26

The Social Process and the Transgenerational Transmission of Trauma in Chile

DAVID BECKER and MARGARITA DIAZ

INTRODUCTION

At the end of the Chilean dictatorship, one could have expected that a central political goal would be the active participation of the population in the democratization process. But this clearly did not happen. To the contrary, in the process of transition toward democracy, it became obvious that the internalization of political threats and the mechanisms of self-repression maintain themselves after the end of the dictatorship. Repressive processes that were open during the military government are being converted into less visible but even more effective authoritarian structures in the new democracy. There is no real social and political participation. People succumb and wait to see what the government will do. A society of alienated subject develops, in which participants feel distant and mistrustful toward the political process, even more so, because they wrongly supposed that they might be central to the new order.

The fact that we see processes of alienation in a modern democratic society is not in itself surprising. But that this happens in a society that only recently suffered the individual and collective consequences of political repression, where one of the main arguments in the fight against dictatorship was the defense of human rights and the necessity of truth and justice, obliges us to ask the following: How is it possible to maintain so much denial? How is it possible that one of the main issues in Chile today is not human rights but the fight against delinquency and terrorism? How can we understand the fact that the victims of persecution, with a certain amount of legitimacy, feel more marginal today than during the dictatorship?

It is in reference to this sociopolitical context that we discuss the problems of the children of the persecuted in Chile. They express, more than any other part of Chilean society, the basic conflict we are dealing with: the necessity to overcome a traumatic past, the impossibility of developing a future without a past, and the obligatory confusion within the present sociopolitical

DAVID BECKER and MARGARITA DIAZ • Instituto Latinoamericano de Salud Mental y Derechos Humanos, Nunez de Arce 3055, Nunoa, Santiago, Chile.

International Handbook of Multigenerational Legacies of Trauma, edited by Yael Danieli. Plenum Press, New York, 1998.

situation. It is difficult to label these children in terms of generation. On the one hand, it would be wrong to describe them as second generation, since most of them experienced persecution directly. On the other hand, it is also true that, officially, and in their own perception, the parents are the real victims. They, the children, have the task of overcoming and repairing the destruction their parents suffered. Very few of the children have direct memories of the Allende Government. They grew up as children of those against whom the military directed their coup. In this sense, they are second generation. At present these children are experiencing a nearly unsolvable contradiction: If they try to be typical youths of today and leave behind the world of the marginalized and the persecuted, then they lose their basic reference to their families and enter into insufferable loyalty conflicts. If they try, on the contrary, to integrate their history and consciously act as children of their parents, then they begin to form part of a social dynamic that is inevitably marginalizing and retraumatizing. Neither society nor their own families seem very interested in allowing them to understand these dynamics.

The Latin American Institute for Mental Health and Human Rights has provided medical, social, and therapeutic help to the victims for many years. Our research has not only been oriented toward detailed registering of the data of our patients and their treatment, but it has also included larger social dimensions, such as the existence of fear in the Chilean population and the existing attitudes toward human rights. The material presented in this chapter is a product of these research activities. But if the destruction we are dealing with is not only individual but also social, then our research cannot be exterior to the reality with which it deals. We are thus not neutral investigators intending to understand an alien reality, but are active participants in therapy and research, operating within the political process. Some people might consider this an unscientific attitude. We would suggest that at least within the context of man-made disasters, real science can only be nonneutral, because the choice here is not between objectivity and subjectivity, but between victims and victimizers.

A CASE HISTORY

Miriam's mother, Juana, sought family therapy at ILAS in 1992. In 1974, Juana, who was 7 months pregnant with Miriam, and her husband, Jose, were taken prisoners. Both of them were severely tortured for several weeks. Miriam was born in prison. In order to not disturb the other inmates, Juana always offered Miriam her breast when she started crying. Miriam met her father for the first time when she was 6 months old, through a fence, in the prison camp where both parents were held. In 1975, the parents were released from prison, expelled from the country, and went into exile in France. In the following years, they pursued various political activities related to Chile, changing countries of residence, and separating several times, with one of them always keeping Miriam. By 1990, when Miriam was 16 years old, they had changed countries four times, and had not lived together for more than 12 months. Deciding that it was time to go home again, they sent Miriam back to Chile to check out the situation. Miriam lived alone in Chile for 7 months, then her mother came back, and in 1991, the father. For the first time in many years, they tried to live a normal family life. Their economic situation was poor. Miriam had shown abnormal eating behavior since early childhood, stuffing herself with all the food she could get. Now, after reunification with her family in Chile, she developed openly bulimic symptoms accompanied by severe states of depression and anxiety. The parents first sent her to individual therapy. When Miriam started to develop a more trustful relationship to her therapist, the mother decided that this therapy did not help, and that there was no money to pay for it anyway. After

3 months with no treatment, they came to ILAS, where treatment costs are low, and where family treatment is available.

Both parents seem a lot older than they really are. A little overweight, Miriam gives a very bright, adult impression. She articulates well the strange way this family communicates, as well as the history of her own suffering. She complains that her parents sabotaged her therapy but also declares that she does not want to pick it up again. The father states that he does not believe in therapists. But all of them confirm that they respect the mother's decision to come to ILAS and ask for family treatment. In the following sessions, Miriam speaks more about her fears, her insecurities, and her confusion. She has stopped going to school, spending the whole day at home crying, eating, and vomiting. The parents express concern, but not to the extent of really taking care of her at home. During sessions, the mother and daughter fight and discuss a lot, while the father either keeps quiet or makes lengthy explanations, which quickly bore mother and daughter, and are even difficult for the therapist to listen to. But once he starts talking, he will not be interrupted.

Listening to the three of them is like attending a course in double-bind communication. Father and mother disagree about almost everything, but at the same time insist that they are a couple, finally reunited, whose only problem is their daughter. Miriam basically tries to confirm this opinion, but at the same time, she makes varying alliances with one or the other in order to disqualify the person outside of the alliance as pathological and guilty of the existing confusion. When the therapists try to pinpoint one of the apparent conflicts, all of them are very quick to rearrange or change the topic of discussion. Each of them convincingly explains the traumatization of the other two but denies his or her own problem. Miriam explains that her parents have suffered, but she, herself, is only ungrateful and egotistical. Juana confirms the extreme suffering of her daughter, having been born in prison, never having had a home and a trustful family atmosphere. She also describes the trauma of her husband, his frustrations, and how he encapsulated the experience of horror and never again talked about it, although he has nightmares, often feels depressed, and so on. She herself though is okay, with only minor problems. The father says that he has overcome his personal problems, but that his wife and daughter have a highly neurotic relationship, that Juana never knew how to control herself, that she is highly aggressive, and so on. In other words, all of them give quite adequate descriptions of the difficulties of the others but deny their own. During sessions, basically two scenarios seem possible: Either there is high tension and conflict, shouting, and crying or there is nothing, a strong depressive silence in which everything seems dead.

EXTREME TRAUMATIZATION

Miriam is one of many youths we have been treating these last few years. Her story is unique but also similar, even nearly identical, to many others. Many times, it is the parents (mothers) that seek treatment for their children, because they exhibit "antisocial behavior," drug addiction, impulsive behavior, aggression (often against their own family), problems at school, and family crises. Less often, the youths themselves ask for help because of difficulties with their boy- or girlfriends, separations, and difficulties in their studies or at work. Symptomatically, we find insomnia, nightmares, fear, depressive crises, and psychotic breakdown. Furthermore, psychosomatic symptoms, such as digestive difficulties, blood pressure problems, allergies, and low defenses are frequent. It is impressive how most of these patients appear to be very adult, while at the same time showing extremely regressive behavior in certain areas. Thus, for example, most use a very developed and rational language, and are able to describe their dif-

ficulties eloquently. At the same time, they are insecure and feel confused in many situations, show the typically exaggerated trustful and dependent behavior so well known in children in public homes, and have difficulties in determining adequately the demands of external reality. Many have histories of being exceptional students that at some point, to the surprise of everybody, feel completely unable to work or go to school and confront the next exam. Symptoms usually appear in connection with an external sociopolitical event that is relevant to them, such as the finding of mass graves in the north of the country, or in response to specific family occurrences such as birth of a sibling, death of a grandparent, and so on.

We define our patients as "extremely traumatized" (Becker, 1992; Becker & Castillo, 1990). The term *extreme traumatization* implies for us that the victims have had traumatizing experiences within the context of state terrorism that surpass the capacities of the psychic structure and therefore cannot be integrated. We believe that the analogous use of Keilson's concept of "sequential traumatization" (Keilson, 1992) is possible and useful in Chile. He shows that a process of cumulative traumatization can turn into chronic trauma whenever the context of the traumatic situation refers to political persecution and repression. He makes it very evident that not only can the consequences of trauma persist a long time after the actual traumatic situation is over, but also that after the end of political persecution, the trauma itself continues. Furthermore, his theories, in agreement with Bettelheim (1943) and others (Grubrich-Simitis, 1980; Mitscherlich & Mitscherlich, 1967; Parin, 1975), help us confirm that external and temporal realities can explain a traumatic (psychic) process, although this does not mean that the internal qualities of experience of the trauma were already understood. Keilson established his sequences in reference to Jewish war orphans in the Netherlands, differentiating between the beginning of persecution, the actual separation of the children and their parents when the parents were taken to concentration camps, and the time after the war, when families in some cases were reunified and others were not. In reference to other countries, the sequences will be different. Also, within the same country, for different persons, different individual sequences will apply, although the overall picture does not change. In Chile, we can differentiate the sequences.

First Traumatic Sequence

It begins with the military *coup d'état* and ends with the specific repressive experience: imprisonment, disappearance, death. The main characteristic of this sequence is the general insecurity because of the military activities, searching of houses, imprisonment, and shootings. Intrafamily tensions, fear, and insecurity occur regularly. Additionally, all kinds of trust in the surrounding world have to be given up. The individual, his or her family, and the group they belong to become suspects, and certain political convictions automatically make one belong to the "enemy." From then on, anything can happen. The family and social context have abruptly changed on September 11, 1973. What was law the day before is now outlawed. Fathers and mothers are still alive, but they could be dead tomorrow. Within the families, parents try to convince their children, husbands their wives, that they do not need to fear, that they can still believe in the traditional roles of parental and marital protection. All this, while in reality, the threat is already omnipresent, and death has become a part of everyday life.

In the case of Miriam, she has not yet been born, but her conception was during this period, perhaps a last try of the parents to go on with life as usual. While they daily risk their lives, they try to maintain the illusion of normal family development. Even before being born, Miriam is already a symbol of a life project, lost forever, or, better said, she is a tangible symbol of life for parents that are dealing with death.

Second Traumatic Sequence

The second traumatic sequence begins with the specific repressive situation and ends with the end of dictatorship, sometime between October 1988 (plebiscite) and March 1990 (first election of democratic government). During this sequence, terror is experienced directly by one or more members of the family. But also the family members not directly affected now basically deal with the political issues, with fighting against the government, looking for those that have been imprisoned. Family life itself has become secondary.

The life of the children in this period is marked by the loss and/or sudden separation from the people most important to them. This loss is not only related to different members of the family but also to the home and the social surrounding, in fact, to the whole world as it was until that time. It is also in this sequence that the affected persons have no choice but integrate into the world of the marginalized and persecuted. In order to survive, this new world of terror cannot be perceived anymore as an exception. It has to become *the* world.

For Miriam, this world of trauma begins with the first day of her life. She is born in jail. Instead of feeding to be nurtured, she is fed in order to be silenced. Her other is alive through her. But life has to be silent and secret. She really meets her father only in exile. From ages 4 to 5, she lives alone with him, then again with the mother, and in-between, a few months with both. In her memory, all of these years feel like having lived alone, occasionally sustaining adult conversations with her parents. She does not feel at home in any country. She does not remember friends or places she specially liked, not even toys. All she remembers is a small orange, made out of wool or felt, that she loved. She gave it away when once again she had to change countries. Coming back to Chile all by herself seems quite normal to her. What she does not understand is why she feels so depressed now, when everything seems to be "okay." Also, she does not know why her tendency to eat a lot has changed into the habit of eating and forced vomiting.

Third Traumatic Sequence

This last sequence begins with the end of dictatorship, and it is uncertain when it will end. Its traumatic character depends on how and if individual and social reparation occurs after the dictatorship. Keilson (1992) has shown that the consequences of this sequence for the victims are possibly more destructive than the other sequences (see also Danieli, 1992). The unfulfilled promise of reparation for the victims is potentially more traumatizing than the worst experience that happened before, because then the faith existed that once the dictatorship was over, truth and justice would occur and the terror would have an end.

We have earlier mentioned the retraumatizing effect this sequence has for the children of the victims. For a Chilean youth in 1983, it was still possible to establish a direct link between his or her personal suffering and that social process. A frequent slogan of these days was "It's okay to die fighting, but, damn no, not of hunger" (Morrir luchando—de hambre ni cagando). It expressed quite adequately part of the individual trauma and its destructive potential, but also a certain amount of hope that was shared with the majority of the Chilean people. But all of this is history in postdictatorial Chile. There is no political participation and even less a political youth movement. The children of the victims are forced to deny their past in order to appear normal. The historical truth can only appear as individual craziness.

When Miriam begins to tell her story, she laments her dependency on others, especially her parents. She is angry about her symptoms, because they forced her parents into therapy. She feels confused and different from everybody else. She had hoped that now everything would be

okay, but life seems more hopeless than ever. When she prepared the homecoming of her parents, she was convinced that everything would turn out fine. And now she feels sad, wanting to be a baby, and hating herself for it. She feels guilty for doing harm to her parents. They feel that they do not know her, that she is less ill and more blackmailing them. They oscillate between ignoring her problems and trying to convince her rationally to overcome them. Miriam feels that she can talk to other youths about her eating problem but not about her past, her time in exile, or the fact that she was born in jail. It is easier to try to be a hysterical youth with severe eating problems than to confess the history of persecution and loss. Since her birth, Miriam has known that dependency is dangerous and has to be avoided. One should not be a child, and if she is, as is happening to her now, it is disastrous. Through Keilson's sequences, we can understand how she came to her strange, contradictory convictions. Her conduct makes sense. But how can we explain the extraordinary process of adaptation this girl managed from her birth day onwards?

Relying on Winnicott (1973, 1974, 1976), we can understand the traumatic situation as a failure of the holding environment (mother) in its function as mediator of the child's needs. Also, afterward, the environment is not able to provide a good enough situation to enable the child to elaborate about the traumatic experience. On the contrary, the threat within the social context is maintained, and grief processes cannot happen. The "holding environment" and/or the "primary object-relationship" (Balint, 1966, 1968) are traumatic in themselves. Individuation and identity formation happen under conditions that permit activities of adaptation but not the development of the true self. The trauma is dissociated, and during adolescence, the crisis becomes visible because this is the moment where instead of real autonomy the pseudoreality of the autonomy enacted up until then can no longer be denied. It is therefore unsurprising that so many of our patients are adolescents.

It was Ferenczi (1988) who first described the extreme division, nearly impossible to overcome, that exists between the traumatic experience and the posttraumatic structure. In his clinical diary, he describes how fragmentation, the splitting into two personalities, helps one to survive the traumatic experience. But this same defense mechanism also implies that, afterward, there is no direct access to the trauma. If in the therapeutic process the trauma is reconstructed, the dissociation is nevertheless maintained, because the split between a destroyed part of the person and a part that perceives this destruction is repeated. On the other hand, if the person "regresses" to the situation of experiencing the trauma, he or she is in a "trance," feeling but not knowing" what is happening. When the patient awakes from this "trance," once more the immediate evidence of the trauma disappears. Once again, it is only reconstructed from the outside, without a feeling of conviction. What, in Ferenczi's terms, could be understood as a mere clinical technical problem in reality describes extremely well the core problem of people that have survived trauma. The theory of sequential traumatization describes how the social context produces breakdown and the maintenance of the dissociative process. Ferenczi offers us a bridge to approach the inner psychic world of a traumatized person.

The English psychoanalysts, Kinston and Cohen (1986), quite similar to Winnicott (1974), understand psychic structure as a lifelong mediating process with the surrounding environment. They speak of trauma as "primary repression," which, in contrast to Freud's (1926) opinion on this issue, can happen at any point in life. Depending on the specific psychological development of the individual, the defense mechanisms might vary but the basic consequence of trauma is always the same: a hole in the psychic structure. The satisfaction of needs lead to psychic representations that themselves are the basis for the development of wishes, without which there can be no object relations. Trauma means that basic life needs are not satisfied. Where there is no wish, there cannot be a psychic representation or capacity of symbolizing. There can only be a hole, primary repression.

The experience of the child in these cases is not "My mother has abandoned me," but the feeling of falling endlessly. Just like Ferenczi's patients, most children survive this experience of death and develop what Winnicott (1973, 1974) calls a "false self." Children are confronted with the obligation to assume premature control over their environment instead of being able to discover it slowly. The healthy fantasies of omnipotence that children can have when they can believe that they invented the object are being replaced within the traumatic experience with an omnipotence that tries to cover up the very real failure of the environment. Instead of inventing the environment, the children have to live with the frustration of having had to assume prematurely responsibility for the world.

Our clinical experience shows that this is exactly what happened to our patients. They had to develop the capacity to understand the world very early in their lives, grow up immediately, and become protectors of their own parents. They really believe that it is their task to solve all family problems, including that of income. They justify their attitude with opinions such as "They (other family members) are still so young, have suffered so much, are so insecure." Even if they want to, they find it extremely difficult to leave behind this role. Miriam, for example, can perceive her parents only as victims that need help. Her own needs seem to appear in spite of her, causing her extreme feelings of guilt. No matter how bad she feels, she still thinks that the inability of her parents to produce a decent income is her problem. She finds a job in addition to attending school and makes more money than her father, who works all day. Just as she took care of her mother's fears in jail, nursing at any time and keeping quiet, so she continues her preoccupation with others. Her relationship to peers reflects the same model: She is the therapist, the mother to whom others tell their troubles. Children such as Miriam have had to learn very early to adapt to the demands of their surroundings. They have, therefore, developed very rigid false-self structures in order to protect their true selves, their spontaneity and, most of all, to defend against feelings of loss, destruction, and death. They have perceived dependency as limbo, as a void. They never experienced the "holding mother," never had an adequate mirroring. They had to dispose of their own need for protection in order to protect the vulnerable objects around them. They had to assume complementary ego functions for their parents. But in this process, it is important not to forget that the vulnerability of the parents was real; it was not the product of some secret illness, but of a sociopolitical process.

Because of their age, the children could not really understand this process. The only choice they had was either to attempt magically to save their parents and thereby themselves, or together with their parents be a victim of primitive fears, feelings of void, and loss of body, all of which were not psychotic feelings but a reflection of a very concrete exterior world.

Paradoxically, the premature recognition of the environment leads to the incapacity to really perceive this environment and construct real object relationships. While a true self permits a person to feel real, a false self always implies a feeling of inexistence, of nothingness, of not being. Miriam often reported this feeling of not being, of being outside herself. She ascribed the same meaning to her bulimic activities: She feels hollow and wants to fill herself up. After eating a lot, she feel stuffed but equally void. So she vomits. In this process, she feels herself a little more, basically as pure pain.

For a true self to develop, the object has to be recognized as a real object outside of the self. Following Winnicott (1974), this is only possible if the child can destroy the object and find out that the object survives. If the child experiences that the object cannot be destroyed, then his or her omnipotence has limits. And because of that, it is possible to believe in the object, to permit its protection. Concern becomes possible in the form of gestures of reparation, while internally the child can go on fantasizing the destruction of the object. Thus, the child learns to use the object and to develop object constancy.

Our patients never had this experience. Aggression as a central element of healthy development had to be repressed. The perceived and very real destructibility of the parents forced the children to succumb to the parents' needs. Instead of being mirrored, they had to mirror. The mirroring of the parents often takes the form of idealization and also copying behavior, beliefs, and social relationships. Miriam and her mother reflect this kind of magical closeness, of artificial symbiosis. They understand each other without talking; they feel the same about everything. Obvious differences are denied. Aggression has to be dissociated. Miriam is bulimic, but she does not feel hate against her mother. When Miriam makes her first tentative steps toward autonomy when relating to her therapist, her mother intervenes and breaks off this *liason dangereuse.* Miriam suffers, but she knows her mother is right.

We believe that children and youths who, together with their parents, have had direct experience with death through torture and persecution, generally tend to understand aggression as an equivalent of destruction. Aggressive feelings within a relationship are experienced as the very real death of oneself and the other. To attack somebody means to be the torturer, the executioner, and there is no experience that would permit a belief in the possible survival of the object. In this manner, aggression as a normal part of human development is being inhibited, while the illusory object relationship that is supposed to cover up the nothingness and represents the subjective object is maintained. The sickening omnipotence is reinforced while feelings of unreality and rupture dominate the internal world and the perception of external reality.

FAMILY AND SOCIAL IDENTITY

It is important to look at the processes of traumatization of the youths that up to now we have been discussing in terms of true and false self, and also in terms of identity development. We have seen that identity development has been severely hindered, if not impossible, because the youths have never been able to experience themselves as persons within a continuity in time and space. As Grinberg and Grinberg (1980) point out, central tasks of the crisis of adolescence are the elaboration and integration of the losses of the childhood object relationships that have invariably changed during psychosocial development. A healthy grief process in these terms is the core of adult identity. Extremely traumatized youths cannot experience this process. Instead of remembering and grieving "holding," fear and experience of destruction reappear. Instead of finding basic elements of identity in the past, they only find pieces of multiple losses of self. Instead of grief, they reexperience death. The only identity that promises some continuity is the identity of discontinuity and rupture. The denial of reality on an individual and social level, the repetition of destruction, rupture, and insecurity thus appear as possibly the most authentic expression of identity in these youths.

These vulnerable identities are not only the inevitable answers of the youths to the destruction they experienced but are also the product and the expression of a sociopolitical process that had implied a series of specific intrafamily delegations and demands in the second traumatic sequence, and confirm the social process of alienation and the maintenance and continuity of authoritarian structures within the third traumatic sequence.

Within the families, the experience of repression and persecution has produced a series of delegations and demands only seemingly independent of the social process:

1. The children are supposed to maintain themselves as closely connected to their families throughout their lives. Any intention of separation, implied by the normal growth

process, is seen as a disloyal act, since separation is seen as identical to the involuntary losses during the original traumatic experiences.

2. The children have to replace the lost or damaged and always idealized objects. Wishes and needs directed toward these objects have to be satisfied by the children, and they have to represent the idealized object in their behavior.
3. The children must help the parents to diminish their feelings of guilt and extreme humiliation. They have to overcome the total powerlessness of their parents. They also have to overcome and right the social stigma that defined them as criminals during dictatorship. They can do this by assuming a scapegoat role, or by hating and seeking vengeance.
4. They must overcome the trauma itself to make the past disappear; they must start living when the parents have stopped doing so. They have to finish the story and live the lives their parents would have lived if disaster had not struck. In accordance with the posttraumatic idealization of the past, they have to be good students, learn an important profession, and build good and lasting partner and family relationships.

It is not difficult to recognize the contradictions, the mutual exclusiveness in these demands. At the same time, it is obvious how these demands seek to solve and overcome within the family the sociopolitical experience of impotence and destruction. Therefore, the children have to accept these delegations but are also condemned to fail. They will fail because a social problem cannot be solved within the family, and also because only in failure can they be completely loyal to their parents.

The political process after dictatorship, for a short time, suggested to the victims that there was a real possibility of ending the madness, of facilitating collective elaboration. But rather quickly, it became evident that this is an illusion, the maintenance of which not only denies the reality of the victims but also reinforces their collective impotence. As Mitscherlich and Mitscherlich (1967), Parin (1975), and, most importantly, Adorno (1982) have pointed out, the negligence of postdictatorial society in dealing with its victims, with the collective past, is a way of pretending that democracy has come, while in reality, authoritarian structures are being retained. We can thus speak of a double victimization where, first during dictatorship, the victims were repressed and persecuted in order to establish a new order. Afterward, these same victims were denied, pushed into the fragile existence of sick people with a private problem.

We can see how the intrafamily delegations and the social process unfortunately complement each other. While the general social process facilitates the development of false-self psychic structures, those structures make it more difficult to recognize the social basis for the individual suffering. The youths are trapped. If they recognize the destructiveness of the social process, they are even more dependent on the family delegations. If they rebel against these delegations and try to integrate normally into society, they can only do so by covering up their personal false selves with social false selves.

TREATING MIRIAM

Therapy cannot solve social dilemmas, but it must be conscious of them if some kind of help is to be offered to the victims. More precisely, if the social context is as we described it earlier, then sometimes therapy loses its connotation of basically being something private and becomes a relevant social space where personal and social reparation can begin. The therapeutic process is the endeavor to begin a relationship, to facilitate a bond, to invent a transitional space

(Winnicott, 1973) in which the patients can play. Basically, the idea is to bring together the bits and pieces of a life history that is full of terror and fear, losses and black holes. The fundamental problem in these therapies is less to establish a relationship than to facilitate a process where symbolization can occur. We have learned that a perspective of life can only be developed if we are ready to recognize the death our patients have experienced as such, and integrate it into a living relationship.

The treatment of Miriam and her parents was long and complicated, and cannot be reproduced here in detail. But some information on the work with her seems helpful. After 6 months in family therapy, as well as individual sessions for Miriam, we had established some kind of trust. While Miriam was getting more and more depressed, in sessions, she was more able to confront her parents. The parents, on the other hand, began reconstructing their own history, facilitating a slow, differentiating process. Miriam stopped vomiting but continued to eat excessively. One afternoon, when her parents were not home and she knew they would be late, she took a considerable amount of sleeping pills and went to bed. Late that night, her father found her. She was unconscious for 2 days and nearly died. After this event, things began to change dramatically. While the parents assumed a real parental attitude for the first time, not only giving love, but also setting limits, Miriam accepted dependency, being a child. Within the following months, she grew rapidly. When a year later we finished therapy, Miriam summed up the experience as follows: "When I tried to commit suicide, a part of me wanted to die, but another part of me wanted to live more than ever. Waking up afterward was painful but intensely gratifying. It was like being born again. In these last months, I feel I have won myself parents. Life is still difficult, but I don't feel lost anymore."

The parents said, "What happened was terrible. But we feel we got a second chance. For the first time, there was no other issue than fighting for her survival. We feel we are a family now. We are sad for the lost time, sad because our child is grown up now. But we are happy to be a family who has had to mourn many losses but survived."

These comments perhaps sound like the typical happy ending reported after so many therapeutic processes. There can be no doubt that, in many cases, we cannot help. But for us, Miriam's case quite dramatically shows the road one youth had to take to begin the process of symbolization. She could have died. But through luck, this suicide attempt could be worked through as the beginning of a healthy grief process, as the end of death as it had been up to now, and the beginning of life.

REFERENCES

Adorno, T. W. (1982). Was bedeutet Aufarbeitung der Vergangenheit. In G. Kadelbach (Ed.), *Erziehung zur Mündigkeit* (pp. 10–28). Frankfurt: Suhrkamp Verlag.

Balint, M. (1966). *Die Urformen der Liebe und die Technik der Psychoanalyse.* Stuttgart: Klett Verlag.

Balint, M. (1968). *Therapeutische Aspekte der Regression.* Stuttgart: Klett Verlag.

Becker, D. (1992). *Ohne Hass keine Versöhnung: Das Trauma der Verfolgten.* Freiburg: Kore Verlag.

Becker, D., & Castillo, M. I. (1990). *Procesos de Traumatizatión Extremas y Posibilidades de Reparción.* Santiago: ILAS.

Bettelheim, B. (1943). Individual and mass behavior in extreme situations. *Journal of Abnormal and Social Psychology, 38,* 417–452.

Danieli, Y. (1992). Preliminary reflections from a psychological perspective. In T. C. van Boven, C. Flinterman, F. Grunfeld, & I. Westendrop (Eds.), *The right to restitution, compensation and rehabilitation for victims of gross violations of human rights and fundamental freedoms* (pp. 196–213). *Netherlands Institute of Human Rights [Studie- en Informatiecentrum Mensenrechten]. Special issue* No. 12.

Ferenczi, S. (1988). *Ohne Sympathie keine Heilung: Das klinische Tagebuch von 1932.* Frankfurt: S. Fischer Verlag.

Freud, S. (1926). *Hemmung, Symptom und Angst.* G. W., Bd. XIV. London: Imago.

Grinberg, R., & Grinberg, L. (1980). *Identidad y Cambio.* Madrid: Paidós.

Grubrich-Simitis, I. (1980). Vom Konkretismus zur Metaphorik. Gedanken zur psychoanalytischen Arbeit mit Nachkommen der Holocaust-Generation—anlässlich einer Neuerscheinung. *Psyche, 38*(1), 1–28.

Keilson, H. (1992). *Sequential traumatization in children (English Ed.).* Jerusalem: Magnes Press, Hebrew University.

Kinston, W., & Cohen, J. (1986). Primal repression: Clinical and theoretical aspects. *International Journal of Psychoanalysis, 67,* 337–355.

Mitscherlich, A., & Mitscherlich, M. (1967). *Die Unfähigkeit zu trauern.* München: Piper Verlag.

Parin, P. (1975). Geselschaftskritik im Deutungsprozess. *Psyche, 29,* 97–117.

Winnicott, D. W. (1973). *Vom Spiel zur Kreativität.* Stuttgart: Klett Verlag.

Winnicott, D. W. (1974). *Reifungsprozesse und fördernde Umwelt.* München: Kindler Verlag.

Winnicott, D. W. (1976). *Von der Kinderheikunde zur Psychoanalyse.* München: Kindler Verlag.