what was troubling him. He relayed that he knew his father was a member of the SS during World War Two, but that beyond that, his father would not discuss what he had done or why. Hans was plagued by his fantasies of the atrocities his father had committed. In anger he had left the family during his mid-teen years. From ages 18 to 28 years he had become a drug addict and lived his life in the drug culture. At age 28, he realized he had to stop using drugs or he would die, as some of his comrades had. He went into a drug treatment program for six months and by the day

of our session, had been in recovery for four years. He was single and unable to stay involved in any long-term meaningful relationship. With all of the treatment he had received in the in-patient program, a twelve-step recovery program, individual therapy, and the family therapy training program's focus on self, no one had touched the critical issue of his father's active allegiance to and participation in the Nazi Party. Hans knew that for him to attain any peace he "needed to know" about his father's history and his heritage.

From the group, he quickly selected a surrogate father, mother, and younger sister, in that order.

As soon as they were seated in a circle in the center of the room, Hans "attacked." His opening thrust spilled out.

"How many people did you kill?" "Why did I have to be born the son of a murderer?" "How could you join the Nazi party?" I had never done a multigenerational session before, real or simulated, that opened with such a dramatic avalanche of anger. I had not had time to welcome them and go over the purpose and ground rules for the session. Before I had time to intervene - the mother forcefully countered, "Why can't you leave him alone? He has suffered enough. You are always badgering him and getting him into trouble. That all happened so long ago. It's over with - let it alone." Sister chimed in, "He's been a good father to us. That's what counts. I love him as the man and father he has been to us. Why must you torment us all with this?"

The father blurted out, "I don't know; I don't remember; its a long time ago. Leave me in peace. If you were alive then you would have gone. Everyone wanted Germany to be victorious and a great country again. We didn't ask how it would be done; we believed in our leaders."

Now that everyone had spoken in his or her own voice, there was a pause. I was able to intervene in a soft, firm, and hopefully soothing voice. At this juncture I had to win the "battle for structure" quickly so the session could proceed; I turned to the father and said:

"Your excruciating pain is obvious and I wish there were some way to alleviate it quickly; but there isn't. My experience is that one must face what has long been festering and unspeakable and go through it rather than ignore it. Only then can it be handled and perhaps some relief experienced...As difficult as it may be for you, it is critical for your son's well-being, perhaps even his survival, that you answer the questions. His goal in bringing you here was not to destroy the family, but to try to find out who you are, what makes you tick, and who he is."

All eyes turned toward the father. Trembling and with tears in his eyes he blurted out "Yes, I killed lots of people, lots of people; we believed it was the right and patriotic thing to do."

Hans' aspect changed visibly. His facial muscles relaxed and he leaned slightly toward his (surrogate) father. He whispered audibly, "Thank you for finally being honest. Maybe now I can try to trust and respect you and become part of the family."

Much more transpired but the above recapitulates the essence of the session. During the "therapy" hour and the debriefing, many of the other workshop participants were sitting either mesmerized or profoundly moved to tears. It turned out that over half of them were children of men who had served in the SS or SA, some as guards in the extermination camps. Many raw nerves had been exposed.

Both the father and the mother in the simulation were children of Nazi servicemen and had thrown the same questions Hans posed to their fathers - only to be silenced. Thus, the simulation had taken on a profound reality for all. They reported that this was the first time anyone had dared to tackle the family issue of greatest and gravest import for them. Several stated that it was like being struck by lightning. They had not realized how essential it was to deal with their shameful nation and family heritage for their own growth and if they were truly going to be able to deal with the special "hell" some of their clients poured out to them.

I have rarely been as deeply moved and, through tears, I shared this with them – indicating that I was experiencing cognitive dissonance being a foreigner and a Jew allowed to see into the most hidden recesses of their souls. I thanked them for this unexpected privilege while pondering if it had really been possible that my empathy had (temporarily?) transcended my own commitment to Judaism and my identification with the oppressed and wronged as I had reached out to try to heal Hans' pain and that of others in the drama that unfolded in that room. Hans gasped, as he had not been aware of my Jewishness. I had thought all of them realized that what little German I spoke was really Yiddish. The stoicism and intellectualism had all vanished.

In the final wrap-up portion of this last day, the feedback was that the simulation had been the most important aspect of their work with me, both professionally and personally. They were most grateful to me for being willing to demonstrate multigenerational family therapy utilizing the "born guilty" theme as the central issue of the conflict in the family system. It had not been planned that way; it erupted out of a seemingly inevitable chain of events.

Retrospective and Speculations

From a psychodynamic therapeutic perspective we see the utilization of many defense mechanisms by the perpetrator families. These include deni-

al, repression, projection, projective identification, and identification with the aggressor. Hans had incorporated the aggressive, attacking, demeaning behavior for which he was critizing his own father. The family members longed for more closeness but instead lacked cohesion and were quite disengaged although negatively bound to one another.

Perpetrator families, like victim families, are still scared by the legacy of the Holocaust. They swing from one extreme to the other – either talking about it too much (and bemoaning the fact that they did not emerge victorious); or they maintain a stony silence – not wanting to bring to light their part in the bloody and cruel actions of their country. The children are left to piece it together from tales they hear and books that they read. Like Hans, many need to know from their own father: "Were you a murderer and if so, what am I if I was born the son of a murderer?"

At the philosophic, existential level, there are a host of different questions to be raised. These have perplexed, even tormented me, since my return home. How long shall the sins of the father be visited upon the sons and daughters? What kind of reparations and apologies are necessary? Will any acts of atonement ever be sufficient? How long will it take? Can one ever be free of the guilt of being born to parents who were part of a country that committed mass murder of six million Jews and millions of others who were not members of the Aryan race they exalted? How can anyone "forgive" and "forget" this inhumane, deliberate annihilation - the premeditated crime of genocide? If we forget, we contribute to the likelihood that future genocides will be committed. Such a thought is intolerable!

[1] *We gratefully acknowledge Contemporary Family Therapy (Human Sciences Press, 1990) for allowing us to draw on parts of her work.*