Family Approach with Grandchildren of Holocaust Survivors

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Although the transgenerational transmission of Holocaust trauma is now well documented, this subject remains a source of considerable controversy. Moreover, the literature regarding the grandchildren of Holocaust survivors (GHSs, the third generation) is much sparser. We present here several clinical observations, that we made during therapy sessions with certain families of Holocaust survivors (HSs). These families consulted with us because of the symptoms presented by the GHSs as adolescents. These families were characterized by some specific patterns in their relationships that led us to consider that the symptoms of the third generation might be a consequence of the transgenerational transmission of Holocaust trauma. We also describe the clinical strategy we developed to assist these families of HSs. This strategy consisted of an attempt to reinforce the relationships between GHSs and their grandparents, the Holocaust survivors.

INTRODUCTION

Although the transgenerational transmission of Holocaust trauma is now well documented, this subject remains a source of considerable controversy (1). On the one hand, psychotherapists usually observe and describe various kinds of emotional distress in the offspring of Holocaust survivors (HSs). On the other hand, most of the controlled studies fail to confirm the assumption of increased rates of psychopathology in this population (2-4).

With regard to HSs, i.e., the first generation in this paper, they are often described as presenting high levels of emotional disorders, psychosocial symptoms, posttraumatic symptoms, and an achievement motivation based

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on the fear of failure (5-7). Their high level of anxiety and depression results in major difficulties in providing an adequate maturational environment for their children (8). The mourning of their multiple losses is assumed to create child-rearing problems centered on both attachment and detachment (8).

With regard to the children of Holocaust survivors (CHSs), i.e., the second generation in this paper, they present an increased vulnerability to psychological distress (9, 10) and to posttraumatic stress disorder (1, 11, 12), which could be related to the presence of PTSD in their parents (12). CHSs appear to be characterized by increased problems in the area of separation/individuation issues (1, 13); by a need to be superachievers to compensate for their parents' losses; and by an unstable, alternating overidentification with the survivor parent(s) as both omnipotent (i.e. as a chosen survivor) and degraded (4, 14). They also suffer from impaired self-esteem (4), from problems with the inhibition and control of their aggression (15), and from difficulties entering into intimate relationships as well as in handling interpersonal conflicts (16).

With regard to grandchildren of Holocaust survivors (GHSs), i.e., the third generation in this paper, the literature is much sparser. In the study of Sigal et al. (16), GHSs were overrepresented by 300% among the referrals to a child psychiatry clinic, in comparison with their representation in the general population. In the study by Bachar et al. (15), GHSs did not differ in their expression of aggression from controls. As difficulties in externalizing aggression are considered in the literature to be a central factor in the maladaptation of survivors, and subsequently in their offspring, the results of the Bachar study were interpreted to be one possible indication that transgenerational transmission of trauma has ceased in the third generation (15).

The clinical concepts developed in the present paper concern the transgenerational transmission of Holocaust trauma in the third generation. In effect, we present several clinical observations made during therapy sessions with certain families of HSs. These families consulted with us because of the symptoms presented by members of the third generation (the GHSs) as adolescents. These symptoms were not specific, and included various categories, such as problems at school, cannabis abuse, eating disorders, depressive or anxiety disorders, and problems with aggression. These families presented some specific patterns in their relationships that led us to consider that the symptoms presented by the third generation might be a consequence of the family's history and the transgenerational transmission of Holocaust trauma. We also describe here the

clinical strategy we developed to assist these families of HSs. This strategy was used in addition to classical individual and linear treatment of the symptoms and consisted of an attempt to reinforce the relationships between GHSs and the CHSs

RELATIONAL MECHANISMS INVOLVED IN THE TRANSGENERATIONAL TRANSMISSION OF TRAUMA

The First Generation

In the course of this family approach, we did not meet at any time with members of the first generation, the HSs, considering that they have the right to live in peace. We preferred to collect information about them through the testimony and narrative of their offspring, which allowed us to reconstruct the family history.

It appears that after the Holocaust the most important mission for the HSs was to perpetuate life by creating a new family. At the same time, due to the aftereffects of the Holocaust, they faced important difficulties in fulfilling their role as spouse or parent. During the Holocaust, they endured massive trauma that resulted, most notably, in psychological consequences, such as a form of "psychological death." This consisted of extinguished areas of emotion, comparable to the affective unavailability described by Levine (14). As outlined by Schindler et al. (17), HSs appeared to be unable to get in touch with their own emotions. They lost their capacity to cope with their own instinctive needs and those of people close to them. All of their energy was invested in their concern about providing for the physical and material well-being of their family. Shoshan (18) emphasized that this constant activity based on material worries helped to distract HSs from their depressive memories.

In the families we followed, HSs did not communicate with their offspring about their Holocaust trauma. As stated by Schindler et al. (17), silence is their only means of expression, and this silence resulted in a discontinuity in the historical legacy of the family. Usually, this historical legacy ensures the continuity of life in the midst of the discontinuity attributed to the succession of generations. Historical legacy is transmitted mainly by means of rituals, traditions, family celebrations, accounts by older family members, photos, family objects, and memories. With regard to our family cases, two factors interfered with the transmission of legacy. First, several instruments of transmission (photos, objects, etc.) disappeared during the Nazi occupation. Second, silence became a rule of survival for the HSs. In effect, they had two psychological choices after the war: either to stay in a form of psychological death filled with Holocaust

memories or to forget them with the aim of living again. Building a new life and transmitting their past history were incompatible with each other.

The Second Generation

In our family cases, CHSs were born after their parents' liberation from concentration camps and so were not directly exposed to Nazi persecution. They experienced the effects of trauma indirectly, through their parents' references. As described by Shoshan (18), from birth on, they absorbed their parents' distress.

For their parents, CHSs were a source of reassurance and confirmation of survival. They were submitted to a role reversal, becoming parents to their own parents, and to an intense emotional overinvestment. They represented a narcissistic extension of their family. HSs viewed their children's development only through a dichotomous assessment of their performance: Were they doing well at school or were they dunces? Were they neat and polite or did they cause their parents shame? CHSs learned to neglect their own feelings, to regard their own problems and anxieties as unimportant compared to those of their parents. They rapidly realized that their most important task was to be a "good son" or "good daughter." However, they soon became aware that no matter how hard they tried to achieve this goal, they would never fully satisfy their traumatized caregivers. They were vulnerable, therefore, to feelings of helplessness.

Moreover, in the suffering families we met, intimate communication was severely restricted, resulting in a form of cognitive restriction. CHSs were implicitly asked not to meta-communicate about the silence of their parents. Historical knowledge of the Holocaust could not be used to supplant things left unsaid by the family. Because of this cognitive restriction, CHSs seemed unable to cope with the feelings of their parents. Most of the time, they felt responsible for their parents' sadness.

This approach-avoidance dilemma around the suffering of their parents results in two contradictory feelings. As put forth by Sorscher and Cohen (19) and by Halik et al. (20), CHSs appear torn between protectiveness based on the perceived vulnerability of their parents; and guilt in response to angry impulses toward them. This ambivalence interferes with their autonomy process. In effect, as any emotional connection outside the parental home is experienced as a desertion of their parents, CHSs report specific trouble in creating intimate, lasting relationships with spouses and children.

In the families we studied, CHSs depended emotionally on their children (the GHSs), from whom they demanded compensation for their

own damaged childhood. Therefore, the issues faced by the CHSs reverberate in their own children, resulting in a double feeling of failure for the CHSs, both as children and as parents.

The Third Generation

The GHSs bore the brunt of the "shock wave" of the Holocaust trauma. Due to the lack of autonomy of their parents, they did not enjoy a family climate that allowed them to experiment with new forms of expression. Fear and anxiety were everywhere, with no room left for creativity.

Moreover, they had to sacrifice themselves in order to protect their parents from their own feeling of helplessness. For GHSs, separation-individuation conflicts appeared insoluble. Saying "I" was felt as a negation of the family contract, which required saying "We." As stated by Kestenberg and Gampel (21), separation from the family meant death; death in a literal, not symbolic sense.

In several HSs families we met, the symptoms presented by the GHSs were linked to the trauma that had occurred two generations earlier. These symptoms originated in the selection of what was transmitted or not transmitted through the two previous generations. Repressed memories interfered with the developmental process. Silence permeated their lives, as GHSs had no opportunity to refer to the historical legacy of the family in order to put their parents' attitudes into perspective. Due to the impossibility of referring to past experience, these families were continually confronted with new situations at each stage of life—particularly when facing issues of separation and independence, thus generating an insurmountable crisis.

THE CLINICAL APPROACH: GRANDCHILDREN AS CATALYSTS OF COMMUNICATION

With the aim of unlocking family history and reactivating family roots, we examined the privileged position occupied by the GHSs with regard to their grandparents. In effect, we frequently noticed that HSs were generally more prone to talk about the past vis-à-vis their grandchildren than they were vis-à-vis their children. Therefore, we assigned to the GHSs the task of reconstituting the family history before and after the Holocaust trauma. To this end, we invited GHSs to consult their grandparents, as well as other members of the family still alive. By interviewing them or by communicating with them through mail, GHSs reconnected themselves with important family members. From the beginning, we introduced to the families an important distinction

between the "memory of life" and the "memory of death." We defined the memory of life as the narration by HSs of some facts regarding their lives before and after the Holocaust, as well as the narration of "anecdotes of survival," i.e., anecdotes describing the coping strategies that allowed them to survive during the Holocaust. Conversely, the "memory of death" included all the unspeakable feelings and emotions related to Holocaust trauma. We considered that HSs have the right to keep their memory of death to themselves. Our therapeutic goal, therefore, was to help them reveal to their grandchildren their memory of life.

HSs generally welcomed this opportunity to share their past, resulting in a progressive improvement in their ability to communicate. GHSs reactivated the process of transmission within the family and created new interactions. This interactive building of an open communication with their grandparents provided much understanding and relief to their families.

During the therapy sessions, we discussed the information collected by GHSs. We also focused on the difficulties they encountered during this process of exploration in order to better understand the changes that this gathering of information caused within the family structure. All these questions gradually allowed new light to be shed on the family history.

In addition to this reinforcement of the grandparent-grandchild relationship, we helped the CHSs to modify their parental and marital attitudes. In the families that we followed, CHSs generally did not present a specific form of psychopathology. They were normal people who had been subjected to an abnormal family structure due to specific historical events. With this in mind, our main therapeutic concern was to strengthen their ability to function as spouses and parents. We helped them to clarify their various roles and to enhance their independence from their own parents.

For the GHSs, improved knowledge of their family history, which helped them to clarify their own personality, together with their parents' enhanced autonomy, resulted in a progressive improvement of their symptoms. By becoming catalysts of communication, the GHSs were able to break the silence established by their grandparents fifty years ago. At that time, silence was a vital strategy that allowed HSs to thrive in life after the trauma. Fifty years later, this strategy had became a source of psychological distress for their offspring.

DISCUSSION

Although the ideas presented in this paper do not permit any generalization about other families, they are compatible with various reports of psychotherapists who described different kinds of emotional distress in the offspring of Holocaust survivors. As explained by Krell (22), family assessment and family therapy techniques are particularly important in the therapy of offspring of HSs. Various authors have commented on the difficulties encountered when treating the offspring of HSs individually. Psychotherapy is likely to fail if isolated from the family's experiential framework (22). However, the clinical work that we present in this paper is relevant to certain specific families. The method only reflects our clinical experiences: it does not claim to be universal, and is probably only applicable to a limited number of clinical situations. Moreover, several limitations must be considered.

First, our clinical approach required that the grandparents still be alive. Second, in some families, the symptoms presented by the third generation may have had another origin than a transgenerational mechanism, thus requiring a mainly individual and linear treatment. Third, according to the descriptions of Weiss et al (23), our observations of family cases were compatible with the notion of indirect general transmission: what is transmitted is not the trauma itself, but the impairment of the first generation's parenting abilities. Conversely, in direct specific transmission, children learn to think in disturbed ways similar to that of their parents. It is likely that our clinical approach would be less efficient with these families.

On the therapeutic level, our method was principally based on the premise that HSs are generally more prone to talk about the past vis-à-vis their grandchildren than they were vis-à-vis their children. This finding is compatible with relevant data from the literature. Apparently, it takes the time span of two generations to stimulate the willingness and motivation to return to a traumatic past. Several authors (5, 17) indicate that upon reaching retirement age, a time generally associated with the need to review life and deal with the crises of age and loss, HSs are able to speak more easily about the past, because in later life the need to share with others becomes more urgent. It is during these later years that the desire to break the silence occurs. Therefore, grandchildren serve as catalysts in unfolding the past (17).

In the literature, reports vary as to the effects the communication of HSs' experiences have on their offspring. Some cite negative effects, while

others mention beneficial ones (24). It appears that the quality of the communication of the trauma determines the quality of the offspring's adaptation (19). In our clinical approach, we encouraged the transmission of the memory of life. For the GHSs, the Holocaust was experienced through stories of their grandparents' survival and/or stories of their families. These testimonies appeared to relieve the GHSs as well as the HSs, who were reconnected with their prewar identities. In contrast, we felt that the communication of the memory of death would be too threatening for the psychological well-being of the HSs and their offspring. As outlined by Lichtman (24), to recount to the family the scope of victimization of the Holocaust experience could emerge as a negative factor for the offspring.

Above all, our clinical approach attempted to supply the GHSs with positive prewar images that could sustain them, and with happy memories that could connect them to life before the Holocaust (18). Offspring of HSs who had a greater knowledge of their grandparents' and parents' prewar experiences had more fully developed identities than those who had little knowledge (24). The refocusing of the Holocaust experience by the third generation into a life-affirming perspective provided the offspring with a way to assimilate their tragic historical legacy. This process brought the generations closer together and filled a long-standing gap.(18).

Finally, our therapeutic goal was not necessarily to resolve the issues completely, but to ease the impact of the trauma on family relationships and to transmit to the third generation some sense of hope and optimism about the family. As mentioned by our supervisor S. Hirsch: "We have to help these families and do all we can to avoid Hitler gaining a victory over the next generations." By attempting to reinforce the memory of life and to attenuate the power of the memory of death, we observed that, in some families, the coexistence of three generations could be used to gradually mitigate the distress of the Holocaust trauma. The development of the third generation could possibly allow the second to resolve separation-individuation issues. As the presence of three generations attests to the victory of survival, the energy inherent in this coexistence can finally be used for other purposes.

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