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Psychotherapists' Participation in the Conspiracy of Silence About the Holocaust[1]

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> *At the risk of offending, it must be emphasized that the victim suffered more . . . profoundly from the indifference of the onlookers than from the brutality of the executioner. The cruelty of the enemy would have been incapable of breaking the prisoner; it was the silence of those he believed to be his friends—cruelty more cowardly, more subtle—which broke his heart.*
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> *There was no longer anyone on whom to count . . . It . . . poisoned the desire to live . . . If this is the human society we come from—and are now abandoned by—why seek to return?*
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> (Wiesel, 1970, pp. 229-230)

In 1930 [1929] Freud wrote,

> No matter how much we may shrink with horror from certain situations—of a galley-slave in antiquity, . . . of a victim of the Holy Inquisition, of a Jew awaiting a pogrom—*it is nevertheless impossible for us to feel our way into such people*—to divine the changes which original obtuseness of mind, a gradual stupefying process, the cessation of expectations, . . . have produced

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[1]A preliminary thematic overview based on part of the data for this systematic study was published elsewhere (Danieli, 1980).

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> upon their receptivity to sensations of pleasure and unpleasure. Moreover, in the case of the most extreme possibility of suffering, special mental protective devices are brought into operation. *It seems to me unprofitable to pursue this aspect of the problem any further.* (p. 89) (Italics author's)

Although this passage was written before the Nazi Holocaust it poignantly foreshadowed psychotherapists' participation in the *conspiracy of silence* that has existed between mental health professionals and Nazi Holocaust survivors and their children. This conspiracy of silence is not confined to psychotherapists but is part of the conspiracy of silence that has characterized the interaction between survivors and society at large since the end of World War II. The harmful long-term effects of this larger scale silence upon the survivors and their families have been described elsewhere (Danieli, 1981a, 1981b, 1981d, 1981e).

Survivors and children of survivors have frequently complained of neglect or avoidance of their Holocaust experiences by mental health professionals. This is corroborated by ample documentation in the literature, primarily clinical, which very often contains the authors' reports of extreme "countertransference reactions."[2]

Workers in psychiatric facilities have noted that they usually find only one sentence at most, in the patients' history, devoted to the topic: "The patient is a concentration camp survivor . . . his/her parents are Holocaust survivors," or worse, ". . . came from Europe . . . Poland." Psychotherapists and researchers who have interviewed survivors and their children, and have worked with them after they have been seen by other therapists, also have repeatedly observed that Holocaust experiences were almost totally avoided in their previous therapy. Whereas society has a moral obligation to share its members' pain, psychotherapists and researchers have, in addition, a professional contractual obligation. When they fail to listen, explore, understand, and help, they too inflict the "trauma after the trauma" (Rappaport, 1968), or "The 'Second Injury' to Victims" (Symonds, 1980) by maintaining the conspiracy of silence.

Although several major "countertransference themes" have appeared in the literature, they are based almost entirely on anecdotal comments, confessional self-reports, and impressionistic statements and observations.

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[2]The term countertransference is used herein as it has been commonly labeled in this literature to describe authors' difficulties in working with this population. A comprehensive review of the literature on the "countertransference reactions" reported by reparation examiners, psychotherapists, and researchers working with Holocaust survivors and their children can be found in Danieli (1981e).

Notably absent are systematic analyses of empirical data. In this paper I present and discuss some of the major findings of a portion of a larger study, which systematically examined the nature of the emotional responses and other problems experienced by psychotherapists in working with this unique group of patients.[3]

Participants in this study were 61 psychotherapists; 40 women and 21 men, with 4 to 40 years of experience. Within this group 28 were social workers, 23 were psychologists, and 10 were psychiatrists. Fifty had completed postgraduate training, and all but one had undergone psychoanalysis or psychoanalytic psychotherapy. All have treated at least two Holocaust survivors and/or their offspring. A survivor in this study is defined as one who was in Nazi Occupied Europe and subjected to Nazi persecution sometime after 1938 until 1945. Of the 56 Jewish participants, 10 were themselves Holocaust survivors and 8 were *post-war children of survivors.*

The participants in the study were recruited for interviewing by announcements at professional conferences, through contact with colleagues known to be working with survivors and their family members, and through contact with the Group Project for Holocaust Survivors and Their Children (see Danieli, 1981c). They responded with great eagerness and astonishing candor. The open-ended interviews ranged from one to three meetings, of an hour to six hours each, and were sometimes completed via telephone conversations or by mail. The atmosphere of the interviews tended to be intense and serious. Many of the participants were deeply involved in the process and expressed themselves with much emotion. All participants stated that their reported reactions in working with survivors or children of survivors of the Nazi Holocaust were unique to this population.

In identifying, abstracting, and labeling the "countertransference themes" I relied most heavily upon the existing literature and the participants' self-observations. Forty nine "countertransference themes" were abstracted from the interviews. These themes and the number of therapists in the study who mentioned each theme at least once are outlined in the table below. Independent interrater reliability for the 49 themes across the 61 participants ranged from .94 to 1.00, and were all significant by t tests ($p < 10^{-11}$). I will now review and discuss some of the therapists' major reactions and attitudes and their consequences more concretely.

[3]The larger study (Danieli, 1981e) also contained a comparison between the "countertransference reactions" of psychotherapists in this sample who were survivors and children of survivors, with those of therapists who were not themselves victims or children of victims of the Nazi Holocaust. Despite the importance of the differences revealed, space limitations do not permit a full report.

TABLE 1
Countertransference Themes

Major Themes and Subthemes	Frequency (N = 61)
Guilt	49
Guilt Expressed	42
Guilt Inferred	24
Rage	47
Rage at Nazis	20
Rage at Being Seen as a Nazi and Fear of Survivor's Rage	15
Rage at the Survivor and Fear of One's Own Rage	26
Identification with the Aggressor and Sadism	16
Rage at Colleagues for Avoiding the Holocaust	14
Rage at Survivor as Parent	13
Rage at Child of Survivor's Treatment of Parents	8
Parent-Child Relationship	32
Therapist Adopting Role of Child to Compensate the Survivor	4
Therapist Adopting Role of Parent to Compensate Child of Survivor	4
Liberate Child of Survivor from Parents	6
Liberate Survivor Parent from Child	3
Overidentification with Survivor Parent	11
Overidentification with Child of Survivor	22
Dread and Horror	46
Grief and Mourning	44
Shame and Related Emotions	45
Shame—Fourth, Ethical Blow to Humanity's Narcissism	32
Shame—Contempt for Survivors Viewed as Having Gone Like "Sheep to the Slaughter"	22
Fear of Contagion	2
Viewing the Survivor as Immoral	10
Pity toward the Survivors	10
Disgust	9
Victim/Liberator	43
Viewing the Survivor as Fragile Victim	27
Viewing the Child of Survivor as Fragile Victim	9
Therapist as Liberator-Savior	27
Liberator Inferred, e.g., Rage at Negative Therapeutic Reaction	17
Viewing the Survivor as Hero	37
Jealousy of Survivor or Child of Survivor Having "Special Status"	7
Me Too, e.g., "We are all survivors."	16
Viewing the Holocaust as Unique	10
Reference to Murder	8
Reference to Death	5

TABLE 1 *(Continued)*

Major Themes and Subthemes	Frequency (N = 61)
Inability to Contain Intense Emotions	45
Defense	54
Numbing	36
Denial	37
Avoidance	40
Distancing	30
Clinging to Professional Role	40
Reduction to Method, Theory, etc.	17
Privileged Voyeurism	23
Attention and Attitudes Toward Jewish Identity	32
Sense of Bond	15
Feeling Like an Outsider	7
Self-Help for the Therapist	9
Conflict over Maintaining Professional Authority	7
Recognizing the Holocaust as Reality	12
Need for More Knowledge and Experience	16
Need for Integration	4

COUNTERTRANSFERENCE THEMES

Bystander's Guilt

The most common of the affective reactions both therapists and researchers reported in their work with survivors and children of survivors is what I call bystander's guilt: "I feel an immense sense of guilt because I led a happy and protected childhood while these people have suffered so much."

Therapists who felt guilty were much more fearful of hurting the patient, and used guilt to explain their avoidance of asking questions. Merely asking a question, they feared, would hurt the patient "who has suffered so much already." Some therapists who felt guilty were also afraid that survivors were very fragile, that they would fall apart, overlooking the fact that these were people who had not only survived, but they had rebuilt families and lives—often literally based on ashes—despite their experiences. In treating children of survivors, therapists also tended to attribute fragility to survivors' offspring. Such therapists tended to do too much for survivors and their children, to the point of patronizing them and not respecting their strengths.

Guilt often resulted in the therapist's inability to set any reasonable limits, in not wanting to hear, or in adopting a masochistic position in relation to the survivor: the survivor or offspring was allowed to do anything, call at any time day or night. Therapists also felt guilty in reaction to their own rage at these individuals, which is elaborated in the following.

Therapists similarly stopped asking and exploring when they saw tears in the eyes of survivors, despite the fact that tears are a perfectly appropriate reaction. They reported feeling guilty for using survivors as subjects and then "trying to put such human suffering into a 'cold' objective scientific design." Some of them feared that demonstrating the long-term negative effects of the Holocaust on its survivors and/or their offspring was tantamount to giving Hitler a posthumous victory. In contrast, others feared that demonstrating these individuals' strengths was equivalent to saying, "Since people could stay normal, it couldn't have been such a terrible experience and it is almost synonymous with forgiving the Nazis."

Elsewhere (Danieli, 1981a, 1981b) I have proposed that survivor's guilt, in part, serves as a defense against the total helplessness and passivity experienced during the Holocaust. The bystander guilt of therapists also appears as a defense when they experience their helplessness to undo the long-term consequences of the Holocaust for their patients, survivors or their children. The pervasiveness of bystander's guilt among psychotherapists and researchers may, indeed, account for what I believe to be their overuse, stereotypic attribution, and reductionistic misinterpretation of concepts such as "identification with the aggressor" (Bettelheim, 1943) and "survivor's guilt" (Niederland, 1961, 1964). It is the concern with the pervasiveness and the misuse in application of the concept of "survivor guilt" in the treatment of survivors that led Carmelly (1975) to divide it into two categories, passive and active. *Passive guilt,* the one actually meant by Niederland (1964) when he coined the term survivor's guilt, is experienced by those who survived "merely because [they] happened to be alive at the time of liberation" (Carmelly, 1975, p. 140) as "I was spared the fate of those who were murdered." *Active guilt* stems from having committed immoral acts and/or knowingly having chosen not to help when one possibly could have done so and is thus valid. Stating that "The great majority of concentration camp survivors are 'passive guilt carriers' " (p. 140), Carmelly (1975) notes that,

> therapists have interpreted hostile, aggressive and depressive symptoms [of survivors] as a direct result of unrelieved active guilt feelings . . . [out of their] mistaken belief that any survivor must have committed immoral acts. . . . As a result of the focus on the relief of active guilt feelings (which did not exist in reality), these patients have not been helped to relate constructively to their present life. Instead . . . they developed distorted guilt

> feelings . . . [and their] already painful life might become more drastically painful. (pp. 143–145)

Rage

Rage, with its variety of objects, is the second most frequent, yet the most intense and one of the most difficult affective reactions experienced by therapists and researchers in working with survivors and their children. They often reported that they became enraged listening to Holocaust stories and were overwhelmed by the intensity of their own reactions.

Nazi Germany created a reality far worse than any fantasy normally available to the human psyche. But the Nazis are not present as targets for bystanders' rage and thus the survivors or their offspring become the symbol of the Holocaust in its totality, available for the displacement of these feelings. "These people remind us of our own anger and destructiveness, of our own meanness"; "I am also angry with them at mobilizing my guilt." Some therapists accused victims of bringing the Holocaust upon themselves. This appears to be a rationalization of their displacement.

Others were seriously disturbed over the conflict between feeling angry toward survivors and the meaning they associated to that anger. "How can I get angry with this person who has already suffered the abuse of the Nazis? That makes me a Nazi." This tendency to identify with the aggressors also contributed to the therapists' fear of further damaging and harming their patients, and often developed into a vicious cycle of rage and guilt. This pattern seemed to be intensified by compliant, and sometimes masochistic behavior of survivors with regard to authorities in general and doctors in particular. As previously noted, guilt renders the therapist unable to set limits, which frequently leads to conscious or unconscious resentment of patients when they understandably become increasingly demanding.

During the war, being separated meant total and permanent loss. When separation issues are addressed, especially in family therapy, therapists are often confronted with the family's perception of them as Nazis. When therapists over-identify with the child's rebellious rage against parental clinging, they "victimize" the parents who were already victimized by the Nazis. The latter behavior is further abetted by the general tendency among mental health professionals to blame parents for their children's problems. Some therapists actually called survivor parents "Nazis" when they described their interactions with their offspring. When they overidentify with the parents' anxiety and hurt at the child's attempts at separation, they inhibit the child's normal anger through, for example, "lecturing" the child to "understand" the parents who "have suffered enough." This dilemma induces helpless rage in therapists who often reported experiencing murderous feelings toward "these parents" or "these children."

Therapists resorted to counter-rage in three major instances: (1) In response to being viewed by these individuals as Nazis; (2) when survivors did not live up to their expectations to rise above hate and prejudice, e.g. "I hate all Germans," discriminating and prejudicial attitudes; or (3) when they became terrified of the bottomless well of rage they anticipated in survivors.

Therapists' inability to cope effectively with the rage they experienced toward their patients led some to reject them or to shorten the therapy of survivors and children of survivors. Often they justified their actions by reference to "patient's resistance," which again appears to be a rationalization. Other mental health professionals sought further psychotherapy primarily to work through issues surrounding (re)awakened intense rage and related imagery.

Dread and Horror

Another reaction which occurs with very high frequency among psychotherapists and researchers is dread and horror. "I dread being drawn into a vortex of such blackness that I may never find clarity and may never recover my own stability so that I may be helpful to this patient." Therapists felt traumatized as if attacked by their own emotions and fantasies. They also reported horror in reaction to cathartic experiences, which survivors tend to relive with much vividness and intensity. Those therapists who attempted to control their own reactions often experienced these sessions as very draining. A few found themselves sharing the nightmares of the survivors they were treating.

One therapist reported experiencing herself "tuning out to the point of fainting" in reaction to her patient's telling her about her own baby being smashed against a wall in front of her eyes and about other children clinging to their parents' bodies in mass graves. This therapist stated that she was "afraid to share this horror with [her] supervisor."

Dread and horror were also a reaction to the sense of total passivity and helplessness conveyed in Holocaust stories, which often led therapists and researchers to prevent the recounting of any Holocaust experiences. In their reports to me they spoke of changing the subject and using other defensive maneuvers, which are elaborated in the following.

Shame and Related Emotions

Two criteria were used in categorizing the following affective reactions as related to shame. First, all have the elements of humiliation and degradation in common. Second, they all assume projective identification of the listener with the protagonist in the Holocaust stories she/he hears.

One aspect of shame is derived from therapists' fantasies of what the survivor must have done in order to survive. Shame was also related to the therapist's *disgust.* Disgust and loathing frequently impelled the therapist to prohibit survivors and their offspring from telling these stories.

Shame was also related to the therapist's acceptance of the myth describing the behavior of the Jews during the Holocaust as *going like sheep to the slaughter.* This myth implies not only that they could have fought, and that they should have been prepared for the Holocaust—as if anyone could have been—but it also assumes that Holocaust victims had somewhere to go to if they chose to escape, and that the rest of the world wanted them, which was clearly not the case.

Therapists who accepted this myth tended to feel contemptuous toward and condemn survivors for having been victims, and as such, weak, vulnerable, and abused. The process usually began with shame and contempt, and when therapists could no longer tolerate their shame, they became enraged. Many therapists who indignantly expressed their contempt and rage consequently doubly victimized their patients.

Perhaps the deepest aspect of shame is what I have called *the fourth narcissistic blow.* When Freud (1917) speculated about the reasons people rejected and avoided psychoanalysis, he said that Copernicus gave the first blow to humanity's naive self-love or narcissism, the cosmological blow, when humankind learned that it was not the center of the universe. Darwin gave the second, the biological blow when he said that humanity's separation from and superiority to the animal kingdom is questionable. Freud claimed that he gave the third, the psychological blow, by showing that "the ego is not [even] master in its own house" and that, indeed, we have limits to our consciousness. I believe that Nazi Germany gave humanity the fourth, the *ethical blow,* by shattering our naive belief that the world we live in is a just place in which human life is of value, to be protected and respected.

A country considered the most civilized and cultured in the Western World committed the greatest evils that humans have inflicted on humans, and thereby challenged the structure of morality, human dignity, and human rights, as well as the values that define civilization. Not only psychotherapists, but all of us, in various degrees of awareness, share this sense of shame. Indeed, this fourth narcissistic blow may have caused many in society to avoid confronting the Holocaust by refusing to listen to survivors and their offspring, those who bear witness to it and to its consequences.

Although all four "blows" forced confrontation with essential truths about human existence, the ethical blow distinguishes itself by massively and mercilessly exposing the potential boundlessness of human evil and ugliness. Unless humanity is willing to integrate this most recent narcissistic

blow, the pessimistic prophecies stated by Freud (1930[1929]) in *Civilization and Its Discontents* may be fulfilled.

Grief and Mourning

Both therapists and researchers reported experiencing deep sorrow and grief during and after sessions with survivors and their offspring, especially when their losses and suffering were recounted. Some found themselves tearful or actually cried at those times. One therapist/researcher reported "becoming progressively crushed to the ground . . . with endless, bottomless sadness" in constructing a family tree in interviews with a child of survivors. Having done his "homework," the patient reported when, where, and how each of the 72 family members had perished, leaving only two survivors: his mother and father. Their four murdered children were among the 72, all killed before their eyes after being torn from their arms.

Some therapists attempted to avoid listening to pain and suffering by asking questions such as, "How did you survive?" instead of, "What happened to you?" or, "What did you go through during the war?" Others spoke of "sinking into despair" and fearing to be "engulfed by anguish."

The anguish they experienced is related to the impossibility of adequately mourning so massive a catastrophe as the Holocaust. "How can one ever mourn all of this?" Most, if not all, survivors view not only the destruction of their lives, whole families and communities, but six million anonymous, graveless losses and the total loss of meaning as their rightful context for mourning.

Therapists who were unable to contain these powerful, intensely painful—yet appropriate—feelings in themselves and in their patients, became intolerant or immobilized. They were, therefore, unable to provide a "holding environment" (Winnicott, 1965) in which patients could begin to grieve and mourn their personal losses, a necessary process for them and their families.

Victim/Liberator

Therapists may view survivors as either victims or heroes. When they view survivors as *victims,* they are seen as fragile, helpless martyrs. This image generates bystander's guilt, rage, and shame in them. Ramifications of these countertransference reactions have already been considered in previous sections.

In the context of viewing the survivor as a victim, therapists reported another response which I have labeled *Therapist as Liberator/Saviour.* When therapists experienced the survivor patient as if still living—passive and helpless—in the camps, they became "annoyed and impatient," and felt

the need to liberate them. This need stemmed from the therapist's intolerance for the patient's experience of survivor's guilt, and its meanings for the survivor, resulting in negative therapeutic reactions. Therapists reported feeling frustrated, angry, and unable to bear the patient's persistent suffering. As stated in previous sections, therapists generalized their view of the survivors to their offspring. When they viewed the child of a survivor as a victim, they tended to respond to the offspring as they did to the parents. Some therapists, however, viewed the offspring as victimized by their parents. These therapists attempted to rescue the children from their survivor parents, compete with them, and/or compensate for parental deprivation.

Viewing the Survivor as Hero

When therapists view survivors as heroes, they see them as superhumanly strong, capable, heroic figures to be worshipped and admired. Some therapists feel awed by the courage, hope, and sheer determination reflected in their Holocaust accounts. Awe led some therapists to glorify the survivors, to conceive of them as special people who, having experienced ultimate evil and destruction, have found the essential truths and meanings of life. Some researchers looked for "superior methods of coping" in them. In addition to the historical distortion involved in such a view, it also implies derogatory attitudes toward the six million dead.

The main pitfall in overestimating the strengths of survivors in therapy is the therapist's resulting blindness to the pain and suffering, and the problems in living, which brought the survivor to therapy. In addition, such therapists' attitudes do not allow for mourning.

The idealization of both victims and heroes humbles therapists and leads them to view the problems and concerns of their own lives as trivial compared to the survivors'. Such attitudes may result in envious and competitive feelings toward survivors and in feeling excluded or like an outsider.

Some therapists who were not themselves victims or children of victims of the Holocaust reported feeling envious of the moral stature that has accrued to survivors because of their sufferings. Much like survivor's offspring, they reported feeling inferior to survivors because they believed they would never have survived the situations described by their patients. Some therapists who were not children of survivors reported envying the fact that survivor's offspring are by definition members of a special group with its own identity, and they condemned the offspring for using their parents' suffering to claim this special status. They stated a preference for working with offspring of only one survivor/parent, assuming that they will share a better cultural rapport: "They are more American."

Most therapists generally preferred working with *heroes* to working with *victims*. One therapist reported wishing to hear heroic stories and "turning off" when his patients "kept complaining." Most therapists also stated that they would rather lead offspring groups than groups of survivors: "Hearing the stories second hand is easier."

Me Too

A somewhat related reaction among psychotherapists and researchers is what I call the "me too" reaction. It may also be stated as: *"We are all survivors."* Although this global attitude may stem from a sincere attempt on the therapist's part to empathize with his or her patient, I believe it poses a real danger of blurring the distinctions among various kinds of survival experiences, under various conditions and degrees of traumata. Therapists who are not survivors or children of survivors of the Nazi Holocaust have claimed "I am a survivor myself" after having initially felt they "had no right being here. I hadn't shared their experience."

Many therapists who are survivors and/or children of survivors used similarity of experience in the service of empathy and understanding, which they reported to be helpful to their patients. But it was sometimes used in the service of defense or was otherwise problematic. For example, the "me too" reaction which assumed sameness of experience sometimes took the form, on the part of some of these therapists, of foreclosing remarks such as, "I know what you mean, I am a survivor [or, a child of survivors] too."

The defensive "me too" response on the part of either group of psychotherapists may interact with the patient's own fears that sharing their traumata would lead to reliving them. As such, this "countertransference reaction" acts to perpetuate the conspiracy of silence, rather than to aid the patient's exploration of his or her own particular experiences. It ignores the uniqueness of both the Holocaust and their particular meaning and consequences these have for the survivors and/or for the survivor's child (see also Danieli, 1981a, 1981b; Edelstein, 1981; Furst, 1978).

Sense of Bond

Therapists and researchers who are survivors and/or children of survivors were uniformly convinced that they were better able to understand and help survivors and their offspring because of their shared complex history and unique experiences, culture, language(s), and customs. For example, "I was there . . . Nobody [who wasn't there] could really know what hunger was really like. Nobody knows what it's like to emerge out of hell to only find out that every single person you knew had perished from the face of the earth. . ." Some acknowledged that "Partly, I also wanted to help myself

with my own issues and I knew my peers, my 'cousins' are the right people to do it with."

This sense of kinship and "connectedness" was often related to these therapists' and researchers' stated need to reestablish their own (extended) families and sense of community. Sharing Carmelly's (1975) belief that " 'professional neutrality and detachment' cannot be helpful in counseling [survivors]" (p. 143), some participants in this study expressed conflict over maintaining professional role and authority in working with "their people." Elsewhere (Danieli, 1981b) I have pointed out that "[in addition to self-assertion,] assuming authority was also frightening because it was associated with the possibility of abusing one's power (and acting like a Nazi) or of becoming ineffectual and inconsistent (like their parents)" (p. 143). This proved to be an additional component of this conflict for therapists who are children of survivors.

Attention and Attitudes Toward Jewish Identity

Several factors determine whether therapists encourage or even permit their patients to raise and explore their unavoidable concerns about the meanings and ways of being Jewish after the Holocaust, and after the establishment of the State of Israel. The first is whether therapists believe that cultural, political, and religious issues belong in therapy, or in psychology in general. The second is their conscious and unconscious attitudes toward these issues in their own lives.

Some participants in this study judged their patients as "ethnocentric" for claiming that the Holocaust was a uniquely Jewish phenomenon. Others were clearly perturbed by the Jewish self-hate, inferiority, and shame expressed by their patients. These therapists needed survivors and children of survivors not only to be proud Jews, but to (re)establish continuity with and belongingness to the whole Jewish history and culture, rather than to define their Jewish identity and their relationship with the non-Jewish world solely in response to the Holocaust.

Murder versus Death

Two related phenomena, albeit more specific, are therapists' use of the words "death" and "dead" as contrasted with "(mass) murder" and "murdered" to describe the fate of the victims and/or the deeds of the perpetrators of the Holocaust. Some of the participants in this study who have worked with survivors of the Nazi Holocaust, and with the elderly and/or the terminally ill (some of whom were also survivors) have used these words to differentiate between their reaction to personal "normal death" and to the evils of mass murder and its anonymity of the Holocaust.

Therapists and researchers who work with members of survivors' families encounter individuals whom the Holocaust deprived of the normal cycle of the generations and ages. The Holocaust also robbed them, and still does, of natural, individual death (Eitinger, 1980) and thus, of normal mourning. The use of the word "death" to describe the fate of the survivors' relatives, friends, and communities appears to be a defense against acknowledging murder as possibly the most crucial reality of the Holocaust.

Privileged Voyeurism

Privileged voyeurism, in contrast to the "countertransference reactions" described previously, tends to lead therapists and researchers to dwell excessively on the Holocaust. Indeed, some professionals reported feeling privileged to work with survivors. One therapist reported feeling "excitement, glamor, and an extra quality of titillation." Therapists' sadism appears to be a major factor in many such reactions. Another therapist chose to treat survivors as a way to learn and understand his family's history and behavior.

These therapists tended to become totally engrossed with the Holocaust and ask numerous questions, many of which may not have been relevant to the particular survivor's or survivor parent's war experiences. Because of their zeal, they sometimes totally ignored their patient's present life situation, including their experiences following liberation. Similarly, they tended to neglect the patient's pre-war history. A major danger of privileged voyeurism is to neglect the survivor or child of survivors as a whole person.

Defense

The various modes of defense against listening to Holocaust experiences recounted by their patients and therapists' inability to contain their intense emotional reactions to them comprised the most frequent "countertransference phenomena" repeatedly reported by psychotherapists and researchers in working with survivors and their children. Some therapists reacted to feeling overwhelmed by numbing themselves. Others reacted with disbelief and accused their patients of exaggerating. Therapists and researchers reported a variety of avoidance reactions: They kept "forgetting," "turning off," "tuning out," and "getting bored with the same story repeated over and over again." Many used distancing. They heard the stories as though they were "science fiction stories," or "as if it happened five thousand years ago." Others became very abstract, "professional," and intellectual, frequently lecturing the patient. An extreme "cutting the Holocaust out" behavior on the part of psychotherapists was to refer (children of) survivors to therapists in the Group Project "to take care of the Holo-

caust part" while continuing to see them "for the rest of their personality problems."

Some psychotherapists and researchers defended themselves by *over-reliance on available methods, theories, theoretical jargon, and prescribed roles.* They used theoretical rationalizations such as: "Let's talk about the here and now. The past is gone . . . there is no sense in complaining . . . You are in the United States now . . ." Some stated that "the children were born and raised in America; They behave just like typical American Jews. They just use the Holocaust to feel special. This is just a variant of narcissism." Or they focused exclusively on the survivor's pre-Holocaust childhood. The latter is especially true of orthodox psychoanalysts. (For example, see Zetzel, 1970: "External events, no matter how overwhelming, precipitate a neurosis only when they touch on specific unconscious conflicts.") This avoidance rendered such therapists unable to consider Holocaust traumata as etiologically significant and often central to the understanding of their patients' psychodynamics. In many cases this omission led to a misinterpreted etiology, one that circumscribed the therapists' understanding—and therefore their therapeutic activity—to their familiar psychodynamic/psychotherapeutic orientation.

In supervision, a therapist described a patient, Mr. S, whose presenting problem was compulsive showering and scrubbing, which resulted in severe damage to his skin. The therapist worked under the assumption that Mr. S's symptomatology was a manifestation of an anal fixation and kept probing into his childhood. An old intake report stated: "In Auschwitz Mr. S worked for 10–12 hours a day" without mention of the nature of his work. Following the supervisor's suggestion to explore the nature of the patient's "work detail," the therapist learned that Mr. S removed corpses from the crematorium. This information served as a breakthrough for both therapist and patient, and resulted in a dramatic reduction of the symptom. Whereas all psychological phenomena are overdetermined, it seems clear that the dramatic result here was related to reviewing the patient's Holocaust experience.

A similar example of theoretical reduction was naming the following Holocaust-derived dream imagery reported by a survivors' offspring as "pregenital sadism": "pits full of hundreds of corpses . . . mutilated bodies against barbed wire . . . a baby blown to pieces while thrown up into the air . . . a skeleton crying for food."

The distortion caused by insufficient understanding of the meaning and functions of the experience of "survivor's guilt" is one of the most poignant instances of how extraordinary human experience exposes the limits of traditional psychological theories of ordinary life. Earlier, I stated that the pervasiveness of bystander's guilt among psychotherapists and researchers may account for what I feel is their overuse, stereotypic attribution and

reductionistic misinterpretation of concepts such as "survivor's guilt" as described by Niederland (1961, 1964) and by Krystal and Niederland (1968) as a major feature of the "survivor's syndrome." A comprehensive analysis of the concept "survivor's guilt" would necessitate a far more detailed discussion than is possible here, nor is it the main focus of this article. As an illustration of what psychotherapists may miss by responding in the ways described previously, I touch upon some of the central meanings and functions of guilt in the survivors' or survivors' offspring's experience.

Some Aspects of "Survivor's Guilt"

One of the most powerful functions of "survivor's guilt" is to serve as a defense against existential helplessness. Being totally passive and helpless in the face of the Holocaust was perhaps the most devastating experience for survivor victims, one that was existentially intolerable and necessitated psychological defense. Elsewhere (Danieli, 1981a, 1981b) I have speculated that much of what has been termed "survivor's guilt" may be an unconscious attempt to deny or undo this passive helplessness. Guilt presupposes the presence of choice, and the power, the ability, and the possibility to exercise it. It states, "I chose wrong. I *could* have done something (to prevent what happened) and I didn't;" or, "There is something I *can* do, and if I only tried hard enough I will find what it is."

Guilt as a defense against the experience of utter helplessness links both generations to the Holocaust: The children are helpless in their mission to undo the Holocaust both for their survivor parents and for themselves. This sense of failure is often generalized as, "No matter what I do or how far I go, nothing will be good enough."

Klein (1968) states that while "it is obvious that survival guilt is . . . a way of working through late mourning and bereavement for loss of beloved people. . . . It also seems to serve as means of survival in a chaotic world where all objects of love have been lost and where there are no people with whom to cry and to share one's grief" (pp. 234–235). In a similar vein, at a memorial for a survivor friend (September 14, 1980), Elie Wiesel said that the hearts of the survivors have served as the graveyards for the known and the nameless dead of the Holocaust who were turned into ashes and for whom no graves exist. Many children of survivors also share this sentiment. Elsewhere, I stated (Danieli, 1981d) my belief that much of the anhedonia and the holding on to the guilt, shame, and pain of the past had to do with these internally carried graveyards. Survivors fear that successful mourning may lead to letting go and thereby to forgetting the dead and committing them to oblivion—which for many of them amounts to perpetuating Nazi crime. Thus, guilt also serves a commemorative function (see also Chodoff, 1970) and as a vehicle of loyalty to the dead. Guilt and suffering are also

expressions of loyalty in families who idealize martyrdom: "I feel the pain that my mother and father went through. If I don't, I am a disloyal son."

Counteracting psychological aloneness and reestablishing and maintaining a sense of belongingness and (familial/social and cultural) continuity are two additional crucially important functions of survivor's guilt. One survivor stated, "I keep thinking over and over again what I could have done to save my mother and brother. Inside me they are not dead. They are all with me all the time . . . It hits the hardest on holidays and happy family occasions: If they could only be here to see it! . . . How can I be happy when all I can think about is that they are not here to celebrate it with us like we used to." And another survivor commented, "If we accept the ashes then we have no past."

Reaffirmation of morality and of the world as a just and compassionate place has served as one of the most adaptive functions of survivor's guilt. Klein (1968) views it as "restitution of lost human values, as well as restoration of one's own human image: and states that "both guilt and aggression serve to restore a feeling of justice and security in relation to the world" which is "in complete contrast to the denial and rejection of any kind of guilt by the mass murderers . . ." (pp. 234–235) and the silently acquiescent world. The need and determination of many survivors and survivors' offspring to bear witness expresses both their commitment to make the world a better place where atrocities such as the Nazi Holocaust will never happen again, and their belief in the moral compassion and responsive participation of their listeners. Many survivors speak of the "unanswerable puzzlement" of their survival and of their survivor's guilt as "automatically triggered precisely because so many good people died. How come so many good ones died? Am I not a good one?"

I hope that the above discussion of some of the functions of guilt in the survivors' or survivors' offspring's experience, brief as it has to be within the context of this article, has hinted at the complexity of the solution of this puzzlement.

SOME CONCLUDING REMARKS

Many survivors suffer amnesia for their lives before the Holocaust. While others idealize their pre-World War II life and psychologically still live in that time period, many are unable to recall their war experiences. The therapist is thus confronted with discontinuity and disruption on all levels: in the order of living—uprootedness, losses of families, communities, homes and countries, and in the order of values. Recreating a sense of rootedness and continuity and meaningfully integrating the Holocaust into their lives are major struggles for survivors and their children. When psychother-

apists focus on certain periods in the patients' lives and neglect others, they hinder survivors and their offspring in this task, and may perpetuate their sense of disruption and discontinuity.

Implications for Training

Traditional training does not usually prepare professionals to deal with *massive, real (adult) traumata* and their long-term effects (see also Wallerstein, 1973). One psychotherapist stated, "I think the biggest problem is not having any guidelines to deal with the Holocaust. The fear is of going into uncharted territory where your only guide is your patient, and yet you are in the role of expert." Indeed, it was not until 1980 that the *Diagnostic and Statistical Manual of Mental Disorders* included the category 309.81 Post-traumatic Stress Disorder, Chronic or Delayed, as a separate "mental disorder."

Knowledge about the Holocaust greatly increases the therapist's ability to help survivors and their offspring. It provides a frame of reference that helps the therapist to know what to look for, and what types of questions to ask. Knowledge of pre-Holocaust background is also important. This may include: (1) the characteristics and dynamics of the survivor's family of origin in pre-World War II European Jewish life, in its heterogeneity; and (2) demographic factors such as the age, education, occupation, and the marital and social status of the survivor at the outset of the Holocaust—to cite but a few. These are of particular significance in understanding the survivors' families' post-Holocaust adjustment.

Familiarity with the growing body of literature on the long-term psychological sequelae of the Holocaust on its survivors and their offspring helps in the same fashion. Nonetheless, mental health professionals should guard against the simple grouping of individuals as "survivors," who are expected to exhibit the same "survivor syndrome" (Krystal & Niederland, 1968), and the expectation that children of survivors will manifest a single transmitted "child-of-survivor-syndrome" (e.g., Phillips, 1978). Indeed, the heterogeneity of the responses to the Holocaust and post-Holocaust life experiences in families of survivors which I have demonstrated (Danieli, 1981) and Rich (1982) substantiated empirically, suggests the need to match appropriate interventions to particular forms of reaction if optimal therapeutic or preventive benefits are to be obtained.

The reader may note that many of the examples above are reactions to patients' Holocaust *stories* rather than to their behavior. The unusual uniformity of psychotherapists' reactions suggest that they are in response to the Holocaust—the one fact that all the otherwise different patients have in common. Since the Holocaust seems to be the source of these reactions, I suggest that it is appropriate to name them *"countertransference reactions"*

to the Holocaust rather than to the patients themselves. The themes that have been described among psychotherapists and reseachers were also observed among other groups such as lawyers and judges, in their interactions with survivors and their children. As stated previously, I believe that professionals share these reactions with other members of society, and that these feelings and attitudes may have contributed, at least in part, to the long-term conspiracy of silence between Holocaust survivors and society.

Despite the absence of therapy outcome findings, I feel urgently and am strongly concerned that without special training of therapists, survivors, the second generation, and possibly others to come will prove fully justified in feeling bitter and hopeless about receiving the right kind of help. I hope that increased awareness of the "countertransference reactions" reported in this article will help therapists and investigators contain and use them preventively and therapeutically. Survivors and children of survivors of the Nazi Holocaust, as many victim/survivors of other real traumata, often "ache with the truth," and they alone are the master experts of their experiences. To my fellow therapists I say: Let us not deafen ourselves and thereby belie our own expertise.

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