Integrity Versus Despair: The Experience of Traumatised Child Holocaust Survivors

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DECLARATION

I declare that this Thesis is my own, unaided work. It is being submitted for the Degree of Doctor of Philosophy in Clinical Psychology, at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

_____

(Signature of candidate)

_____day of_____20_____in_____

In Memoriam of my family who were killed during the Holocaust with the six million.

My great grandmother Meryl Farber and my great uncle Yehuda Farber who were shot and died in mass graves in the forest near Janova, Lithuania.

My great grandfather Shimon “Uri” Diner and my great grandmother Channah Diner who died in the Dvinsk ghetto in Latvia.

I honour the memory of my dearly loved grandfathers David Farber and Max Diner who suffered these tragic losses. I am their firstborn grandchild and I carried their stories both told and untold.

Their legacy lives on in all their grandchildren and great-grandchildren.

DEDICATION

To my beloved father Mervyn Farber who dreamed of the completion of this research. He was a devoted father and is remembered for his warmth, kindness and love.

To Hessie Gordon my psychotherapist who taught me about the emotional pain of Holocaust survivors and the “silk bandages” they use to cope. Her compassionate wisdom continues to guide me.

To my grandmother Dolly Farber whose love made this possible.

May their Souls be Blessed

ABSTRACT

A qualitative study was conducted into the long-term impact of the Holocaust on nine child survivors who were interviewed in their old age with a focus on how their life trajectory had shaped their engagement with the life tasks associated with integrity versus despair. The survivors comprised a community rather than a clinical sample of individuals and consisted of those who volunteered to take part in the study on the basis of an invitation from their community leader. All of the participants had been interned in concentration camps for periods during their childhood or adolescent years and all were resident in South Africa at the time that they were interviewed. A case study method was employed to examine the experiences of aging survivors and extended, in-depth, semi-structured interviews were used to generate data on the following features: pre-Holocaust life and family of origin; Holocaust and concentration camp trauma exposure, impact and coping; life post liberation; and experiences of aging. Thematic content analysis, informed broadly by psychodynamic theory, was used to extrapolate themes of trauma and resilience, and to understand how participants appeared to be navigating old age specifically in relation to Erikson's (1965) formulation of the life stage of Ego Integrity versus Despair. Aspects of each participant's developmental trajectory were explored in order to better understand the impact of Holocaust trauma as experienced during the life stages of childhood or adolescence. Both within case and across case features were identified. Findings demonstrated that survivors who had stable attachments in early life seemed to be more resilient in their coping after liberation. Participants varied in their capacity to function adaptively for a range of reasons, but significantly many of those who had led apparently productive lives had employed repression, suppression or compartmentalisation to keep Holocaust related recollections at bay. Responses to negotiating ego integration and despair fell on a continuum with some participants evidencing the capacity to view their lives with a sense of acceptance and retrospective appreciation, and others experiencing extreme despair. All survivors reported some symptoms consistent with complex traumatic stress, although many functioned well despite their symptoms. A ubiquitous finding was that all survivors expressed catastrophic grief for the loss of their parents and siblings enduring into the present many decades after the Holocaust. This catastrophic grief had consequences for the structure of the self, for the quality of their interpersonal relationships, and for their spiritual relationship with religion and God. This impacted aging child survivors' experience of despair in old age in a profound way – the continuous unresolved grief led to a sense of existential loneliness. While some were able to compartmentalise their despair, catastrophic grief was present to a large extent in both resilient and depressed survivors. The findings of this study indicated that the burden of catastrophic grief was a defining theme in the life trajectories of child survivors and the present research identified a 'Trauma Trilogy' that linked catastrophic grief to anger and survivor guilt contributing to their sense of despair in old age. Finally, the study examined the process of reflexivity as this proved very significant in conducting the research and also recommended directions for further research and some potential interventions to better support aging child Holocaust survivors.

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1 INTRODUCTION

The word Holocaust is derived from the Greek word “Holoskaustos”, meaning “whole” and “burnt”. It refers to a burnt offering. In Hebrew, the Holocaust is referred to as “Ha Shoah” which translates to “the catastrophe” (Kellermann, 2009). The Holocaust is the commonly used term to describe the destruction of European Jewry during World War II. Six million Jews were systematically persecuted and exterminated, including one and a half million children (Barel, Van IJzendoorn, Sagi- Schwartz & Bakermans-Kranenburg, 2010; Gutterman & Shalev, 2008). Jews were tormented, maltreated and murdered solely based on their identity as Jewish people. The genocide was perpetrated primarily by forces operating under or in conjunction with Adolph Hitler’s Nazi Germany army during World War II; lasting from 1939 to 1945. From 1941 to 1945 Jews were systematically murdered as were Romani, homosexual and mentally and physically disabled populations (Gutterman & Shalev, 2008). “That attempt at the systematic destruction of an entire people falls like a shadow on the history of Europe and the entire world; it is a crime which will forever darken the history of humanity” (Pope John Paul II, in Kellermann, 2009, p. 1).

The Holocaust was a tragic, man-made catastrophe, where human beings were exposed to destruction on a vast scale (Gutterman & Shalev, 2008). The Nazis perpetrated atrocities against Jews and other minority groups who were forcibly rounded up and transported in cattle cars to concentration camps. Here, those who managed to survive witnessed the murders of their families and friends, suffered humiliations, and endured dehumanising living conditions, including facing starvation, cold and disease. Others lived in hiding or fought as partisans (Barel et al., 2010; Gutterman & Shalev, 2008). Research concerning Holocaust survivors provides a framework for understanding the long-term consequences of massive trauma for aging Holocaust and other genocide survivors (Carmil & Breznitz, 1991). Insights from this understanding may be applied to helping victims of more recent genocides (Barel et al., 2010). Brice (2005) argues that the Holocaust was different from other genocides and processes of ethnic cleansing, as the primary aim of the Holocaust was the physical extermination of the Jewish people. He explains that killing in war ends with surrender, however in the Holocaust killing was aimed at the most defenceless and there was no mercy. As such, the extermination of Jews justifies the name Holocaust (Brice, 2005).

Understanding the long-term effect of trauma on child survivors is important for both clinicians and researchers and in the case of Holocaust survivors has become urgent as this population has reached old age and end of life stage (Barak, 2013). The trauma of the Holocaust was extensive and there cannot be hope of complete healing or cure however, we need to understand as much as possible about the Holocaust to try to alleviate some of the ongoing suffering (Tauber, 1998). Nobel Prize winner, Eli Wiesel, wrote about his experiences as a fifteen-year-old boy during the Holocaust in his book *Night* (1960). He was in the same age group as the participants who took part in this study and his quote is used to describe the trauma he endured when he was interned in Auschwitz and Buchenwald:

> Never shall I forget that night, the first night in the camp, which has turned my life into one long night, seven times cursed and seven times sealed. Never shall I forget that smoke. Never shall I forget the little faces of the children, whose bodies I saw turned into wreaths of smoke beneath a silent blue sky. Never shall I forget those flames, which consumed my faith forever. Never shall I forget that nocturnal silence which deprived me, for all eternity, of the desire to live. Never shall I forget those moments, which murdered my God and my soul and turned my dreams to dust. Never shall I forget these things, even if I am condemned to live as long as God Himself. Never. (Wiesel, 1960, p. 43)

Wiesel (1960) conveys very evocatively how as a fifteen-year-old boy he experienced the devastation of the Holocaust and the impact it had on the rest of his life. He describes how he has been forever scarred by what he witnessed and how the trauma impacted his world view and his spiritual relationship with God. Based on his experience he maintains that "time does *not* heal all wounds; there are those that remain painfully open" (Wiesel, 1978, p. 222). Kellermann (2009) states that no mental health professional can capture the human predicament of the Holocaust with the level of intensity such as that conveyed by authors like Eli Wiesel and Primo Levi. As such, their quotes are used in this thesis to highlight experiential aspects of living through the Holocaust and their reflections upon this as now elderly child survivors (although both authors are now deceased).

Since time immemorial humankind has endured trauma and tragedy as expressed in art and literature. (Van der Kolk & McFarlane, 2007). According to Laub (2002): "The massive psychic trauma of genocide produces excessive fragmentation in its survivors - fragmentation of

perception, fragmentation of a sense of coherence in their life histories, fragmentation of their relationships to their families, and to the wider human community" (p. 1). Such observations suggest that significant life trauma continues to be a legitimate area of study for psychologists and other social scientists.

In her book, *Trauma and Recovery* Herman (1992) pointed out that: "Atrocities refuse to be buried. They keep penetrating the conscious and unconscious minds of survivors and their offspring until they are properly remembered, mourned and worked through within a safe, healing relationship" (p. 1). Kellermann (2001) says that the long-term effects of Holocaust traumatisation have been evident several decades after the war in both survivors and their children and even grandchildren, as explored from a range of psychological perspectives. This perspective was substantiated by Klein[1] (2012) and Wardi (1992) who also wrote about Holocaust survivors and second and third generational effects. Van der Kolk and McFarlane (2007) state that traumatic experiences alter individuals' physiological equilibrium and observe that traumatic memories affect the appreciation of present positive experiences. All of these authors have highlighted that the trauma of the Holocaust had significant impact on the lives of Holocaust survivors. The trauma of the Holocaust caused a shattering of the psyche that did not necessarily heal with time and impacted on the later generations (Wardi, 1992).

Herman (1992) argues that the study of trauma represents a cycle of episodes over historical time in that knowledge about traumatic stress is periodically forgotten and then reclaimed. She explains that trauma evokes intense controversy, involves the unthinkable and raises basic questions of belief. The study of trauma exposes human vulnerability and humankind's capacity for evil. Herman (1992) suggested that a predictable pattern emerges after an atrocity. The victim is blamed and there is a collective denial surrounding the trauma. In addition, victims feel alienated and isolated and this exacerbates their suffering (Herman, 1992). Such conditions were true of gender-based violence, for example, until feminist activism brought such trauma into prominence. The Holocaust is a mass trauma that also produced considerable denial. For example, within the broader Jewish community it was not widely discussed until the 1980's with the event of the establishment of the Spielberg foundation that requested that survivors give testimony to memorialise their Holocaust experiences. Danieli (1984) argues that even the mental health professionals contributed to the 'conspiracy of silence' by not acknowledging the trauma of the Holocaust. At its most extreme there has been a denial that the events of the

[1] In this study Klein will refer to Hillel Klein. When referring to Melanie Klein her first name will be specified

Holocaust took place at all. While aspects of the Holocaust impact have been quiet widely researched, there is limited research on the long-term impact on child survivors.

The Holocaust that took place during World War 11 was a genocide aimed at the destruction of the Jewish people in Europe. This is an example of a man-made catastrophe. The study of the long-term effects of the Holocaust facilitates the understanding of how trauma impacts on the life cycle starting with young children and ending in the phase of old age (Fridman, Bakermans-Kranenburg, Sagi-Schwartz & van IJzendoorn, 2011). In addition, understanding the long-term effects of trauma may help to anticipate how survivors from more recent genocides are at risk. Examples of these genocides include those that occurred in Cambodia, Yugoslavia and Rwanda.

During the Holocaust, children were segregated with their parents in ghettos and were subjected to starvation, overcrowding, cold, lice, poor hygiene, shootings and humiliations. Some went into hiding and survived, whist others were captured. Some were gathered with their parents and put in cattle trucks to be sent to concentration or extermination camps (Valent, 1998). Within the camps individuals were subjected to horror and death (Gutterman & Shalev, 2008; Valent, 1998; Wiesel, 1978). Children were treated with cruelty and brutality. For instance, in the Lodz Ghetto children were thrown out of hospital windows and used for target practice (Chalmers, 2015). Of those interned in Auschwitz concentration camp many were subjected to medical experimentation (Gutterman & Shalev, 2008).

One and a half million children were killed during the Holocaust (Valent, 1998; Gutterman & Shalev, 2008). Those that survived were generally separated from their parents and many children were orphaned (Valent, 1998). Children lost their parents and extended family and were uprooted from their homes. The loss experienced was enormous and in addition, school and play were disrupted. This massive trauma halted the normal developmental process (Valent, 1998). According to Wardi (1992), survival was the ultimate goal of individuals in the ghettos, the forced labour camps and concentration camps. Those imprisoned used all their physical and psychological resources to survive. This survival focus was sustained for months and years, involving terrible physical suffering, including coping with illness, cold, ravenous hunger and exhaustion. The psychological warfare of the Nazi's involved individual dehumanisation and "the destruction of the identity and personality of each individual as a person and as a Jew" (Wardi, 1992, p. 8). Wardi (1992), detailed the way in which Holocaust survivors were repeatedly traumatised. The traumatisation began with the transportation to the camps and extended into the selection upon arrival at the camps where family members were separated.

Life in the camps involved ongoing traumatisation which was intended not only to physically eliminate but also to obliterate the inner reality of the survivor. In addition, life in the camps annihilated all representations of an external, familiar world (Klein, 2012). According to Auerhahn and Laub (1998) "failed empathy" (p. 1) was a central theme in the Holocaust survivor's experience. The empathic response was absent from the Nazis and society at large, including in many instances from the allies. The victims felt there was "no longer anyone to count on" (Wiesel, 1970, p. 229). The Nazi ideology defined Jews as sub human and in this respect the Holocaust represented a socially sanctioned sadistic racism that had pervasive effects (Auerhahn & Laub, 1984).

Hillel Klein (2012), a psychiatrist and psychoanalyst born in Krakow Poland, was sixteen years old when the Holocaust began. He was a survivor of the Krakow ghetto. After joining the resistance, he was captured by the Germans and interned at Plaszow concentration camp, where he experienced many horrors (Klein, 2012). After he was taken on a 'death march' he spent time in Thereseienstadt concentration camp, where he was later liberated by the Soviet Army. He was twenty-two years old when the war ended, his health was poor and he was the only survivor of his large family. After studying medicine, psychiatry and psychoanalysis in Israel, his professional interest was drawn to Holocaust survivors. Klein's writing has considerable relevance for this study as he endured the Holocaust in his late teenage years. Klein's strength was that he resisted generalisations and avoided discussing Holocaust survivors as a group. Rather, he viewed survivors as individuals within a group, each survivor having a different personal history and consequently, a unique psychological reaction to his or her Holocaust experience (Klein, 2012). Klein wrote about survivors from a psychodynamic point of view and reported that the psychotic nature of the concentration camps produced a trauma of catastrophic proportion. Both Hillel Klein and Eli Wiesel wrote prolifically about their experiences as adolescent survivors during the Holocaust from their different perspectives, Klein as a psychiatrist and psychoanalyst and Wiesel as a writer and Nobel Prize laureate. Their testimony and insight have special relevance for this research project as this was a retrospective study where aging survivors described their experiences as children and adolescents in the concentration camps and their impressions of how this experience had impacted their life trajectories.

Chalmers (2015) wrote about massive trauma during the Holocaust. She quotes Desbois, a Catholic priest who has researched the deaths of Jews in the Ukraine and Belarus during the Holocaust:

> I am convinced that there is only one race: a human race that shoots two-year-old children. For better or for worse I belong to that human race and this allows me to acknowledge that an ideology can deceive minds to the point of annihilating all ethical reflexes and all recognition of the human in the other (Desbois in Chalmers, 2015, p. 256).

At present, there are reports of a genocide in Syria, where hundreds of children are suffering. In addition, there has been an ethnic cleansing in Myanmar. It would seem that mankind is unable to learn from experience. While technology has advanced, humanity is still unable to protect children from genocides. According to Chalmers (2015) ideological fanaticism is evident worldwide and continues to be a destructive force for humankind, including for young people growing up in such contexts.

The present research explored the experience of aging Holocaust survivors who were children or adolescents during the Holocaust and who had been interned in concentration camps at least for some period. Since the study was retrospective in nature, aging survivors were interviewed about their pre-Holocaust life as young children and special focus has been given to the loss and trauma that they endured during the Holocaust. Their adjustment post-liberation was of interest, most specifically the way in which the Holocaust appeared to have impacted on them in the final developmental phase of 'Integrity versus Despair', as described by Erikson (1982).

The research objectives of this study were to explore the psychological effects of the Holocaust experience on child survivors who were now in late life stages of development in terms of the following features:

1. Developmental life cycle processes including early childhood experiences prior to the Holocaust.
2. Subjective accounts of exposure to traumatic events during the Holocaust
3. Mental health impacts including post-traumatic stress symptoms and related conditions.

4. Patterns of affective experiences, with particular reference to loss and mourning and exposure to further traumatic stimuli.
5. The development of (adaptive) coping mechanisms.
6. The negotiation of integrity versus despair and existential beliefs.

This thesis will introduce the theory and research around developmental trauma, child Holocaust survivors and aging in the literature review. The method chapter will describe the qualitative research methodology that was used in the present study. The findings and discussion chapter are divided into two sections. Firstly, the findings section will describe each participant's case history and then the second part of the discussion chapter will extrapolate on common themes found in the narratives of child Holocaust survivors.

2 LITERATURE REVIEW

2.1 Introduction to the literature review

This literature review will attempt to present the theorization concerning trauma exposure and its impact largely as understood from a psychodynamic perspective, as well as covering the diagnostic aspects of post-traumatic stress and complex traumatic stress. Thereafter, a focus will be drawn to the existing research into the trauma of Holocaust survivors specifically. Because this study views trauma through a developmental lens, aspects of Erikson's Psychosocial Theory of human development will be outlined. Since the participants of this study were child survivors at the time of the Holocaust the literature review will draw attention to previous research that outlines the impact of massive trauma on the developmental process. Child Holocaust survivors' experiences will be discussed with a particular focus on the themes of trauma and loss. Themes related to trauma and affective impact will be presented. In addition, coping strategies such as defence mechanisms, will be explored together with debates concerning resilience in child survivors. Since the focus of this research is on aging survivors, special emphasis will be given to the developmental stage of aging and end of life, that is the stage of Integrity versus Despair (Erikson, 1965). This literature review will also document previous research that has to some extent examined the long-term effect of the Holocaust on aging survivors. The debate regarding resilience in aging survivors will be presented and issues such as meaning making will be explored. Special focus will be given to the impact of trauma on the spirituality of aging survivors

2.2 Traumatic Stress

2.2.1 Introduction to Traumatic Stress

Owing to the constant challenges facing mental health professionals to meet the needs of survivors of ongoing trauma the field of traumatic stress is an area that continues to grow in research, theory and practice. Ongoing wars, terrorist attacks and genocides ensure that this field is called on to address human suffering in its most extreme form. Eagle (2000) states "It is evident that the experience of post-traumatic stress impacts at multiple levels from neurological and biological to the social and spiritual" (p. 9).

Herman (1992) argues that traumatised victims are overwhelmed with helplessness and traumatic events disrupt the individual's sense of control, connection to others and sense of meaning. Two central aspects of traumatisation have been described as helplessness and terror. Herman (1992) continues to explain that traumatised people feel and behave as if their nervous systems have been "disconnected from the present" (p. 35). She explains that the symptoms of trauma, such as hyperarousal, intrusive thoughts and emotional constriction, are connected to the nervous system. Hyperarousal represents the continuous expectation of danger; intrusive thoughts reflect the enduring imprint of the traumatic experience and emotional constriction represents the numbing response of helplessness or surrender. These effects are often enduring and extensive, demonstrating that perhaps trauma seems to alter the human nervous and psychic systems, in some instances more severely than others depending on the extent of the trauma exposure and the developmental capacities of the individual concerned.

The following discussion will offer a primarily psychodynamic view of trauma in keeping with the over-arching theoretical frame of the study.

2.2.2 The Psychodynamic Approach to Traumatic Stress

Proponents of the psychodynamic approach include classical theorists such as Sigmund Freud, as well as Object Relations theorists such as Melanie Klein, Wilfred Bion and Donald Winnicott. The psychodynamic school of thought emphasises unconscious conflict, memories and feelings. Psychic determinism is a basic tennent that underscores the view that to a large extent we are characters, living out a script written by our early experiences and informed by our unconscious. Early infancy and childhood are considered to be defining influencers in the development of an adult personality. Defence mechanisms are understood to be a core function of the psyche and play a role in reducing anxiety in relation to threatening experiences. Eagle (2013) singles out three theoretical bodies within the psychodynamic tradition that have contributed to our understanding of how trauma impacts on the psyche: Classical Psychoanalytic, Ego-Psychological and Object Relations perspectives. Each of these perspectives will be elaborated in the discussion that follows.

2.2.2.1 Psychoanalytic Contributions to Trauma

Freud (1920) developed his psychoanalytic theory regarding trauma as a result of working with 'shell shocked' combat veterans after World War I. As his theory of trauma influenced many later theorists it is important to outline his conceptualisation. Freud (1920) described the conflict between the life instinct and the death instinct, Eros and Thanatos. In his opinion, the goal of the psyche is to optimise pleasure and minimise pain. To maintain balance and lessen anxiety the ego attempts to mediate and moderate the individual's experience of the external world, guarding the person from becoming overwhelmed by anxiety. The impact of traumatic stress is sudden and overwhelming for the ego and its function in the containment of anxiety becomes compromised (Eagle 1998).

Freud (1920) described the protective shield of the ego as a 'stimulus barrier'. When trauma impacts on the individual the stimulus barrier is overwhelmed and this ruptures the protective interface between the self and the external world. He described trauma as a consequence of a breach in the 'protective shield' against stimuli that were overwhelming. This conceptualisation of trauma emphasizes the core issues of disruption and the breaks in continuity in experience (Benyakar, Kutz, Dasberg & Stern, 1989) as well as the manner in which it compromises overall functioning. Once the rupture has happened, the ego is weakened and its ability to mediate inner and outer reality is compromised. Thus, in the immediate aftermath of trauma the ego is unable to contain anxiety and becomes overwhelmed. The individual's reality contact is impaired (Eagle, 1998). Primitive regressed forms of thinking may be dominant, as more id driven primary process thinking and impulsivity are apparent. Freud (1920, 1948) made an important contribution to our present understanding of traumatic stress in explaining that catastrophic trauma causes regression, leading to cognitive deficits and primitive defences, which lean toward dissociation.

Freud (1920) coined the term "repetition compulsion' to describe the way in which memories about the trauma continued in the form of intrusive thoughts and nightmares, usually evoking high anxiety levels. Freud speculated that the function of repetitive memory was "to work over in the mind some overpowering experience so as to make oneself master it" (Freud in Gay, 1995, p. 600). Later, his formulation included the way in which trauma survivors re-enact their trauma as an attempt to gain mastery over it. According to Van der Kolk (2007), Freud thought that the aim of repetition compulsion was to achieve mastery, but clinical experience

demonstrates that the opposite happens, the repetition tends to cause more suffering for the victims and those around them.

According to Herman (1992) survivors do not consciously seek to relive the trauma to gain mastery, in fact they fear and dread it. Whether the traumatic experience is relived in the form of images dreams or actions, it involves re-experiencing the accompanying emotional intensity of the traumatic event. The survivors are overwhelmed with feelings such as terror and rage, to the extent that they may become unable to process or tolerate the emotion involved. Because the experience of reliving the trauma is so distressing, survivors go to great lengths to avoid these kinds of emotional experiences. In the attempt to avoid the trauma further symptoms of post-traumatic stress are caused, such as depersonalisation, avoidance and dissociation. This leads to a withdrawal from relationships and an "impoverished life" (Herman, 1992, p. 42).

2.2.2.2 Ego Psychology Writers

According to Eagle (1998), Horowitz (1992) extended aspects of Freud's thinking on trauma impact as he clarified the way in which trauma overwhelms an individual, specifically, the individual's ability to process information, and to connect adaptively to the external world. Horowitz (1992) contributed to our understanding of both intrusion and avoidance symptoms of post-traumatic stress. As far as traumatic stress symptoms are concerned, he demonstrated that an individual can have a mixed experience of both denial and intrusive thoughts and emotions. Horowitz (1992) argued that in order to 'live with' the impact of traumatic experiences the psyche is compelled to integrate (assimilate and accommodate) the disturbing information into long- term memory. The process of integration requires finding a balance between engaging with traumatic material and becoming overwhelmed by anxiety and moving away from this kind of information. The attempt to absorb the traumatic material is often reflected in cycles of intrusion and avoidance. Horowitz (1992) argued that both the intrusion and avoidance related symptoms of trauma disrupted meaning systems, interfered with memory and challenged the capacity to integrate experience. His theory set the foundation for a theoretical model of understanding that included intrusion related, avoidance and numbing symptoms as part of the diagnostic picture of post-traumatic stress. (American Psychiatric Association, 2000).

Lifton (1979), after World War II, described the reaction to death anxiety after catastrophic trauma. His experience was in working with survivors of Hiroshima and Nazi doctors. He described trauma with reference to the 'death imprint'. Lifton (1979) argued that a traumatic experience can damage the capacity for libidinal investment in the world and the capacity for thinking. Dissociation occurs as a result of severe death anxiety in reaction to overwhelming trauma and leads to a deadening of the mind. Dissociation becomes an intrapsychic phenomenon when affect is severed from knowledge or awareness of reality. The self is severed from its own personal history. In addition, the self is detached from compassion for others, community involvement and other important values (Lifton in Wilson and Raphael, 2013).

For both Lifton (1979) and Horowitz (1992), severe trauma affects the individual's worldview, relationships with others and sense of self. For both authors, exposure to traumatic life events creates a preoccupation with mortality and the purpose of life or lack of it. In addition, interpersonal relationships become the focus of concerns surrounding harm and protection, isolation and solidarity, as well as issues of dependence and trust. Thus, there appears to be consensus regarding a fundamental questioning of issues pertaining to human existence, the self and others (Eagle, 1998). Eagle (1998) describes that Freud, Horowitz and Lifton explain that trauma is an attack on biological and psychic survival, particularly the personality organisation of the individual. In addition, the capacity for symbolisation, the capacity to think in metaphors, as well as basic thought is compromised. This is reflected to some extent in a propensity to favour dissociation.

2.2.2.3 Object Relations Understanding of Trauma

According to Garland (1998), a combination of Freudian and Kleinian thinking offers a theoretical framework to understand trauma. A deep understanding of the impact of traumatic events upon the human psyche can be derived from a knowledge of what the particular meaning was for the individual of their traumatic experience. From this perspective, detailed attention is given to childhood memory and developmental history, as this is understood to form the foundation of the psychic structure and internal world. This psychic structure will receive the wounding from the external world in an idiosyncratic way which will have a bearing on how the trauma is understood and interpreted. Central to this view is the understanding that an

external trauma will trigger unresolved emotional pain and conflicts from infancy and childhood.

In Garland's (1998) view trauma disrupts the core of the survivor's identity and compromises the individual's capacity to filter reality and process anxiety. There is a breakdown of a sense of a predictable external world where the established defensive system is overwhelmed and shattered. "Thus, a trauma is an event which does precisely this: overwhelms existing defences against anxiety in a form which also provides confirmation of those deepest universal anxieties… and has long term consequences for the entire personality" (Garland, 1998, p. 11). A further aspect of such experiences is that trust in the protective role of the internal and external 'good object' is shattered. This will lead to an escalation of fears about the cruelty and power of 'bad objects'. In this way, trauma resonates with all past injuries in object relationships (Garland, 1998).

The object relations perspective understands trauma through the lens of early developmental experiences and difficulties, such as difficulty in the mother infant relationship. From the perspective of a Kleinian lens, trauma leads to splitting and a regression to the paranoid schizoid position. Eagle (2013) explains that the object relations view of trauma will emphasize a way in which trauma echoes difficulties in relation to early developmental parental introjects or objects within the theatre of the psyche. For example: "the trauma can be experienced as an absence of or abandonment of the 'good object' introject" (Eagle, 2013, p. 124) According to Eagle (2013): "The fact that one has been allowed to suffer so terribly suggests the failure and/or impotence of good objects to protect one and this may lead to the sense that such objects have been destroyed or cannot be trusted" (p. 124). Laub & Auerhahn (1993), who worked with Holocaust survivors, offer observations that resonate with this formulation.

> Trauma disrupts the link between the self and empathic other, a link first established by the expectation of mutual responsiveness in the mother child bond and 'objectified' in the mother child introject. Indeed we… proposed that the essential experience of trauma was the unravelling of the relationship between the self and nurturing other, the very fabric of psychic life (Laub & Auerhahn, 1993, p. 287).

A major contributor to the Object Relations school was Donald Winnicott (1960), who spoke about the infant's experience of a 'good enough mother'. The internalisation of this experience

leads to the establishment of the first structure of the ego. In addition, Winnicott (1971) emphasised the importance of the maternal attunement to the infant's needs. Winnicott also spoke about the establishment of hope in a predictable environment where the child's needs are met. Hillel Klein (2012), believed that all traumatic events hold a personal meaning for survivors, based on their background and personal history and this perspective clearly resonates with Garland and other object relations theorists. Auerhahn and Laub (1993) and Eagle (2013) each explain how trauma damages the relationship to the good internalised introject (providing one has had 'good enough' early developmental experiences), shattering subsequent trust in others for the trauma survivors.

Garland (1998) draws on Bion's formulation of the centrality of the containing function of the maternal object. According to Garland (1998) when trauma occurs the external and internal containers are shattered - the world becomes experienced as dangerous and persecutory. The dangers are overwhelming and good internal objects are powerless to protect and prevent a calamity from occurring. The capacity to symbolize is shattered rendering the internal container as powerless to function in the realm of thinking and understanding. Trauma thus shatters the internal container and in addition compromises the trust in external containment. The aim of therapy is to restore its containing function.

Garland (1998) makes an important contribution to the object relations view of traumatic loss. She explains that from a psychoanalytic view all relationships reflect both loving and hostile feelings, which are conscious or unconscious. Survivor guilt is intensified if prior relationships were problematic or deeply ambivalent. She acknowledges that survivors of traumatic events have often lost family or loved ones. These survivors are faced with the traumatic event as well as the traumatic loss. Mourning, in this context, is difficult. The individuals are unable to mourn as they are in a fight for their own survival and their coping resources are stretched. "Some of this mourning, as has often been pointed out, must be for himself - for his own lost world, his own pre-trauma life and identity" (Garland, 1998, p. 17).

Garland (1998), indicates that some survivors are overwhelmed by survivor guilt and rage about being abandoned by their lost, loved ones. The task of mourning for both their loved objects and the loss of their pre-trauma self is overwhelming. Consequently, they may well develop a pathological form of mourning - melancholia. In the case of chronic melancholia, as Freud wrote about in *Mourning and Melancholia* (1917), a survivor may over-identify with the dead

love object and carry unconscious guilt about survival that precludes the ability to mourn appropriately. Garland (1998) states that chronic post-traumatic stress, or complex traumatic stress and its symptoms of numbing and dissociation, are reminiscent of Freud's (1917) concept of melancholia. Temple (1998) adds that melancholia resembles the modern-day picture of clinical depression. According to Pines (1986), many survivors of severe trauma use regression and splitting. They have an impaired ability to symbolise in fantasy and "return to a state of psychic death to avoid overwhelming and unbearably painful feelings" (p. 304). Melanie Klein (1935, 1952) described how the inability to mourn losses and retain a relationship with the internalised good object may lead to a paranoid-schizoid mode of functioning. This results in a strong 'splitting' into 'good object' and 'bad object' representations both internally and interpersonally (Klein, 1935).

Gerson (2009) describes the experience of a massive trauma in the case of genocide in the following terms: "When the container cracks" there is no continuity (p. 1343). The experience of a genocide shatters one's ability to regain faith and has an extensive impact on the sense of human relatedness. Andre Green's (1986) concept of the 'Dead Mother' is used by Gerson, both literally and figuratively to describe the impact of such mass individual and social level trauma Green's (1986) metaphor was used to describe a mother who was so preoccupied with her own traumatic loss that she was experienced by the infant as "blank and dead… a distant figure, toneless and practically inanimate… a mother who remains alive but who is psychically dead so to speak in the eyes of the young child in her care" (p. 170). Gerson (2009) explains that the 'dead mother' can symbolise the traumatic loss of a nurturing object. This could be a parent, a significant other, a doctor or even a community at large. The loss of this nurturing leaves the survivor with an anxiety that their needs will not be met. Thus, Gerson's work elaborates the theorization on the damage done to 'good object' introjects by trauma and also resonates with Melanie Klein's formulation that the world is experienced as pervasively persecutory and threatening as in the paranoid schitzoid position.

Both Laub (2005) and Gerson (2009) use the metaphor of the 'Dead Mother' to describe the psychodynamics of infantile maternal loss and the traumatic loss of the internal good object at any age in the life cycle. Laub and Auerhahn (1989) and Gerson (2009) each use the term 'Dead Mother' to describe the survivors of genocide, who experience the world as unconcerned in relation to their fate and not empathic to their suffering. Survivors of genocide experience

humankind as the universal ‘Dead Mother’, as it remains silent and unresponsive to the pain of the victim.

For Laub and Auerhahn (1993), trauma ruptures basic trust and creates barriers in intimacy. Gerson (2009) describes a state of catastrophic loss, where “the absence of an involved and caring other leaves only a dense and collapsed heap of destroyed internal and external objects for whom no one mourns” (Gerson, 2009, p. 1349). He uses this metaphor to describe the internal world of the genocide survivor, as well as the infant born to the survivor. He describes the way in which dissociation is experienced by Holocaust survivors in relation to their unprocessed loss and describes how this state is transmitted to the second generation. Gerson’s (2009) central point is that survivors of genocide live with a sense of ‘unfinished business’ and a sense of permanent “damage done to the experience of goodness” (p. 1350). From this perspective, Gerson (2009) concurs with Garland’s (1998) understanding that survivors of genocide live with the unfinished business of unresolved grief.

As discussed just previously, from the psychoanalytic perspective, the unresolved traumatic grief associated with significant trauma can be understood to take the form of melancholia; as described by Freud (1917): “the shadow of the object fell upon the ego” (Freud in Gerson, 2009, p. 1351). According to Gerson (2009) the unfinished business of melancholia “leaves life devoid of meaning through an unconscious and tragic embrace of deadliness” (Gerson, 2009, p. 1351). From this perspective survivors of genocide are unable to ‘work through’ the loss, as it is too traumatic and overwhelming for the psyche to encompass. They struggle with the ongoing challenge of bearing or living with the enormity of the losses and violations they have endured and witnessed.

2.2.2.4 Herman’s Contribution to Theorization of Trauma and its Impact

Herman describes the importance of understanding the effects of captivity on the traumatised survivor. According to Herman (1992):

> Traumatized people suffer damage to the basic structures of the self. They lose their trust in themselves, in other people, and in God. Their self-esteem is assaulted by experiences of humiliation, guilt and helplessness. Their capacity for intimacy is

> severely compromised by intense and contradictory feelings of need and fear. The identity they have formed prior to the trauma is irrevocably destroyed (p. 56).

Herman (1992) explains that traumatic events impact on the psychological structures of the self, as well as on attachments and meaning systems that connect the individual to the community. In addition, victims of chronic trauma may feel that their sense of self has been entirely violated. They have repeated experiences of trauma and suffer from intense hyperarousal symptoms, feeling constantly anxious and agitated. The intrusive symptoms of post-traumatic stress may continue for many years after liberation from an ongoing traumatic experience. Goldstein, Van Kammen, Shelly, Miller and Van Kammen (1986) found that soldiers who were taken prisoner in World War II and the Korean War were suffering from nightmares, flashbacks and extreme reactions to memory triggers 35 to 40 years after their release from captivity. Their symptoms were more severe than those of soldiers of the same era who had not been imprisoned (Sutker, Winstead, Galina & Allain, 1991).

According to Herman (1992), the diagnosis of PTSD fails to capture the ongoing intense symptoms of prolonged and repeated trauma and the psychological damage on the personality of the victim in captivity. One of the populations that Herman understood to have suffered prolonged and chronic trauma exposure was that of Holocaust victims and she cites the observations of psychiatrist Emmanuel Tanay who said: “The psychopathology may be hidden in characterological changes that are manifest only in disturbed object relationships and attitudes towards work, the world, man and God” (Herman, 1992, p. 120). Herman (1992) coined and distinguished the syndrome of what she terms complex traumatic stress disorder or C-PTSD. She describes seven features that characterize this syndrome:

1. A history of subjugation to totalitarian control over a prolonged period (months or years). Examples include: hostages, prisoners of war, concentration camp survivors and survivors of religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life; including survivors of domestic battering, childhood physical or sexual abuse and organised sexual exploitation.
2. Alterations in affect regulation, including: persistent dysphoria, chronic suicidal preoccupation, self-injury, exploitative or extremely inhibited anger (may alternate), and compulsive or extremely inhibited sexuality (may alternate).

3. Alterations in consciousness, including: amnesia or hyper amnesia of traumatic events, transient dissociative episodes, depersonalisation/derealisation and for reliving events, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation.
4. Alterations in self-perception, including: Sense of helplessness or paralysis of initiative, feelings of shame, guilt and self-blame, a sense of defilement or stigma, and a sense of complete difference from others (which may include a sense of specialness, utter aloneness, a belief that no other person can understand, or non-human identity).
5. Alterations in perception of perpetrator, including: preoccupation with the relationship with the perpetrator (includes preoccupation with revenge), unrealistic attribution of total power to the perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's), idealisation or paradoxical gratitude, a sense of special or supernatural relationship, and acceptance of belief system or rationalisations of perpetrators.
6. Alterations in relations with others in general, including: isolation or withdrawal, disruption in intimate relationships, repeated search for a rescuer (may alternate with isolation and withdrawal), persistent distrust, and repeated failures of self-protection.
7. Lastly, alterations in systems of meaning, including: a loss of sustaining faith, and a sense of hopelessness and despair.
(Herman, 1992, p. 121)

As will be evident from Herman (1992) the impact of prolonged subjugation and exposure to traumatic stimuli can have a profound and far reaching symptomatic and psychological effect that may endure for decades.

Herman's (1992) understanding of complex traumatic stress is important in explaining how ongoing trauma impacts on the personality over time. This is particularly relevant when understanding child Holocaust survivors as they suffered multiple trauma's over years. Child Holocaust survivors were interned in concentration camps and became captives who were victims and witnesses of immense cruelty. Herman (1992) captured the impact of ongoing trauma on consequent personality changes such as alterations in identity, lack of trust and alienation (Prot, 2010). Kellermann (2009) states explicitly that Herman's (1992) description of complex traumatic stress is relevant in describing the experience of child Holocaust survivors. The specific relevance for Kellermann (2009) was that Herman (1992) emphasised

the impact of ongoing traumas over an extended period of time leading to the fragmentation of the self and "the loss of a sense of safety, trust and self-worth" (Kellermann, 2009, p. 60)

2.2.2.5 Some Caveats in Applying Herman's Formulation of C-PTSD to Child Holocaust Survivors

Herman (1992) made an important contribution to understanding child survivors, her description of complex traumatic stress has particular relevance for children who were exposed to physical and sexual abuse within the family. This is highlighted by her description of the survivor's relationship to the perpetrator in that an aspect of the formulation of C-PTSD implies the perversion of core attachment relationships. Her description of the breakdown of trust as well as difficulties in self-regulation as a result of ongoing abuse by caregivers contributed significantly to understanding how children experience trauma of this kind (Luxenberg, Spinazzola, Hidalgo, Hunt & Van der Kolk, 2001). However, child survivors of the Holocaust are different to child survivors of physical and/or sexual abuse that takes place within family systems. Importantly the trauma was not created by their parents or caregivers, i.e. by primary attachment figures, as the Nazis were a largely anonymous, dangerous force. As such, the Holocaust did not involve a breach in trust in relation to core attachment figures but involved harm from a cruel socio-political force (Sagi-Schwartz et al., 2003). This allowed children to maintain some uncontaminated internal good objects even if these objects were seen as powerless to protect them from harm, as discussed previously. However, children were not required to manage fear and love of the same figure in the complex manner that children abused by caregivers are required to do. This is not to minimize the fact that it was very traumatic for child Holocaust survivors when the kinds of unconscious fears of harm that are arguably held by most human beings were mirrored in the psychopathic world of the concentration camps (Klein, 2012). In the main, however, child survivors had the opportunity to build solid attachments within the context of families for several years before the Holocaust began. This sense of trust in their attachment figures enabled many of them to draw upon a reservoir of resilience that enabled them to survive.

While child Holocaust survivors may not have had to negotiate the complexity of holding discrepant feelings towards abusive caretaker figures to whom they were attached they faced a different kind of attack on their caretaker relationships with equally severe if somewhat different psychological costs. According to Sagi-Schwartz et al. (2003) it may be impossible

for child survivors to resolve their Holocaust trauma owing to the traumatic death of parents and close family under such diabolical circumstances. Thus, their trauma related to the inability of caretaker objects to resist their own and others' dehumanisation and destruction. It is argued that parent figures were rendered helpless in the context of concentration camp living and children may have lost faith in the capacity of their primary attachment figures to protect them as children, or themselves as adults, consequently losing trust in the potency of good objects. From this perspective it is evident that while the experience of child survivors of the Holocaust and victims of abuse share many features of complex traumatic stress, there are important differences.

Herman (1992) described the victim's preoccupation with the persecutor. This is always relevant within the context of domestic abuse or parental attachment. However, in the case of child survivors they did not tend to develop a personal relationship with the persecutor owing to the huge numbers of Jews who were held captive in the concentration camps and the large number of Nazi personnel running such camps. Thus, it can be argued that Herman's (1992) description of complex traumatic stress has relevance for child Holocaust survivors as it describes the long-term impact of ongoing trauma on the personality. However, her comments on the complicated relationship between the victim and the persecutor and the implications of this for intrapsychic dynamics may be less relevant for child survivors when compared to child victims of domestic abuse. Within the context of the present study, Herman's (1992) description of the loss of faith and despair in relation to child survivors making meaning may be particularly relevant. This issue will receive further attention later in the discussion.

2.2.2.6 Summary of Psychodynamic Theorization of Trauma Impact

In summary, it is apparent that many psychodynamic writers use metaphors and symbols associated with shattering and destruction to describe the way in which trauma damages the psyche, most especially in the case of severe trauma exposure as was the case for most of those who were victimised during the Holocaust. Freud (1920) described the shattering of a protective shield, Melanie Klein (1935, 1952) described splitting as part of movement into the paranoid-schizoid position, and Bion describes the shattering of the internalised container. Garland (1998), Benyakar et al., (1989) and Herman (1992) explain the way in which trauma disrupts the core identity of survivors. In much psychodynamic thinking the trauma barrier is understood to be comprised of the individual's set of defences that are designed to cope with everyday

anxiety, modulating it to allow normal functioning (Benyakar et al., 1989). When trauma occurs, defences become overwhelmed and ruptured. Benyakar et al. (1989) also subscribe to the notion of trauma as a psychological wound that shatters the self-structure. This structure includes the capacity to operate autonomously, the sense of a coherent identity and the capacity to self-regulate affective states. Trauma leads to a sense of helplessness and disrupts internal continuity. Trauma shatters the individual's sense of self, and in addition can destroy their sense of meaning (Frankl, 1962) and their core assumptions about the world (Janoff-Bulman, 1985). Trauma carries different levels of injury associated with loss, rupture and unpredictability. Traumatised individuals not only sustain losses in the external world but also lose their sense of dignity or humanity and their sense of a self with a continuous personal history and future. The sense of unpredictability that arises with exposure to traumatic events disrupts the capacity to self-regulate. "When events lose their lawfulness, faith in one's self-regulating capacity is diminished or lost completely, hopelessness and helplessness prevail, and one resigns, not only to the events but also to the loss of one's former capacity and identity" (Benyakar et al., 1989, p. 439). Lifton (1979) highlights that the fragmentation of personality organisation leads to dissociation, which is generally reflected in a split between thinking and feeling. In extreme cases depersonalisation and derealisation occur and may become enduring because the overwhelmed individual needs to distance themselves from their reality as the only viable mechanism to continue to exist (Eagle, 1998).

In related but somewhat different vein Garland (1998) emphasises the shattering of internalised good objects because violation to the self has occurred and there has been an absence of protection against this. She also emphasizes that current trauma is mapped onto and processed through early relational templates. Laub and Auerhahn (1993) describe the way in which trauma disrupts attachment; and in keeping with others, Eagle (2013) also elaborates how the trauma survivor feels abandoned by the good object. Such formulations are amplified by Gerson (2009) who presents the concept of the 'Dead Mother' to describe the trauma survivor's feeling of desolation in relation to having to live in a world that abandons them without empathy or caring.

It is evident that many object relations authors describe the loss of trust (Erikson, 1965; Herman 1992) in the good object, and in the world at large (Gerson, 2009; Herman, 1992) as being a fundamental aspect of traumatisation. Psychodynamic writers agree that trauma ruptures the self and the attachment to the outside world, leading to a sense of mistrust, and vulnerability to feelings of abandonment and loss (Benyakar et al., 1989; Eagle, 1998; Erikson, 1950; Garland,

1998; Herman, 1992; Laub & Auerhahn, 1993). All of these observations about the impact of severe and mass traumatization are important to acknowledge with regards to the present study. One begins to understand that when a Holocaust survivor is struggling to symbolise, for example, because of trauma related dissociation, they may consequently struggle with ego integration in Erikson's (1950) stage of 'Ego Integrity versus Despair' (Dasberg, 2001). Thus, it is possible that exposure to severe and prolonged trauma in early life may have lifetime effects, including influencing negotiation of end of life psychological tasks. Having discussed the work of several key psychodynamic writers and their understanding of trauma this discussion will now focus on formulations of traumatic stress associated with more psychiatric or clinically focused diagnostic models, with a particular emphasis on post-traumatic stress disorder (PTSD).

2.3 Diagnostic Formulations of Traumatic Stress Conditions

Given that the primary lens through which the data was interpreted was psychoanalytic the discussion of diagnostic formulations of traumatic stress related conditions is rather brief. However, given that the research addresses aspects of the mental health impact of childhood internment it was considered important to address some more psychiatrically focused understandings of trauma impact.

According to Van der Kolk and McFarlane (2007) the diagnosis of post-traumatic stress aims to establish a commonly accepted formulation or structure that is understood to describe the impact of trauma on an individual's personality features, biological functions and understanding of the world. The central issue in the diagnosis of traumatic stress conditions is the recognition of the reality of exposure to an extraordinarily stressful event. However, there is also a degree of recognition that the subjective experience of the event and the victim's subjective experience of feeling helpless and threatened is also significant to diagnosis. Although the reality of the traumatic event is central to diagnosing traumatic stress, for psychologists the meaning that the survivor attaches to the event is as important as the nature of the trauma itself. In addition, it has also been recognised that the individual's ongoing interpretation of the trauma continues after the trauma has ended and that traumatisation can occur sometime after the event and in some instances even years later. This is often triggered by a new event in the present that resonates in some way with the prior trauma. According to

Van der Kolk and McFarlane (2007) the post-traumatic stress syndrome represents "the failure of time to heal all wounds" (p. 7).

While diagnostic systems focus on general patterns that are observed in trauma survivors there is also recognition that individual features and vulnerabilities may contribute to degrees of distress and debilitation. When an individual is traumatised the psychological defences that come into play are a function of their developmental stage, temperament, personality make up and environmental supports. A central issue, in this regard, is the difficulty in integrating the reality of the traumatic experiences and associated trauma related symptomatology. Symptomology expresses itself in the flashbacks of traumatic images, nightmares and associated feelings and behaviours, as well as in avoidance related features and hyperarousal related indicators, such as startle responses. In addition, the most recent diagnostic manuals have placed greater emphasis on alterations in cognition and potential difficulties in interpersonal relationships. Trauma is recognised to affect an individual psychologically, physically, socially and spiritually. Regarding psychiatric diagnosis, post-traumatic stress disorder, or PTSD as it is commonly referred to, requires that a specific symptom set is present in order for diagnosis to take place. While traumatic stress related responses to traumatic events are common and perhaps almost inevitable, the translation of such responses into full-blown PTSD, with its associated compromising of everyday functioning, is less frequent. While individual vulnerability plays a part, it is also recognised that severity of exposure is predictive of the likelihood of development of PTSD and the events characteristic of the Holocaust would certainly be of the kind of severity that would produce PTSD in many if not most exposed to such stimuli. However, as has been discussed previously with reference to Herman's work, it appears that the prolonged nature of captivity and multiple forms of traumatization suffered by camp survivors may more likely have produced complex forms of trauma syndromes, such as C-PTSD, a condition recognised by clinicians even if not formally included in the diagnostic manual of the American Psychiatric Association. In addition, it is also important to note that PTSD has high comorbidity with mood, dissociative and anxiety disorders, as well as with substance abuse and personality disorders (Davidson, Hughes, Blazer, & George, 1991; Green, Lindy, Grace & Leonard 1992; Kulka et al., 1990).

Since the participants in this study were interviewed while the Diagnostics and Statistical Manual, fourth edition revised (DSMIV-R) (American Psychiatric Association, 2000) was in use, this diagnostic system will be utilised for further discussion on PTSD in the thesis,

recognising that features of this framework have altered with the introduction of the DSM-5 (American Psychiatric Association, 2013). Interesting to note is that DSM-5 places greater weight on negative beliefs arising as a consequence of trauma (American Psychiatric Association, 2013). Since most readers familiar with the traumatic stress field will be cognisant of the diagnostic features of the condition these are not detailed in the text but for a detailed description of PTSD as outlined in DSMIV-TR see APPENDIX 1. The following section will describe the history of diagnosing PTSD in relation to Holocaust survivors in particular.

2.4 Depression as an Associated Feature of PTSD in Child Survivors

The National Comorbidity Survey showed that most of the subjects who met the criteria for PTSD also met the diagnostic criteria for depression (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). According to Kellermann (2009) the most appropriate diagnostic category for Holocaust survivors who form part of a clinical population is 'Chronic Posttraumatic Stress Disorder' (Kellermann, 2009, p. 35) with depression as a commonly associated feature. (Conn, Clarke & Van Reekum, 2000; Yehuda, Kahana, Southwick & Giller, 1994). Yehuda et al. (1994) found that Holocaust survivors with PTSD had a greater number of depressive symptoms. In addition, a high proportion of Holocaust survivors experienced major depression and most of the remainder experience symptoms of subclinical depression (Trappler, Cohen & Tulloo, 2007). Kellermann (2009) makes the point that it is important to distinguish between normal sadness as a result of aging and ongoing traumatic bereavement and major depression in child Holocaust survivors. Research has demonstrated that aging survivors are more prone to depression as they age (Barel et al., 2010; Joffe et al., 2003; Trappler, Cohen & Tulloo, 2007). Aging child Holocaust survivors were found to have higher levels of depression when compared to older adults in Israel and Canada and significantly the experience of early life trauma increased depressive affect and the absence of wellbeing in Holocaust survivors (O'Rourke, Carmel & Bachner, 2018). The prevalence of both PTSD and depression were found to be high among survivors. In addition, an increased risk of suicide was found among aging survivors with depression. (Barak et al., 2005). It's important to note that not all child survivors suffer from depression however those who were depressed also suffered from significantly worse psychosocial functioning than non-depressed survivors (Trappler, Cohen & Tulloo, 2007). The DSM IV-TR (American Psychiatric Association, 2000) describes the diagnostic features of Major Depressive Disorder see APPENDIX 2.

2.5 History of the Study of Post-Traumatic Stress and Mental Health in Holocaust Survivors

After World War II, a considerable body of research focused on the long-term effect of trauma on Holocaust survivors. Their psychiatric difficulties were documented and the term 'Survivor syndrome' (Niederland, 1981) or 'concentration camp syndrome' (Eitinger, 1961, 1964, 1972) were coined, to describe their PTSD symptoms. These terms were also used to describe the enduring personality changes that occurred as a result of their trauma (Eitinger, 1964; Krystal, 1968). Henry Krystal (1968, 1978, 1988), a psychoanalyst who studied the long-term effect of trauma on concentration camp victims, suggested that the core experience of trauma in this population consisted of 'giving up'; feeling hopelessness and helplessness in the face of death and destruction. Krystal (1968) described a pattern he observed in survivors that evolved from a state of high anxiety and resulted in a blocking of emotions and inhibited behaviour. He noted that traumatised survivors lost their ability to experience and identify their feelings. They were unable to interpret the meaning of what they felt and were unable to respond in an adaptive manner in certain contexts. Many of the above-mentioned writers and researchers were personally involved in the Holocaust in that they themselves or members of their families had been interned in the camps. (Davidson, 1979; Des Pres, 1976; Eitinger, 1964; Klein, 1974; Krystal, 1968). It is possible that they were writing about Holocaust trauma as a way of understanding and processing their own trauma in an attempt to find healing and meaning.

Wiesel (1960) conveys the way in which survivors became deeply isolated in their contemporary lives owing to the devastating impact of their trauma in the concentration camps and the lack of appreciation of the magnitude of what they had been exposed to in the environments in which they found themselves post the war. In the 1950's and 60's psychiatrists worldwide were asked to write recommendations for indemnity claims for survivors. Niederland (1964), himself a survivor and a psychiatrist, conducted research on over eight hundred survivors and suggested that many survivors suffered from 'concentration camp syndrome', as previously mentioned. This syndrome was characterised by the following: self-preoccupation; depressive states; unresolved mourning; feelings of emptiness and guilt; emotional dullness and inhibition; and states of chronic anxiety based on the loss of sense of coherent self. The anxiety overwhelmed the ego, compromising the capacity to verbalise feelings and limiting the capacity for symbolisation, or employment of metaphor. Various physical and psychosomatic disturbances were also observed as were nightmares and mood

instability. In addition to these symptomatic manifestations Niederland also theorized the impact of the Holocaust from a psychoanalytic perspective arguing that the experience produced defective superego functioning and splitting of the ego and objects in the superego. He observed a conflict between identification with and rejection of Nazi morality. In his opinion ego functions could become automatic and the ability to relate to others empathically could be compromised. The avoidance of mourning and inability to process grief limited the capacity to form attachments with others. (Niederland, 1964).

According to Klein (2012), early studies tended to focus on the psychopathology of camp survivors. The diagnosis of 'concentration camp syndrome' in the late 50's and 60's created the foundation for a diagnosis in psychiatry and behavioural sciences, that explored and examined the consequences of catastrophic stress situations. This became a blueprint for the early formulation of post-traumatic stress (Davidson, 1979). Kellermann (2009) states that early research had a specific historical context and aimed to help survivors to gain recognition and compensation. However, it also tended to construct survivors as damaged and mentally and psychically compromised.

Both Klein and Davidson, a fellow psychiatrist who was also a Holocaust survivor, described the reality of the ghettos and camps as 'psychotic' (Davidson, 1979; Klein, 2012). Under these kind of conditions individuals' psychological defences were necessarily overwhelmed. Klein (2012) described that being exposed to massive traumatisation, genocide and dehumanisation, overwhelms the capacity of the psyche to adapt and recuperate. He states that while survivors shared common issues and employed similar defences and coping strategies, it is equally important to distinguish their differences as individuals (Klein, 2012). "All survivors suffered physical impairment as a result of continuous extreme hunger and sleep deprivation, in addition to infections and deficiency diseases" (Klein, 2012, p. 23). He added: "Enriched by our clinical experience and the testimony of survivors, we have become increasingly aware, however, that each survivor's social and intrapsychic life was just as different during the Holocaust as before and after." (Klein, 2012 p. 27). Therefore, Klein (2012) emphasised that each survivor had a unique response to the Holocaust and he cautioned against making over-generalisations.

According to Klein (2012), early history, including the achievement of developmental milestones and family attachments, influenced the survivor's ability to adapt and cope. He emphasised that a number of questions need to be considered when evaluating differences

between survivors: How long did the individual suffer from traumatisation.? Was he/she alone or with family or friends in the Holocaust? This is important as social support was a protective factor. Those who formed dyads helped each other to survive. Was he/she a witness to mass destruction in the Ghetto or the camp? What was his/her experience in the camp? Some survivors were personally tortured or attacked and this would be a risk factor. What work was he/she assigned? This is important as those who worked with dead bodies in the Sonderkommando, for example, were at risk as described by Greif (2005). For Klein (2012), the differences in early history combined with the above features of their exposure during the Holocaust contributed to protective or risk factors in relation to levels of impact on the psyche.

Academic research and scholarly writings about Holocaust survivors expanded in the early 1960's. At this stage most survivors had relocated and adapted to their new countries. There was an upsurge in academic and theoretical criticism, with scholars arguing that early studies had tended to overly pathologise survivors, failing to accurately acknowledge their coping and capacity to integrate their suffering and to become functional in subsequent life (David, 2011). According to Krystal (1986) most of the early writings on survivors were based on a minority who were suffering from poor health or psychiatric issues and who were not representative of the larger population. Yet for two decades this pathologizing literature dictated the understanding of the entire population. According to David (2011) narratives emphasizing the resilience and coping mechanisms deployed by most survivors were not fully reported or considered in the early 1950's by psychiatrists who worked with survivors. Those who emphasized pathological impacts felt that survivors had sustained permanent psychological damage and would have shorter life spans as a result of the trauma, violence and abuse they had suffered during the Holocaust (Cohen, 1977; Krystal, 1968 Niederland, 1964). This is not surprising as such understandings of Holocaust survivors was skewed by small groups of survivors who sought psychiatric treatment and were most debilitated.

Fishman (2014) reiterates the point that many early theorists writing about Holocaust survivors emphasised their psychological damage at the expense of acknowledging resilience related features. In addition, Fishman (2014) notes that much of the early research on Holocaust survivors was conducted on those who had requested clinical help. Most of the survivors did not request psychiatric intervention and those that coped without such intervention were not represented in the early research (Lee, 1988). Hass (1995) reasoned that the hesitation in focusing on resilience and coping of survivors might reflect a fear of denying or undermining

the severity of the catastrophe that people had suffered. This tension reflects what developed as a key debate regarding whether Holocaust survivors should be viewed as primarily vulnerable or resilient, and this continues to be a debate in the literature until the present time.

By the 1990's, the bias in the early literature was well documented. Later research included more qualitative studies that extended their scope beyond clinical samples and began to contemplate how later life circumstances, such as becoming employed and having children, affected resilience and coping in survivors. Kellermann (2001, 2009) argues that the psychopathology and resilience of Holocaust survivors remains a controversial issue. Indeed, several decades after the Holocaust there is a debate in the literature regarding the traumatic damage versus psychological resilience observed among Holocaust survivors and which may be more prevalent (Barel et al., 2010). Any statement describing this population in general as emotionally disturbed will evoke intense protest since this would in fact stigmatise an already disempowered people (Herman, 1992).

Kellermann (2001) argues that it is essential to differentiate between clinical and non-clinical populations, as well as to highlight that there is a sub-group of chronically mentally ill survivors who may have had pre-Holocaust predisposition for mental health issues. However, he suggested that it should be recognised that the non-clinical group may still present themes of Holocaust trauma when undergoing psychological evaluation, despite their adequate general functioning. He argued that all survivors are vulnerable to developing emotional difficulties when stressed or traumatised. To develop a diagnostic label that best described the presentation of clinically impaired Holocaust survivors Kellermann offered the category of "Chronic post-traumatic stress disorder with depression as an associated feature" (Kellermann, 2001, p. 4). Kellermann (2009) discussed child survivors and he observed that complex traumatic stress needs to be considered as a diagnosis. In his opinion, as a result of the severe and prolonged trauma of the Holocaust, many child survivors developed forms of personality disturbance, most particularly because the experience required adaptation to a pathological environment at life stages in which personality was being laid down and formed. Kellermann's (2001, 2009) formulation, combining both the theorizing of complex traumatic stress and proposing the idea of chronic PTSD and co-morbid depression, may be a relevant clinical diagnostic framework for survivors who continue to suffer from trauma and depressive symptoms and may be particularly applicable to aging populations.

Complex traumatization (Kellermann, 2009) has emerged as a further diagnosis that describes survivors who appear functional and have adapted by hardening of particular kinds (Dasberg, 1987), despite the fact that they still suffer from symptoms of PTSD. This group of survivors appeared outwardly to be resilient although upon further investigation it became evident that they suffered from distressing trauma related symptoms such as nightmares and emotional blunting. This mixed or paradoxical picture was observed by Cohen, Brom and Dasberg (2001) in a non-clinical group of Holocaust survivors. According to Brom, Durst and Aghassy (2009) PTSD is not an appropriate diagnosis to describe the complexity of symptoms that are observed in Holocaust survivors, even decades after the Holocaust – in part because the diagnosis does not fully capture the complexity of presentation of such survivors. They maintain that limiting understanding of impact to PTSD is a gross under estimation of the suffering endured by Holocaust survivors. "The deep-seated injury and lack of basic trust, the extreme restriction of emotions and characterological difficulties (Krystal, 1981) are not accounted for by the criteria of PTSD" (Brom et al., 2002, p. 199). Kellermann (2009) states that at present survivors are being understood as utilizing a 'paradoxical integration' that includes both vulnerability and resilience. According to Kellermann (2009) the clinical population of Holocaust survivors in Israel stands at 15 to 25 percent of the total population of survivors. For this clinical group, the diagnosis of chronic Post-traumatic Stress Disorder with depression is suggested (Kellermann 2001, 2009), however he says that around 50 percent of Holocaust survivors have suffered from PTSD at some stage after liberation. This clinical 20 to 25 percent tend to remain symptomatic and may well require ongoing treatment.

For decades the conspiracy of silence meant that survivors were not recognised and their suffering was not addressed. This denial seemed to operate on a societal level as well as a community and individual level. According to Aron and Starr (2013) throughout the first five decades after the Holocaust psychoanalysts tended to minimised the importance of the Holocaust for both survivors and their children. In addition, it ignored the sociological impact of the Holocaust, as well as its impact on the profession and the development of psychoanalytic theory and practice. Given that Freud, Segal and Kohut all escaped Nazi Germany, psychoanalysis is somewhat of a 'Holocaust survivor' (Prince, 2009, p. 180). Philipson (2017) suggests that the overwhelming impact of the Holocaust trauma that led to a form of denial and repression. While this may be true, sociological and historical factors should also be considered. The above-mentioned psychoanalysts were new immigrants in England or the United States. In the period of the 40's 50's and 60's they were making a name for themselves in an Anglicised

society where anti-Semitism was rife and writing about the Holocaust would not have been a popular career move. In contrast, Klein (2012) and other analysts who lived in Israel were not constrained by the same cultural bias, and they produced theory and research concerning survivors. In addition, Israeli mental health workers were faced with many thousands of survivors who had emigrated to Israel where they presented for treatment and were available for research.

The discussion above has described aspects of the historical context of research in the field of trauma regarding Holocaust survivors from the 1950's to the present. The dilemma surrounding the description of Holocaust survivors as damaged versus resilient has been highlighted. This debate will be picked up on and elaborated upon in greater detail later in discussing the research findings related to survivors.

Having discussed formulations of trauma impact the discussion now moves to outlining Erikson's developmental theory, as this grounds the present research. Erikson's (1950) theory was chosen as it follows a developmental life trajectory from infancy to old age. This is relevant because it tracks developmental disruption in childhood or adolescence and looks at its impact across the life trajectory and may be helpful in exploring the impact of trauma in old age and end of life stage, when the cumulative impact of trauma across the life span is evident.

2.6 Erikson's Psycho-social Theory of the Life- Cycle

2.6.1 Introduction to Erikson's Theory

Erikson was a student of Anna Freud. His contribution to ego psychology emphasised the adaptive function of the ego (Erikson, 1959). Erikson focused on the normal developmental crisis that an individual faced at each of the lifespan developmental stages that he identified as significant. Mastery of the challenge, posed by the crisis led to the acquisition of psycho-social skills, whereas failure to master these skills led to being fixated in relation to the issues associated with this life phase. Erikson argued that successful resolution of lifespan stages from birth to death led to a sense of identity that constitutes a core sense of self (Goldstein, 1995).

Erikson (1965) conceived of eight significant consecutive stages from infancy to late adulthood. Erikson's (1950, 1965) first stage begins in infancy and looks at trust versus mistrust and ends in old age with integrity versus despair. Negotiation of the final stage is dependent upon the cumulative outcomes of the previous seven stages. From this perspective, Erikson (1950) proposed his theory of epigenesis, arguing that personality development unfolds, in part as a consequence of environmental influences, with each developmental stage impacting on the next and so forth. Integrity versus despair is based on the form of resolution of the previous stages and the capacity to find meaning and glean a sense of wisdom based on previous life experience (Cheng, 2009). Whereas Freud emphasised libidinal conflicts between the id and the superego, Erikson's psychosocial stages described the interplay of libidinal and psychosocial elements in ego development. In each stage, the individual is faced with the challenge of adapting his or her physical and psychological needs to the challenges and demands of the social environment. As such, Erikson emphasised the role of the social context in the individual's life span development (Smith & Osborne, 2008). Since many readers may be familiar with Erikson's developmental theory a fairly brief exposition of the life stages is offered here, with some emphasis on issues that may have relevance for this particular study.

2.6.2 Stage One: Hope, Basic Trust vs Mistrust

According to Erikson (1965) this stage occurs in the first year of life. The foundation of personality development is established where the infant develops a sense of trust in having his or her needs met in a predictable manner (or not). Intrinsic to this stage is developing a sense of hope that the maternal figure will respond to primary needs. Erikson (1964) said: "Hope is both the earliest and the most indispensable virtue inherent in the state of being alive. If life is to be sustained hope must remain, even where confidence is wounded, trust impaired" (p. 115). Thus, for Erikson, this is a time when in addition to having physical needs met the baby is hopefully soothed and the mother regulates the infant's sense of safety in the world (Erikson, 1977).

Erikson (1982) goes on to describe the early origins of projection and introjection: "In introjection we feel and act as if outer goodness had become our inner certainty. In projection, we experience an inner harm as an outer one; we endow significant people with the evil that is in us" (p. 223). He emphasises the importance of the facilitative maternal relationship in infant

development of a sense of trust and stated that this sense of trust would form the core of the individual's identity. Erikson (1982) also identifies basic trust as lying at the core of religious faith. For Erikson, the opposite of trust is a sense of mistrust. For him, this state characterised an individual who withdrew from relationships and was uncomfortable with themselves and others (Goldstein, 1995). The child who has a sense of mistrust is fearful, empty, depressed and has an inner sense of badness (Erikson, 1977). According to Erikson (1982), hope emerges when the conflict of 'Trust versus Mistrust' is successfully negotiated.

2.6.3 Stage Two: Will, Autonomy versus Shame and Doubt

Although the child strives to be autonomous, he or she still has dependency needs, which mobilise him or her to turn to parental figures for protection and nurturing. This coincides with Freud's (1920) 'anal stage' of development: at this stage, the child is exposed to the imperative to conform to societal rules and regulations. As such, the child's will and the parent's control may come into opposition. Erikson (1982) describes the sensitive dynamic of control that enters the parent-child relationship during the process of toilet training. A child's rudimentary sense of will begins at this stage and the child comes to establish a sense of faith in self, as he or she practices autonomous self-control. According to Erikson (1977) young toddlers are very sensitive to shame about both their lack of control and their smallness in relation to adults. If children are excessively shamed within the family, defiance will ensue.

2.6.4 Stage Three: Purpose, Initiative versus Guilt

This stage describes the developmental process of a four or five-year-old child and tallies with what Freud (1920) described as the phallic/oedipal stage. At this stage, the child is concerned with catching and conquests. The child's identity begins to strengthen and he/she embraces fantasies about the future. Conquest, competition and behaviour is driven by a sense of purpose. Gender role modelling also becomes important and sexual curiosity intensifies (Goldstein, 1995). The core of a superego is formed at this stage, and the ego defence of repression is used to cope with excessive guilt.

2.6.5 Stage Four: Competence, Industry versus Inferiority

This stage coincides with Freud's 'latency stage'. Erikson (1965) viewed this as an active stage where the child engages socially and intellectually at school. The child strives to develop a sense of competence, particularly intellectual competence (Erikson, 1982). The child learns perseverance in relation to the completion of tasks. This is essential to the attainment of ego mastery. The opposite of the mastery of industry, is inferiority. According to Erikson (1982), when a child has a sense of inferiority, he/she loses hope in his or her ability and begins to view the future negatively.

2.6.6 Stage Five: Fidelity, Identity versus Role Confusion

According to Erikson (1982), the ego starts to integrate at the stage of adolescence when there is sufficient stability and continuity in the social environment. Identity forms around self-confidence, sexual identity, commitment to social values and the anticipation of a career. When there is acceptance within the social group the individual can separate from the family to some extent, in order to find his or her role in the world apart from family of origin. In addition, the individual tends to move towards a chosen ideology to fortify his or her sense of identity. Role confusion occurs when the environment is not able to offer opportunities for the individual to adaptively form his or her identity. As such, low self-esteem may be reinforced. Role confusion may lead to anti-social behaviour in some young people who fail to resolve this life stage (Goldstein, 1995).

2.6.7 Stage Six: Love, Intimacy versus Isolation

The consolidation of an ego identity enables the individual to engage in an intimate relationship, without losing a sense of self. (Goldstein, 1995). In Erikson's (1982) view, a rewarding relationship should enable a couple to regulate sex in a trusting relationship, where work, procreation and recreation are regulated and mutually satisfying. This stage also entails the ability to be intimate and is to a considerable extent predicated on the early negotiation of Trust versus Mistrust.

2.6.8 Stage Seven: Care, Generativity versus Stagnation

For Erikson (1982), the establishment of a sense of guiding the next generation is central to this stage. In specific terms, in its early phase generativity in often associated with child bearing and rearing. However, generativity can also take other forms such as engaging in mentoring or formal or informal teaching. Productivity, creativity and caring are the core developmental tasks of this stage. After experiencing old age, Erikson revised his theory and realised that generativity deserved more emphasis than he had originally thought. Erikson said "Much of older people's despair is, in fact, a continuing sense of stagnation." (Erikson, 1982, p. 63) Recent research has suggested that attaining generativity may be the most important factor in establishing and attaining ego integrity (James & Zarrett, 2006). Hannah, Domino, Figueredo and Hendrickson (1996) studied predictors of ego integrity in a large sample of men and women age fifty-five to eighty-four years. Results showed that ego integrity was preceded by generativity, intimacy, identity, autonomy, and trust. However, generativity alone accounted for 78% of the variance in ego integrity

2.6.9 Stage Eight: Wisdom, Integrity versus Despair

Ego integrity is understood by Erikson to be associated with a sense of wisdom that is gleaned from a retrospective view of one's life. This involves a sense of acceptance of what 'was'; in the face of accepting physical changes related to aging, and the final stage of death. Erikson (1982) points out that in infancy a sense of trust engenders hope; and in old age a mature hope and faith is included in a sense of integrity and wisdom. Erikson states that the opposite of wisdom is a sense of despair and hopelessness. "In this case the old person mourns for autonomy weakened, initiative lost, intimacy missed, generativity neglected… an all too limiting identity lived" (Erikson, 1982, p. 63). For individuals to integrate their experiences of the previous stages they can look back on their lives and find a sense of meaning, despite the physical and psychological deterioration associated with old age.

Integrity represents the ego's need to establish a sense of order and meaning. "It is the acceptance of one's one and only life cycle as something that had to be and that, by necessity, permitted no substitutions" (Erikson, 1977, p. 241). Despair is described as the acknowledgement that one faces death, without the time to "attempt to start another life and try out alternate roads to integrity "thus there is a hopelessness about the future. (Erikson, 1977, p.

242). Despair is often expressed in the individual's expression of disdain or even disgust on multiple levels. Erikson (1982) and his wife reflected on their own aging process in formulating the stage of integrity versus despair

2.6.10 A Critique of Erikson's Theory

Erikson's life span theory described the chronological formation of human development (Smith & Thelon, 1984). Erikson's lack of academic credentials has been a focus of criticism in relation to his theory. In addition, his theory was not based on systematic research, rather he and his wife based his theory primarily on case studies of Ghandi and Luther (Smith-Osborne, 2009). A further criticism is that his theory is culturally biased and described life span development in the U.S.A as if it were universal. However, a questionnaire study in South Africa, that included both black and white men and women, established that Erikson's stages could be universally applied (Ochse & Plug, 1986). In addition, many criticise his theory for being unclear. For example, there is overlap between autonomy and initiative. Nevertheless, the continuing widespread employment of his life stage theory in both scholarly and applied settings suggests that despite its flaws his life stage formulation has considerable merit.

A more specific critique of Erikson's (1982) theory of the life stage of integrity versus despair is offered by Loevinger (1987) who observed that few aging people reach full integrity. Fillit and Butler (2009) criticise the idea that identity is established and remains consistent through the life span. They argue that an identity can be transformed as a result of significant life events such as the lived frailty of old age. The increasing occurrence of illness and loss of energy that is associated with old age challenge the individual's identity, invoking perceptions of frailty and the need to come to terms with a new identity as an "old person" (Fillit & Butler 2009, p. 349). From this perspective Fillit and Butler (2009) argue that an aging individual may be overwhelmed by their frailty and consequently may be more likely to sink into despair as a result of their suffering rather than attain ego integrity. They make a valuable criticism of Erikson (1965) by stating the physical vulnerability associated with aging may deeply influence the individual's experience of aging and may block the capacity for acceptance and making meaning – the hallmark of integration. Loevinger (1987) who developed her theory of ego and moral development based on Erikson's psychosocial model, called the final stage of aging the "Integrated Stage", where the ego has a capacity to demonstrate wisdom and empathy towards the self and others. She based her work on Erikson's (1982) stage of integrity versus despair

and offers a somewhat more positive perspective than that of Fillit and Butler (2009) and more in keeping with Erikson's original position. However, in keeping with others she cautioned that full resolution of this stage is rarely attained as it involves the capacity to tolerate inner conflict and ambiguity and an acceptance of one's destiny. It would seem that Erikson (1982) was more optimistic in his belief that aging people could reach a stage of ego integration than many subsequent theorists. His critics, including Fillit and Butler (2009) and Loevinger (1987) are more pessimistic in their view that aging individuals can attain full resolution leaning towards a sense of wisdom and ego integration. In spite of these cautions there would be few who would argue against the fact that this end of life stage tends to involve a degree of stock-taking and a retrospective reconciliation with personal history. The present study tends to view the developmental theory of Erikson's (1982) stage of Integrity versus Despair on a continuum rather than as a fixed stage. Despite the criticisms of Erikson's theory there is sufficient research to support his stages and his concepts are regarded as useful, meaningful and valid (Dunkel & Harbke, 2017; Perry, Hasselvoort & Stompel, 2015)

The present study explores the experience of aging child survivors who were traumatised during the Holocaust and for this reason is interested in how this form of life experience may impact upon the negotiation of integrity versus despair. The child survivors were traumatised during childhood or adolescence and the long-term impact of their trauma was explored in the present study, using Erikson's idea of the negotiation of integrity versus despair as a lens through which to understand their current life position. This discussion will now look at previous research conducted into child Holocaust survivors.

2.7 Child and Adolescent Holocaust Survivors

2.7.1 Introduction

Of the six million Jews who died in the Holocaust an estimated one million were below the age of fourteen. Child survivors were rare as only 11% of Jewish children survived in Nazi occupied Europe (Dwork, 1991).

Despite developmental differences such as different family histories and different actual experiences in the Holocaust, when children were faced with the reality of their own and other's

deaths psychological regression was universal. Van der Kolk (2007) asserts that the experience of trauma during childhood can disrupt normal developmental processes. Children have unique patterns of reaction to trauma because of their dependence on caregivers for survival, as well as their biological and psychological vulnerability (Van der Kolk, 2007). Van der Kolk (2007) describes the child as developing a sense of 'self' in the process of interacting with his or her caregivers. Therefore, trauma during childhood may interrupt the development of a self and a coherent ego identity and this thwarts the capacity to develop trusting relationships. Trauma also interferes with the child's ability to self-regulate emotional arousal levels (Herman, 1992).

McFarlane and Van der Kolk (2007) observe that "Emotional attachment is probably the primary protection against feelings of helplessness and meaninglessness" (p. 24). Such attachment is critical for the biological survival of children and vital for the attainment of existential meaning in adulthood. Early secure attachment can operate as a defence against trauma and aids in buffering and protecting the individual, assisting in building psychological resources to face further distressing situations. Secure attachments enable children to self-soothe and self-regulate their emotions (Van der Kolk, 2007). They serve as a protective factor in trauma induced psychiatric issues in both adults and children (Finkelhor & Browne, 1985). According to McFarlane (1988), the quality of the parental bond is the most important predictor of long-term damage in children, who have been traumatised. The secure parent-child bond serves as a foundation for teaching the child a host of skills, including emotional regulation and it extends to facilitate the capacity to derive comfort from social support. Coping with trauma necessitates a group of skills such as self-care and accessing social support. Research states that traumatised adults with a history of childhood neglect had a poor long-term prognosis in terms of mental health when compared with traumatised adults who had a history of secure attachments in their childhoods (Van der Kolk, Hostetler, Herron & Fisler, 1994).

Research trials for PTSD, for DSM-1V, found that the younger the age of trauma onset and the longer its duration, the more likely it was that individuals would have long term difficulties with the expression of anger, with managing anxiety and with sexual impulses (Van der Kolk, Roth, Pelcovitz & Mandell, 1996). Trauma impairs basic trust and in young children it may increase a sense of self-blame and magical thinking. However, traumatic self-blame, guilt and shame is also found in adults, which reflects a sense of a loss of control in relation to trauma exposure (Perry, Herman, Van der Kolk & Hoke 1990; Rutter, Taylor & Hersov, 1995).

According to Klein (2012), child survivors of the Holocaust in many if not most instances faced the destruction and loss of their entire families, including the loss of parents, siblings, grandparents and extended family. The loss experienced was not only of loved ones, but of familiar social structures like school and friends. They were often physically uprooted from their country of origin and could not speak the language of countries in which they relocated post the Holocaust, contributing to a diminished verbal capacity for the expression of feelings in general including grief. They emerged from the camps starved, exhausted and sick, with a reduced cognitive ability to process what was happening in their world. Many remember their inability to cry and a sensation of living in a dazed state. In some cases, growth had been stunted owing to malnutrition and many children and adolescents had a damaged body image. Those survivors who returned to their homelands confronted the death of their families and the eradication of their communities and this resulted in feelings of rage and helplessness, without an opportunity for retribution or justice. For many decades child survivors struggled to accept the death of their parents. Mourning was avoided because of the overwhelming pain it engendered (Klein, 2012).

Owing to their young age at the time of persecution there was an assumption amongst some theorists and clinicians that child survivors did not have clear memories of their experiences and therefore that their trauma was not as great as that of older survivors (Durst, 2003). This meant that despite the fact that many children did have vivid memories of what had occurred their experiences were to some extent minimized. Further complications involved the German reparation system that failed to consider child survivors' legal claims as they were less easily able to present specific factual memories or validated evidence of persecution (Shklarov, 2013) and to represent their experience to others in these settings. This outward lack of validation of experience only served to exacerbate the ongoing traumatic experience child survivors faced after the Holocaust ended.

2.7.2 Traumatic Stress and Developmental Disruption

According to Pynoos, Steinberg and Goenjian (2007) it is important to understand the impact of trauma on child and adolescent development. Trauma exposure can disrupt the child's sense of safety in the world and has potential to cause long term psychiatric difficulties. According to Pynoos et al. (2007) research into PTSD in children has found evidence to suggest that children experience a full clinical spectrum of post-traumatic stress symptoms. The intensity of

the trauma is strongly linked to the severity and duration of the post-traumatic stress reactions. Bereavement, PTSD, depressive mood and separation anxiety, are related but independent of each other but may all occur in children faced with loss and damage.

According to research (Gleser, Green & Winglet, 1981; Pynoos & Nader, 1993; Pynoos, Sorenson, & Steinberg, 1993; Yule & Williams, 1990) the following factors are strongly associated with the onset and persistence of PTSD in children and adolescents: exposure to a direct life threat as well as an injury to self (including the extent of physical pain); the witnessing of an injury or grotesque death (especially of family members or friends); the perpetration of violent acts against others; being helpless and trapped or without assistance; being in close proximity to a violent threat; the extent of violent force employed; the number and nature of threats; and the nature of the relationship to the assailant and other victims. Overall whether there was physical coercion or the violation of the physical integrity of the child, the degree of malevolence and brutality evident in the incident are highly predictive of vulnerability to disturbance in mental health (Pynoos, Steinberg & Goenjian, 2007). In addition, research has indicated that there is a positive correlation between parent and child distress reaction in response to the same traumatic experience. Thus, if parents or caregivers are traumatised under the same conditions as the child and reflect signs of damage and distress children are more likely to become symptomatic themselves.

It is important to understand the context of the developmental issues at the onset of the trauma and to understand the psychodynamic symbolism of the threats, while understanding the possible cognitive implications, fantasy, emotional and physiological reactions. For example, when there is a threat of injury children may become preoccupied with issues about the injury and the need to rescue and make reparation. In violent situations, children may be forced to repress wishes to retaliate out of the fear of provoking more violence. Adolescents are particularly at risk in terms of threats to nascent ideological belief formation and need to be understood in terms of how the trauma may impact their identity development and consolidation (Erikson 1968). Pynoos et al. (2007) emphasise the ‘existential dilemma’ of the adolescent regarding, for example, the conflict between rescuing others or prioritization of self-protection. Durst (1995) argues that the fact that pre-adolescents and adolescents endured the Holocaust during the phase of identity formation was critical in their later developmental trajectory. “These children experienced personal suffering, starvation, dehumanization and daily

confrontations with death" (Durst, 1995, p. 296). The experience of loss and danger forced them to become adults prematurely and they lost their faith in humanity.

According to Van der Kolk (2007), childhood trauma has a major causative role in the development of adult psychiatric difficulties. Klein (2012) observes that all young children, age two to eight who survived the Holocaust, were injured in areas of psychosocial development, being unable to negotiate the fundamental tasks of development from the establishment of basic trust to the negotiation of an identity. In all cases there was an element of developmental regression. Hillel Klein (2012) explains that universally, there was regression in children who survived the Holocaust: "Normal childhood sadomasochistic fantasies paled in comparison to the nightmares of the Holocaust" (p. 56). There was unlimited horror and cruelty and basic trust at an existential level was destroyed. For Klein (2012), the child's capacity for fantasy became a hallmark of ego functioning and those who had lost the capacity for fantasy were dehumanized. They were unable to hold onto a sense of self (Klein 2012) and to use fantasy or the sense of an internal world to ward off some of the external pressures.

Both Herman (1992) and Erikson (1977) emphasise the establishment of trust in the earliest developmental phase of infancy. Herman (1992) explains that trust is developed in relation to the caretaker and sustains an individual in all the developmental phases of the life cycle. It is the foundation of all interpersonal relationships, as well as the cornerstone of faith in a God. Caretaking in infancy allows the individual to trust in a world in which they belong and a world that embraces and sustains human life. "Basic trust is the foundation of life, the order of nature and the transcendent order of the divine" (Herman, 1992, p. 52). Herman (1992) explains how the experience of trauma breaks basic trust in that it produces a primitive loss of comfort and protection. When traumatised people are desperate they call out for their mothers or for God. When their cry remains unanswered their sense of basic trust is shattered. Traumatised people feel abandoned by both humankind and God and feel cast out. As a result, a sense of alienation and disconnection becomes pervasive in all close relationships across the spectrum, extending to a sense of alienation regarding community and religious links (Herman, 1992).

In addition to compromises to the negotiation of trust, trauma also affects the negotiation of other developmental tasks. Herman (1992) explains that in child development, competence, mastery and the ability to take initiative builds self-esteem. Guilt and inferiority result when there are unsatisfactory resolution of these motivations. A traumatic experience blocks initiative

and thwarts the individual's competence. The individual is aware that no matter how brave or competent their actions were, they were unable to prevent disaster. According to Herman (1992) it is universal for trauma victims to judge their conduct at the time of the trauma, thus being vulnerable to guilt and inferiority. Lifton (1980) found 'survivor guilt' to be common in survivors of war, natural disaster or nuclear Holocaust. Feelings of guilt are severe when the survivor has been a witness to the suffering of others or in a situation in which it was equally likely that one may have been injured or died oneself. Survivors struggle with mental images of those who they could not save. In addition, they feel guilty for not risking their lives in order to rescue others or for surviving at all, even if by chance or fate.

Durst (1995) described the way in which child survivors' developmental processes were disrupted during the Holocaust. There was no continuity or predictability. Children learned that the future was unknown and that they could not expect anyone to comfort them in moments of terror and they were frequently overwhelmed by loss. They used defence mechanisms such as dissociation to 'forget' their losses. The children who survived with parents, were forced to witness the humiliation and degradation of their parents who could not save themselves or their children from immense suffering. The frequent reversal of child and parent roles, or taking on of premature responsibility by young children often evoked anger and guilt, even when child survivors appreciated that such behaviours were necessary under the circumstances. Hass (1995) adds that unconsciously in many instances child survivors felt anger towards their parents for not protecting them from harm.

According to Durst (1995), after liberation child survivors were often not allowed to discuss their experiences and they were not given the opportunity to mourn and grieve within a supportive environment. This void made it difficult for child survivors to integrate their past and their present experiences. Their environments encouraged them to construct new lives and they coped by using denial and suppression of their trauma and grief. The loss of family and lack of 'space' gave child survivors a sense that "a part of them is dead and empty" (Durst, 1995, p. 300). Thus, there was a numbing of feelings in response to ongoing inhibited mourning. Dasberg (2001) describes the three severe types of 'traumatic impact' on child survivors. Firstly, he indicates that childhood deprivation as the result of no home and exposure to dirt, lice and inadequate hygiene was significant. In addition, enduring hunger, cold and exposure to dangerous infectious diseases was traumatic in terms of physiological survival. Secondly, Dasberg (2001) argued that the experience of traumatic stress, as a result of exposure to death

and horror, caused the child to feel afraid, terrified, unprotected and helpless. Thirdly, children suffered massive loss on many levels, including the loss of parents and family. The extensive loss resulted in lifelong, unresolvable mourning. The grief was generally repressed or experienced in unanticipated bouts of grief. (Dasberg, 2001). In addition, child survivors experienced a sense of loneliness, and anhedonia. The trauma was experienced at physiological, psychological and existential levels and required engagement not only with threats to the self, but also with threats to and loss of those who were significant to one.

Dasberg (2001), argued that after the Holocaust children were forced to adapt to their new environments and traumatic experiences were largely supressed and repressed. To do this, the child survivor developed a split self. On the outside, they appeared to be adapting however, inside they had an inner sense of loneliness, low self-esteem, anxiety and insecurity. They were under pressure to learn a new language and adapt to a new environment. Many were deprived of the opportunity of finishing school and were vocationally disadvantaged. Based on the deprivation and trauma experienced by the child survivor, Dasberg (2001) coined the term "Child Survivor Complex" (p. 5). to describe both the trauma and deprivation, as well as its impact on the developmental process. Deprivation was understood to occur in relation to the lack of functioning parents, who were initially anxious and traumatised themselves by the threats within their environments and then later being unable to protect their children. Either the parent died or was unable to carry out their parental functions when reunited with the child, being deeply affected by massive traumatisation him/herself. Child survivors felt an enormous pressure to please their caretakers and to be accepted in their communities based on their need to belong and succeed. The suppression of their mourning and traumatisation, as well as the pressure to adapt, left them feeling an inner sense of loneliness and estrangement, contributing to identity problems, (Dasberg, 2001).

Dasberg's (2001) reference to 'splitting' as a form of coping mechanism differs from Melanie Klein's understanding of 'splitting' that may be familiar to many clinical theorists. Dasberg (2001) states that child survivors used splitting to enable them to cope, and as such, splitting became the characteristic feature of child survivors: "This split is a feature of incomplete and postponed mourning, and also between a traumatized inner core and outward adaptation" (Dasberg, 2001, p. 6). There is a split between outward apparent psychosocial adaption and an inner self that has unmet dependency needs and remains highly traumatized. Survivors hid their vulnerabilities in an attempt to seem normal and adapt to their new environments as refugees.

This left them at risk for bouts of depression and symptoms of post-traumatic stress, and for experiencing emotional outbursts that alternated with emotional detachment. In addition, survivors experienced anhedonia, guilt and amnesia regarding periods of their childhood. According to Dasberg (2001) child survivors struggled to regulate aggression and experienced conflict with authority figures, as well as experiencing frequent marital conflicts. Thus, when child survivors presented clinically, they were often given diagnoses such as those of chronic depression, anxiety disorders, personality disorders, PTSD, and in rare cases, psychotic disorders. According to Brom (2001) Dasberg's (2001) concept of the Child Survivor Syndrome is helpful as it encapsulates the full picture of "the psychosocial consequences of the Holocaust in those who grew up under Nazi occupation" (Brom, 2001, p. 1).

2.7.3 Child Survivors of Genocide in Other Populations

Since the Holocaust, there have been other genocides where children have suffered. Kaplan (2006) looked at the impact of genocide on the affect regulation of traumatised children in Rwanda. It is estimated that 400,000 Rwandan children became orphaned because of the Genocide. (Rakita, Des Forges & McClintock, 2003). Kaplan (2006) makes the point that anxiety and humiliation are extreme in the case of genocide:

> [Children] live with a sort of 'doubling', a 'vertical split' in the self. The past and the present are in different compartments with no associative connection, that is, the trauma is constantly kept present in one part of the self, while the person lives his ordinary life and seemingly appears untouched (p. 732).

This split in the self was previously observed by Dasberg (2001) in relation to child survivors of the Holocaust as discussed in previous sub-sections. It seems that both Kaplan (2006) and Dasberg (2001) identified a split in child survivors of genocide, a kind of dissociative split that enables them to compartmentalise the trauma and continue to function. It is possible that the capacity to split successfully worked in the service of survival as it was a defence mechanism that cut off the trauma to facilitate subsequent adaption and resilience. Affect regulation is a central organizing structure of human emotion.

Child survivors of the Bosnian genocide were researched to assess risk and moderating factors in terms of the development of psychological and social difficulties. In a sample of 339 children

aged 9-14, all children were found to have high levels of post-traumatic stress symptoms and grief reactions. (Smith, Perrin, Yule, Rabe-Hesketh, 2001). In addition, the mothers of the children were assessed. Results showed that the children's levels of distress were related to both the intensity of their trauma and maternal reactions (Smith et al., 2001), reinforcing previous observations that caregiver and child distress are inter-related. In Africa, a further research study on post-traumatic reactions focused on 1547 Rwandan children between the ages of 8-19 (Neugebauer, Fisher, Turner, Yamabe-Sarsfield, & Stehling-Ariza, 2009). The trauma that respondents endured included: witnessed killings (90%); lost family members (35%); witnessed rape or molestation (15%); and hid under corpses (15%). Respondents reported a high incidence of re-experiencing symptoms (95%) and blunting or avoidant symptoms (95%) of PTSD. Amongst those most heavily exposed to trauma the rate of probable PTSD was 100%. The study concluded that the elevated levels of PTSD, when compared to victims of violence in industrialised societies, was a function of exposure to the catastrophic man-made genocide. Psychological resilience among youth was largely absent or inadequate to cope with the trauma load in this situation (Neugebauer et al., 2008).

In another Rwandan study, 3030 children aged 8-19 were interviewed regarding their traumatic experiences, thirteen months after they survived the genocide (Dyregrov, Gupta, Gjestad, Mukanheli, 2000). These children had been exposed to extreme trauma, including witnessing the death of a family member, as well as other massacres. The majority of participants (90%) believed, at the time of the genocide, that they were destined to die. Although most had to hide, in some place children had to resort to hiding under dead bodies to survive. Results demonstrated that they had high levels of traumatic stress that were associated with traumatic loss, exposure to violence and feeling that their lives were in danger.

In a study of 20 Bosnian refugees who emigrated to the USA PTSD was diagnosed in 65% of the group, whilst depressive disorders were found in 35%. The study concluded that ethnic cleansing led to high levels of psychological morbidity, including PTSD and depression. (Weine, Becker, McGlashan, Thomas, Laub 1995).

Research on survivors of the Cambodian Genocide demonstrated that survivors suffered from long term PTSD (Hansen, 2014). Recent research (Stammel, 2013) has focused on prolonged grief in Cambodian genocide survivors who sustained massive losses over three decades ago. Prolonged grief was linked to the severity of PTSD. In addition, prolonged bereavement was

understood to be integrated into the social and cultural realities of Cambodians (Stammel, 2013).

In summary research indicates that child survivors of genocide in general suffer from and continue to present with clinically concerning symptoms of PTSD and from traumatic bereavement, in many instances decades after the initial events took place. In every genocide children are amongst the most vulnerable victims given their limited developmental capacities to process catastrophic traumatic stimuli and to absorb extreme loss. In genocides child and adult traumatization tends to occur simultaneously, compromising caretaker capacity to ameliorate traumatic experiences for children. As previously mentioned, children were often so overwhelmed by trauma that they used splitting in the service of survival. This resulted in a parallel process where their trauma and grief remained underground together with symptoms of PTSD, however, outwardly they focused on coping and adapting to their later environments and may have appeared to be well-adjusted and functional. This discussion will now move to explore child Holocaust experiences from a psychodynamic perspective.

2.7.4 A Psychodynamic Perspective on Child Holocaust Survivors

Although psychodynamic perspectives on traumatization and on Holocaust trauma have been discussed to a considerable extent previously, it is useful to elaborate more specifically on psychodynamic research findings related to child Holocaust survivors in particular. According to Hillel Klein (2012) it was Winnicott (1960) who coined the term ‘protective shield’ to describe the way in which parents protect their children against psychological harm. He stated that during the Holocaust parents were not able to function as ‘protective shields’ for their children nor as strong caretaking models for identification. Children witnessed their parents being ridiculed and shamed in their role as men and women. In addition, children witnessed mass extermination. “The child was forced to be a witness of the massive destruction of his family and community and first became aware of himself as a ‘victim’ when he perceived his parents’ intensified anxiety and intense preoccupation with survival” (Klein 2012, p. 54). Thus, not only were parents unable to provide barriers to traumatic experiences for their children, they were also directly traumatised in front of their children, contributing to a profound sense of loss of functioning “good objects” who could provide a source of containment and optimism.

Klein argues that dealing with survival issues of life and death led to a lessening of more conventional intrapsychic conflicts. Thus, tensions relating to intrapsychic aggression and to conflicts within the family were directed outward towards the oppressor or 'outside group' (Klein, 2012). While this may have been helpful to a degree it also precluded the likelihood of integrating conflicting feelings towards the same person or working through aggression. The latency age child was often burdened with responsibilities of finding food for their families or making decisions in dangerous situations. This led to an intensified fidelity to their family, or gang, and a lack of feeling towards those outside their family circle – contributing to potential forms of isolationism and out-group prejudice. Children's fantasies were concerned not so much with pleasure as with safety. The Holocaust comprised a series of many traumas that overwhelmed the child's ability to cope in multiple respects (Klein, 2012).

Klein (2012) contends that psychoanalytic insights may deepen the understanding of the specific conflicts and psychological defences utilised, as well as the meaning of life during and after the Holocaust for child survivors. It is essential to take account of pre-internment family structure and experience and the vicissitudes of life in the pre-Holocaust period, as well as the personality attributes and stage of development of the individual when the traumatisation occurred. Only then, can one develop a comprehensive picture of a Holocaust survivor's experiences and adjustment. Klein (2012) emphasizes that each survivor had a unique psychological profile and experience. Dasberg (1987), Kestenberg and Brenner (1986), and Valent (1998) all align themselves with Klein's (2012) psychodynamic formulation of child survivors, agreeing that child survivors were uniquely influenced by their family histories as well as the developmental disruption caused by the Holocaust trauma. From this perspective early history and quality of attachments are crucial in understanding the long-term impact of the Holocaust. In addition, risk and ameliorating factors need to be considered when assessing post liberation adjustment of child survivors. For example, Klein maintained that when evaluating the survivor's experience, one needed to pay particular attention to the time between persecution and the time that followed liberation, as the psychosocial environment could either be rejecting or supportive and might worsen or ameliorate the impact of Holocaust experiences.

Expanding on the importance of developmental life stages for appreciation of Holocaust impact Kellermann (2001) divides child survivors into three groups: infants and children who were younger than six; child survivors who were between six and twelve; and adolescents who were between twelve and eighteen at the end of the Holocaust. The age at which trauma was

experienced is important to take cognisance of as it draws attention to the child's cognitive ability to understand as well as other capacities. "Apparently the younger the survivor, the more traumatic the circumstance, and the more damaging the war experience" (Kellermann, 2001, p. 8). From Kellermann's (2001) understanding, the lack of safety and trust instilled from experiences in the camps left the child feeling powerless and this affected their sense of autonomy and subsequent development. Older children were better able to comprehend their circumstances and as a consequence their sense of a just world in which there is a balance of good and evil was severely compromised contributing to a kind of existential alienation. This also had enduring effects.

According to Dasberg (1987) child survivors may be well adjusted in their current daily lives however, they are a group that is vulnerable regarding emotional distress and instability. They differ with regard to relating to their past. For example, some are obsessively preoccupied with traumatic memories, while others are avoidant in this regard. When confronted with current stress, memories of loss and separation may be retriggered and they may suffer from increased anxiety and depression. According to Kellermann (2001) the clinical depiction of child survivors has features similar to that of 'complex post-traumatic stress'. Kellermann (2001) argues that the developmental arrest of child survivors manifested in various DSM category personality disorders related to unmet emotional needs and chronic deployment of defences such as derealisation and dissociation. Distrust of others featured as a frequent emotional component. (Kellermann, 2001). This discussion will now look at previous research on Child survivors.

2.7.5 Empirical Research on Child Survivors of the Holocaust

Keilson (1979), a Dutch researcher, did a follow up study on child survivors 25 years after liberation. He randomly selected a non-clinical group of 204 child survivors who had become orphaned during the war. Some were in hiding, while others were in concentration camps during the Holocaust. His findings showed that children aged 11-14 at the time of liberation suffered from anxiety while those who were over 14 tended to suffer from reactive depression. He found that generally, the younger the child was at the time of the Holocaust, the more harmful the effects on their later personality development. This finding is in keeping with the premises advanced by Kellermann (2001).

Keilson (1979) described three phases or 'traumatic sequences' that could be observed in the accounts of the children he researched. The first phase of distress or traumatization in the group's accounts related to the disruptive and anxious atmosphere before the outbreak of World War II. This included suffering from discrimination or anti-Semitism, including ghettoization. At this stage parents were overwhelmed, anxious and worried about being able to protect their children. Older children and adolescents felt the threat of danger and death, resulting in their frequently taking over adult responsibilities. The second sequence began after children were separated from their parents, uprooted from their schools and communities, moved into concentration camps or had to go into hiding. In this second phase, children were exposed to terror and persecution (Dasberg, 2001; Keilson, 1979). The third sequence began at liberation and re-entry into the post war world, involving adaption and adjustment to new environments as refugees. Dasberg (2001) emphasised that at this third stage childhood deprivation was experienced because of the impact of massive loss, chaotic post-war conditions and the difficulty of confronting the world with a refugee status. Keilson (1979) found that a positive and supportive post-war environment was a mitigating factor and children who found themselves in a favourable environment coped well, even if their trauma during the Holocaust had been great (Durst 1995). Both Durst (1995) and Dasberg (2001) mention the importance of Keilson's (1979) contribution in the understanding of child survivors. Traumatic experiences can cause developmental regressions or catapult the child or adolescent into developmental processes that are inappropriate. In addition, post-traumatic symptoms may disturb the development of peer relationships, leading to social isolation. Furthermore, when a child survived the Holocaust with a parent, they suffered their own loss and trauma as a survivor in addition to absorbing the stress and trauma of their surviving parent (Sossin, 2007). However, despite these vulnerabilities Keilson's work was also able to demonstrate that access to a supportive environment post-trauma had substantial benefits in ameliorating trauma scars. While Keilson's research involved investigation of a similar population to that focused upon in the present study his research took place almost 50 years ago when survivors were much younger than those interviewed for the current research project and it was thus not possible to establish implications for longer term life trajectories.

Moskowitz (1983) did a follow up study of young children who spent the war in concentration camps, as well as in hiding and who were placed in an orphanage after liberation. Twenty-four subjects were interviewed 35 years after liberation. Some had successful careers and many were married with families. Moskowitz (1983) stated that as a group, his participants were resilient

and had adapted well to their new environments, however, they continued to suffer from the loss of their parents, as well as a loss of faith. They felt that nobody could adequately grasp the extent of their trauma. Although they had high levels of anxiety and family problems, none had sought psychiatric or psychological help.

Hemmendinger and Krell (2002) took care of a group of males, child concentration camp survivors (from the Buchenwald children's camp) at an orphanage in Paris. Initially the boys who were orphaned seemed chaotic due to extreme neglect. They interviewed fourteen child survivors thirty years later: most were married and had never received psychiatric help although they reportedly suffered from depressed moods, anxiety and nightmares. This indicates, that although child survivors seemed well adjusted, in many instances they suffered ongoing PTSD and related symptoms. There was some evidence of a kind of dual existence of adaptive functioning alongside periodic symptomatic expressions of distress related to past trauma exposure and bereavement.

Mazor, Gampel, Enright & Ornstein (1990) also researched child survivors, thirteen of whom had been in concentration camps and two in hiding during the Holocaust. Many experienced late grief and some experienced anger and depression, reporting strong feelings of early abandonment and loss. Robinson et al. (1994) researched 100 non-clinical, aging survivors. Using rating scales, it was found that symptoms of depression and anhedonia were present in 50% of child survivors who were in concentration camps, as well as in 30% of those who were in hiding. Although most were working in their vocations far beyond retirement and were socially active they reported suffering from 'survivor syndrome' distress ever since the Holocaust had ended. Camp survivors were found to be more symptomatic when compared to children that were in hiding.

Valent (2002) interviewed ten child survivors. The survivors described how their childhood experiences during the Holocaust had shattered their lives. In addition, they described how being surrounded by death and torture became a normalised experience in the psychotic world of the Holocaust. Tauber (1996) described the compound personality of child survivors, suggesting they in some respects remained fixated at the developmental stage of the trauma while continuing to function reasonably effectively in their adult worlds.

From 1967-1969 Klein (2012) conducted a three-year study on Polish Holocaust survivors and their families who were living on Kibbutzim in Israel. All the participants had been adolescents at the time of the Holocaust. He observed that adolescents during the Holocaust did not have a moratorium on responsibility and did not have the opportunity to experiment with different roles in their peer group. In addition, they were not able to express sexual curiosity because of the abnormal circumstances. In these respects, aspects of their development had been foreshortened.

What appears evident from the several previous empirical and generally interview-based studies into the experiences of child Holocaust survivors is that the nature of the damage they suffered and how this manifested was complex, with many appearing more functional in subsequent life than may have been anticipated. However, it was evident that there was simultaneously fairly extensive evidence of vulnerability to mental health difficulties and the possibility of triggering of traumatic memories and significant losses by stimuli in the present.

2.7.6 Loss and Grief Experiences of Child Survivors

The intrapsychic, psychodynamic view is that a loss of a parent figure and adversity in childhood necessarily has serious pathological consequences (Bowlby, 1973; Nelson et al., 2007). However, according to Pynoos et al. (2007) it is important to differentiate between post-traumatic stress symptoms and the reaction to loss and related grief that may be observed in child trauma survivors. Their research (Pynoos, 1992; Goenjian et al., 1995) established that children can experience both complicated grief and bereavement related depression, such as that found in adults (Prigerson et al., 1995). In addition, they observed the way in which PTSD complicated grief by distracting from the experience of loss and drawing psychological resources to focus on processing the trauma (Pynoos, 1992).

Child Holocaust survivors lost their families and their communities. For many, there was and still is a lack of closure, complicated, for instance, by the fact that there are no grave sites to visit, nor family pictures to retain. This lack of closure complicates the process of grieving (Sicher, 1998, 2000). Kellermann (2001) states that child survivors suffered multiple losses that subsequently loomed over them for the rest of their lives. Children were torn away from their parents and siblings in tragic and brutal ways. Separation was often sudden, with little preparation, and the ongoing trauma made it difficult for mourning to take place. In this

interruption to grief many child survivors used defence mechanisms to block feelings of overwhelming loss, contributing in some instances to shallowness or distancing in subsequent interpersonal relationships (Kellermann 2001, 2009).

Wardi, (1992) explains that after liberation survivors of concentration camps began moving around Europe. Some went to their home-towns searching for family, but most landed up in displaced person's camps that had been set up in different parts of Europe. Many hoped to find lost family members but, in many cases, found that families had perished during the Holocaust. They suffered unbearable loneliness and isolation, as they had lost their immediate and extended family connections, their communities, their friends and their homeland. Wardi (1992) explains that the survivors needed to continue the process of splitting that started in the camps as their psyches could not cope with the extent of loss. According to Davidson (1987), the experience of profound loss left a sense of emptiness that engulfed and overwhelmed them. Wardi (1992) explains that the capacity to dissociate enabled the survivors to cope with this overwhelming loss: "All those who were unable to dissociate themselves from their memories - all those whose hearts did not turn to stone - did not survive" (p. 23). In keeping with both Wardi and Kellermann, Lifton (1980) explains that in the process of dissociation the survivor's capacity for trust and dependence became limited. To form loving attachments again was not only a betrayal of the dead, but also represented the threat of being overwhelmed by emotions in intimate situations and the possibility of having to bear future loss.

According to Wardi (1992) the trauma of separation from family is the deepest wound a person can suffer and is the most difficult to treat. The experience of separation from families caused survivors to feel "pain, anger, guilt feelings, and feelings of loss and emptiness. It remained a wound in their souls, which may seem to have been covered by a scab, but still gives them no rest" (p. 9). He observed the intensity with which Holocaust survivors held on to the memories of their final moments with their loved ones who were later killed. Owing to the overwhelming nature of these traumatic situations, survivors experienced intrusive nightmares and psychosomatic and related symptoms related to family separation and loss (Durst, 2003). Mazor et al. (1990) also reported that the process of remembering intensified post-traumatic stress symptoms such as nightmares, flashbacks, sadness and crying. In a long term follow up study with child survivors Krell (1985) found that the loss of parents was a central issue, leaving what he termed "a gap" in the core of the survivor's identity (Krell, 1985). However, remembering the Holocaust experience may create a narrative cohesion in the personal histories of survivors,

which some people may find beneficial. From Kellermann's (2001, 2009) perspective child survivors struggled with an ongoing sense of grief that has no closure. Lifton suggests that despite being painful and perhaps triggering intrusive recollections, experiencing distress and anger in remembering may be representative of the fact that a necessary mourning process, that these adults did not experience as children, is taking place (Lifton, 1967). Thus, it is evident that there is considerable debate as to whether memory retrieval, especially of loss and death, is harmful or helpful to survivors.

Witztum & Malkinson (2009) challenge the psychoanalytic assumption that Holocaust survivors were unable to mourn their losses. They present research to demonstrate that an inner relationship is maintained with the deceased person throughout life (Klass, Silverman & Nickman, 1996). In contrast, Klein (2012) spoke from his clinical experience of working as a therapist and psychoanalyst with Holocaust survivors observing that many survivors were not able to face the grief related to the loss of their parents as the mourning was too painful.

According to Herman (1992), survivors of traumatic loss need to mourn as failure to grieve perpetuates the traumatic symptoms. In normal bereavement there are rituals and social support for the mourners. By contrast there is often no common ritual for mourners after a traumatic experience, such as the Holocaust. According to Herman (1992) when there is a bereavement with no social support the potential of developing pathological grief and severe depression is extremely likely. As discussed earlier, the deliberate rupture of familial and community structures entailed in the Holocaust precluded externally containing rituals from being performed and compounded difficulties in grieving in a population that was enjoined to move on and put their camp experiences behind them.

Loss and traumatic bereavement nevertheless remain core themes in relation to Holocaust survivors (Witztum & Malkinson, 2009). Recent research suggests that trauma and bereavement very often co-exist, particularly when loss is under traumatic circumstances such as that exemplified in 9/11 (Cohen & Mannarino, 2004), terror attacks in Israel (Karniel-Lauer, 2003) and the Holocaust. Research on Cambodian survivors also indicated that prolonged grief was linked to ongoing PTSD in genocide survivors (Stammel, 2013). According to Witztum and Malkinson (2009), based on their clinical findings, Holocaust survivors experience 'continuous bereavement'. Malkinson and Bar-Tur (2005) observed that elderly Holocaust survivors continued to express their loss and grief. Witztum and Malkinson (2009) propose

that Holocaust survivors be understood through a lens of "traumatic bereavement" that allows for acknowledgement of both experiences of catastrophic trauma and of devastating loss.

Having looked at theory and findings related primarily to bereavement and loss this discussion moves on to focus more carefully on traumatic stress related aspects of child survivors' experiences.

2.7.7 PTSD and Complex Traumatic Stress related to Victimization and Perpetration

Complex traumatic stress in children and adolescents results in a disruption and loss of core functions of self-regulation and capacity for interpersonal attachment (Cook et al., 2005; Cook et al., 2017). These difficulties place children at risk for additional trauma and psychiatric disorders such as PTSD, anxiety, depression, sleeping disorders, attention deficit disorder, conduct disorder, oppositional defiant disorder and reactive attachment disorder. Each of these diagnoses captures a specific aspect of the traumatised child's compromised capacity to self-regulate and relational difficulties. (Cook et al., 2005, p. 392).

According to McFarlane (1995) the ongoing experience of PTSD symptoms may cause the child and family to feel demoralized and distressed and may undermine the child's ability to cope with post-trauma life challenges and adversity. The experience of secondary adversity may place the child at risk for depression. Experiencing depression could in turn interfere with the resolution of the post-traumatic stress symptoms. The combination of PTSD, a depressive disorder, loss, and secondary difficulties in coping, constitute a harmful interactive constellation of difficulties that compromises recovery and adaptation of traumatized children and adolescents. This would cause complications for their support systems. While this theory is derived from more conventional forms of trauma exposure it is feasible to think of Holocaust survivors as suffering from ongoing PTSD symptoms and from complications related to this. Klein (2012) described the horror and indignity of camp life as involving ongoing dehumanisation. In addition, meaning systems were ruptured in significant ways by a range of experiences in the camps.

A particular area of risk for some trauma survivors and Holocaust survivors in particular is when they have been compelled to become involved in their own or others suffering in some way. Herman (1992) points out that the final point of psychological control is when individuals

are forced to violate their moral principles and betray their basic human attachments. When a victim is forced to participate in sacrificing others, they develop self-loathing and become psychologically devastated and 'broken'. Herman (1992) quotes Eli Wiesel (1960), who writes about his experiences at Auschwitz–Birkenau with his father. Wiesel reported that he and his father supported each other through terrible experiences yet he is tormented by memories where he felt that he let his father down, and when he felt angry with his father for being unable to protect himself from the violence of the camp guards. Herman (1992) points out that Wiesel was humiliated by his own helplessness. In this instance the betrayal was of a more cognitive kind, taking the form of critical judgement of his father, but in other instances betrayal took more concrete material forms. Victims in captivity report that in the process of being "broken" they relinquish autonomy, their principles or their connection to others in order to survive (Herman, 1992). As will become apparent in subsequent discussion there were groups of prisoners and individuals who either cooperated with the Nazi's in some way in order to survive or who felt that they compromised their own principles in competing with other inmates for survival or in failing to intervene on their behalves.

Krystal (1978), who worked with Holocaust survivors, described the emotional shutdown of many of those interned as "robotization". According to Holocaust Survivor, Primo Levi (1959), the final stage of being "broken" is losing the will to live. Survivors of Nazi concentration camps describe this fatal condition as evident in what were termed "musselmen": "Prisoners who had reached this point of degradation no longer attempted to find food or warm themselves, and they made no effort to avoid being beaten. They were regarded as the living dead" (Levi, 1959, p. 85). Klein (2012) writes that survivors who witnessed exterminations "spoke about hell, literally not metaphorically" (p. 51) and carried an enduring sense of helplessness at their failure to intervene. A state of impotence to protect or intercede on behalf of those one is attached to produces a kind of psychotic state or negated self.

Gideon Greif, a historian from Yad Vashem and writer of *We Wept Without Tears* (2005), interviewed survivor inmates who were part of the Jewish Sonderkommando in Auschwitz. The Sonderkommando consisted of mainly Jewish prisoners who were forced by the Germans to facilitate mass exterminations and to work with dead bodies after they had been killed in the gas chambers. They described ongoing complex traumatic stress as a result of their experiences. In addition, they faced moral and human challenges while being involved with this appalling work. Greif (2005) interviewed eight survivors of the Sonderkommando regarding their

experiences. Although his perspective was historical, the testimonies revealed that the survivors were suffering from severe post-traumatic stress decades after their experiences. “You cannot dwell on it too long…if it would help to cry then I would cry, but it doesn’t help” (quoted in Greif, 2005, p. 8). Leon Cohen, was one of those interviewed by Greif (2005). He said that some sixty years after the Holocaust ended he was still troubled by intrusive memories and post-traumatic stress.

> For six months after I left Auschwitz, I couldn’t do a thing. I couldn’t close my eyes at night. I had nightmares all the time. I woke up at night screaming in agony at the sound of Jews crying as they were being suffocated in the gas chambers. The screams the groaning, the prayers of these people. In my dreams, I heard the sound of the elevator that brought the corpses up to the furnaces… Auschwitz was the tragedy of my life. It wasn’t easy to liberate myself from the experiences I had there (Leon Cohen, in Greif 2005, p. 308).

According to Herman (1992) when an individual is forced to violate another human being the risk of PTSD is very high. This is because the survivor has not only witnessed but is also an active participant in the violent murder or atrocity. In addition to risk of PTSD is the risk of becoming almost permanently dissociated or alienated from the self.

Greif (2005) explains that Sonderkommando members felt forced to adapt to their ‘occupation’ and settled into a daily routine. They came to accept their situation with “total indifference”. Greif (2005) quotes a survivor of the Sonderkommando who described the experience of numbing in the following way:

> We were human beings devoid of human emotion. We were really animals not people. It’s frightening but that’s how it was – a tragedy. None of us went insane in Auschwitz since we had stopped being human. We’d become robots (p. 305).

It is evident that the range of damage to survivors of the camps varied fairly extensively but that it was as likely that those who might have been viewed as complicit in some way were vulnerable to later PTSD or C-PTSD as those who were treated purely as victims.

2.7.8 Guilt and Survivor Guilt in Child Survivors

Primo Levi (as cited in Hass, 1995) described the emotional torment of survivor guilt in the following way:

> Are you ashamed because you live in the place of another? It is more than a supposition, indeed the shadow of a suspicion: that each man is his brother's Cain, that each of us has usurped his neighbour's place and lived in his stead. It is a supposition, but it gnaws at us; it has nested deeply like a woodworm; although unseen from the outside, it gnaws and rasps (Primo Levi in Hass, 1995 p. 17).

According to Hass (1995), "survivor guilt" captures the cognitive and emotional experience of those who are fortunate enough to emerge from a catastrophe which mortally strikes down others. Researchers have different views about the pervasiveness of this phenomenon. Harel, Harel, Kahana and Kahana (1993) wrote extensively about its prevalence among Holocaust survivors, while Hass (1995) claimed that it was not prevalent among the survivors with whom he worked. Hass (1995) suggests that the prevalence of survivor guilt was strong after the war, but faded as the survivors moved on to building their post-war lives

Klein (2012) offers a unique contribution to an understanding of how one views guilt in Holocaust survivors. For him, guilt was a sign of "recovery" as it signalled the survivor's engagement with the mourning process. He said: "I believe that guilt for surviving is the only possibility to start the process of mourning and to promote a process of individuation" (p. 13).

Chalmers (2015) argues that the severe living conditions, including starvation, fear, danger and humiliation, often led to "understandably inhumane behaviour among some prisoners" (p. 203) towards each other. She attributed the "untoward behaviour" among some Jews to the camp or Ghetto conditions created by the perpetrators, where Jews were forced to fight for their own survival. According to Levi (1989) it is unfair and inappropriate to judge the behaviour of Jews in concentration camps where the impact of the perverted world of the Nazi doctrine and related practices is difficult to comprehend. This is a controversial topic as some of the Jewish Kapos were reportedly self-serving, or worse, collaborated with the Nazis. As discussed previously, however, many of these collaborators carried profound guilt or suffered from severe PTSD. Their physical survival was often at the expense of their psychological integrity and survival.

This discussion will now move on to exploring anger and rage in child survivors as these affects were identified as significant in addition to the pain and anxiety already mentioned.

2.7.9 Anger and Rage in Child Survivors

Herman (1992) explained that because of the difficulty in regulating intense anger, survivors of significant trauma move between expressions of uncontrolled rage and intolerance of aggression. This split seems to be indicative of the struggle of the trauma survivor who identifies with both the victim and the aggressor.

Forty years after the Holocaust, the majority of survivors felt anger and hatred towards their persecutors. According to Lifton (1967) and Auerhorn and Laub (1984) anger and rage have a role in the integrative "working through" process and in reaching mastery. However, if these feelings become fixed and repetitive an embittered worldview develops. These authors also suggested that anger may represent a reaction to abandonment and unresolved mourning for loss experienced. This anger may be directed towards the survivor's own children who leave their parents to live their own lives (Gampel, 1988; Kestenberg, 1984). In addition, there are actual external events, such as being in a continuous state of war (in countries such as Israel), which may reactivate fear and helplessness, as well as feelings of revenge (Dasberg, 1987).

According to Klein (2012) survivors had to suppress their anger and rage towards their Nazi persecutors, and this had a destructive impact on the self-esteem of all survivors. This was particularly true for adolescent males who were struggling to create a masculine identity. According to Hass (1995) some survivors coped with their sense of personal responsibility by focusing their rage on the Nazis. According to Herman (1992) the prisoner in captivity cannot afford to express humiliated rage at the perpetrator as this would threaten his or her survival, however, this does not mean that the feelings are not present. In addition, the prisoner may also carry unexpressed rage at bystanders. The survivor may withdraw in an effort to control rage, deepening social isolation. The survivors may direct rage against themselves leading to depression and suicidal feelings. Former prisoners internalise the hatred of their captors and sometimes continue being self-destructive. Herman (1992) explained how rage develops in the victim who has experienced captivity. Their identity becomes contaminated with shame, self-hatred, loathing, and a sense of embodying a failure. It is evident that many Holocaust survivors carried feelings of rage during their internment but were unable to express or act on these

feelings for fear of retaliation and annihilation. Thus, they became vulnerable to a range of the kinds of outcomes described here – including self-hatred and a propensity to perhaps displace aggression onto others in the present. Linked to rage are feelings linked to subjugation and helplessness.

2.7.10 Helplessness, Humiliation and Shame in Child Survivors

There is ample evidence that powerlessness is a central theme for people who are traumatised (Eagle, 1998). Krystal (1978) described the infantile helplessness of people who had experienced catastrophic events such as the Holocaust. The loss of power, especially over an extended period and of an extreme kind, such as that evident in the camps, may result in a general attitude of submissiveness and this may manifest in symptoms similar to clinical depression. The impact of helplessness may depend on pre-existing personality factors as well as the recovery environment (Eagle 1998). Herman (1992) defined and explained ongoing trauma in the context of captivity: "A single traumatic event can occur anywhere. Prolonged, repeated trauma, by contrast, occurs only in circumstances of captivity. Such conditions obviously exist in prisons, concentration camps and slave labour camps" (p. 74). Captivity sets the stage for repeated trauma and coercive control of the victim by the perpetrator. The victim is enslaved while the perpetrator exerts total control over every aspect of the victim's life. Psychological domination is inflicted through repetitive psychological trauma.

As previously mentioned, Benyakar et al. (1989) argued that the loss of autonomy is a central theme in the experience of trauma. Its impact causes a shattering of personal identity, continuity, and self-regulation. Herman (1992) linked the idea of humiliation to the experience of helplessness. According to Herman (1992), in states of captivity fear is induced by episodes of unpredictable violence and the enforcement of meaningless rules. The perpetrator becomes so omnipotent that the victim realises that resistance is futile. The perpetrator instils in the victim a fear of death and the perpetrator who controls the victim's body functions destroys the victim's sense of autonomy. The perpetrator is in control of what the victim eats, wears and when he or she goes to the toilet: "When the victim is deprived of food, sleep or exercise, this results in physical debilitation" (Herman, 1992, p. 77).

Van der Kolk and McFarlane (2007) argue that trauma generally engenders feelings of shame and humiliation. The experience of feeling helpless and out of control results in the survivor

feeling that they failed to manage the situation. “Shame is the emotion related to having let oneself down” (p. 15). The emotional intensity of shame is so unbearable that it often leads to dissociation. Hass (1995) also notes that feelings of powerlessness, humiliation and being at the mercy of another person cause some survivors to carry an enduring sense of shame and inadequacy and Herman (1992) too, emphasised the sense of shame and helplessness that arises from ongoing dehumanisation in captivity. Chalmers (2015) conducted an extensive study of women in the Holocaust and based her research on diaries, archives and testimony of concentration camp survivors. A central theme in the testimony involved the experience of dehumanisation, entailing emotional and physical humiliation. Chalmers (2015) included ‘excremental attack’ as part of the abuse and dehumanisation. The excremental attack involved dirty public toilets and restricted toilet use times. If concentration camp inmates lost bladder or sphincter control this would lead to further beating and humiliation. She quoted the testimony of Holocaust Survivor, Des Pres, who said that the excretemental attacks caused disgust and self-loathing in the survivors and were a major weapon of psychological dehumanisation (Chalmers, 2015).

The humiliation of existence in the camps included the shaving of body hair, body searches and nakedness. Forced nudity was particularly humiliating for female concentration camp inmates who were forced to strip and parade naked in front of soldiers in order to be ‘disinfected’ and were often subjected to taunting, searches and inappropriate touching. In addition, the inmates were poorly clothed, starving and cold. They were not given an opportunity to bath and were lice infested. According to Chalmers (2015) it is overwhelming to conceive of the physical suffering, in addition to the psychological humiliation, that was inflicted on concentration camp inmates. Herman (1992) explained that when the persecutor targets the bodily functions of the victim this type of attack produces a sense of shame and humiliation and also contributes to dependence and regression that may instil further shame. In addition to rage, helplessness and shame, survivors also carried complicated feelings about strategies for survival and about surviving at all when thousands of others perished.

Having discussed the main affective impacts of Holocaust related trauma as identified in the literature subsequent sub-sections look at the function of coping defences in the face of trauma.

2.7.11 Coping and Defences against Trauma Impact

From a psychodynamic perspective repression and suppression are understood to be psychological defences that remove uncomfortable thoughts or feelings from awareness (Boag, 2010). Repression is understood to be unconscious whereas suppression is considered to be conscious and Boag (2010) suggests that the differences may be unclear. Erdelyi (2006) suggested an "unconscious-conscious continuum" to clarify this definition (p.169). Defence mechanisms have been mentioned throughout this discussion in relation to the psychodynamic and psychoanalytic understanding of traumatization. This discussion will move on to examine in a more focused manner how Holocaust survivors used defence mechanisms to cope with their overwhelming trauma. According to Laub and Auerhahn (1993) trauma shatters the functional barrier created by the ego and leads to a fragmentation of the self. Constructing defences against knowing is often an initial response to a trauma. Laub and Auerhahn (1993) explained that in the case of massive trauma, primitive defence mechanisms such as denial, amnesia, splitting, depersonalisation and derealisation are used by the survivor to block out the reality of the event/s. For Laub and Auerhahn (1993) there is a continuum on which the memory of atrocity is preserved reflecting the degree to which the observing ego is involved in "knowing and not knowing, massive psychic trauma". (p. 1). Thus, some survivors may recall a traumatic event in great detail whereas others may be amnesic regarding the entire event. They suggest that the more severe the trauma the stronger the pull towards "not knowing".

According to Herman (1992), victims in captivity develop altered states of consciousness to cope with their unbearable reality. They use coping defences such as dissociation, denial, thought suppression and minimisation. These coping defences are used to withstand cold, hunger, cruelty and pain. They narrow the individual's focus of attention to limited goals. A concentration camp inmate's range of initiative narrowed to plans to get a pair of shoes, a spoon or blanket. Thinking about the future brings up yearning and hope that prisoners find unbearable, as it makes them feel vulnerable to disappointment and desperation (Herman 1992). She described the psyche of the survivor in captivity in the following way: "The past, like the future becomes too painful to bear, for memory like hope, brings back the yearning for all that has been lost" (Herman, 1992, p. 89). Thus, Herman suggests that in such contexts it may be functional to restrict one's consciousness and to live in a psychologically constricted world that matches the external environment. Herman explains that these alterations in consciousness are central to constriction or numbing, symptoms associated with PTSD. "Sometimes situations of

inescapable danger may evoke not only terror and rage but also, paradoxically, a state of detached calm, in which terror, rage and pain dissolve" (Herman, 1992, p. 42). Although the trauma victim is aware and conscious of events that occur, these events are detached from emotional experience and personal meaning. Perceptions may be numbed and sense of time may be experienced in slow motion. The survivor may feel as though the event is not happening to him or her, as though he or she is observing it from outside their body. Where this kind of psychological way of being would normally be considered dysfunctional it may be helpful in inescapable situations of ongoing traumatization.

Different researchers have described the manner in which severely traumatized victims, such as war veterans (Kardiner, 1941) and Holocaust survivors (Krystal, 1968), withdraw and detach emotionally from everyday activities. Herman (1992) described these detached states of consciousness as hypnotic trans-states, as they share the same core features of surrender, loss of initiative, subjective detachment and/or calm. Such states also often include depersonalisation and derealisation. Numbing and hypnotic dissociation was described in Holocaust literature as pertaining to the way of being of "Musselmen" as previously described and was thought to characterize a necessary way of being for those who had no sense of agency and were likened to the 'walking dead'.

According to Klein (2012), in an attempt not to draw attention to themselves within the concentration camps victims compromised their self-esteem, judgement and desire for self-expression. Thus, a cultivated invisibility was understood to be adaptive in this context. Victims disconnected emotionally to cope with the overwhelming loss and terror in the camps. Klein (2012) said that most Holocaust survivors had continuous experiences of derealisation and depersonalisation as a result of being confronted with a reality that exceeded their most awful nightmare and, in many senses, felt surreal. In addition, according to Wardi (1992) the concentration camp inmate constructed a kind of psychological armour around him/herself as a protection from feelings of pain. Thus, the inmate became rigid and emotionally shut down. Wardi (1992) explained that the camp inmates suffered physically and lived in constant fear, compromising their capacity for empathy and attachment. The facility to mourn friends or family was lost, and primary process or primitive thinking dominated the inmates' internal world. According to Wardi (1992) "Denial, repression and emotional isolation… became appropriate and vital mechanisms for psychological survival" (p. 19).

Herman (1992) explained that after liberation there was a rupture in continuity between past and present, and observed that many prisoners remained psychologically imprisoned. The sense of the power of the perpetrator continued to exist in the victim's inner life long after liberation. The victim struggled to integrate their experience in captivity into their present lives and used powers of thought control to avoid thinking about it. These observations are similar to those of Laub and Auerhahn concerning the capacity to engage or "know" one's experience. Krystal (1984) found that concentration camp survivors were unwilling to talk about their past confirming that the integration of the material perhaps felt beyond the capacity to process or comprehend.

In relation to child survivors, Kellermann (2001), in particular, suggests that as a consequence of overwhelming emotional trauma, powerlessness and isolation, they employed defence mechanisms as children to help them disconnect on an emotional level, in part because they observed that "children who cried, died". Thus, similar to adults, children were aware that emotional constriction and invisibility were functional within the context. When they were overwhelmed with "speechless terror", the emotional experience was dissociated. In adulthood, this sometimes manifested as emotional numbing and a need to fit in and not be 'seen'. The cultivation of this way of being at an early age may have made it more difficult to generate a more flexible way of being in later life. It may have also led to constricted emotional regulation in later life.

Isserman, Hollander-Goldfein and Horwitz (2013) commented on the defence mechanisms used by the ninety-five Holocaust survivors interviewed in their qualitative research. It was clear from the interviews that amidst the terrible circumstances of the Holocaust, defence mechanisms could be an effective way of dealing with difficult and life-threatening situations. Numbing, compartmentalisation and even dissociation were important strategies in protecting the survivors from the horrors they experienced during the war. Defence mechanisms continued to play a role in coping in later years too. Isserman et al. (2013) are one of the first sets of authors to mention compartmentalisation as a specific defence. This is perhaps as helpful a way of understanding the defences used by Holocaust survivors as reference to dissociation (which generally implies disconnection between cognition/perception and affect) – given that in the writing on Holocaust survivors it is evident that they were able to access memory contents concerning experiences in the camps very quickly, as if these contents continued to exist in vivid form but were shut-out of consciousness in general.

Dasberg (2001) described the way in which child survivors used a form of splitting in order to cope with their trauma and grief. As indicated previously he uses the term 'splitting' in a somewhat different manner to that associated with the work of Melanie Klein and the post-Kleinians and it is in his sense that the term will be employed in the discussion of the findings. Dasberg (2001) maintained that survivors created a split between their outer resilient and functional selves and their inner damaged selves that experienced turmoil related to childhood losses and traumas during the Holocaust. He said that this split was characterised by denial, repression, and dissociation, all of which underpinned different forms and intensities of splitting. One might also understand this form of defensive style as involving compartmentalisation where the damaged part of the person is sealed off from the outwardly apparently well adapted personality.

The above discussion indicates that different writers agree that Holocaust survivors used profoundly impactful defence mechanisms to cope with their unbearable pain, many of which would be viewed as dysfunctional in non-perverse contexts but which proved necessary for survival (both physical and psychological) within the camps. While Klein (2012), Herman (1992), Wardi (1992), Kellermann (2001) and Isserman et al. (2013) described derealisation and dissociation as significant in coping, alongside affective constriction, Dasberg (2001) additionally described splitting, particularly in the aftermath of the Holocaust, as useful to survivors. These writers are all in agreement that Holocaust survivors disconnected their emotional worlds from their thoughts in order to cope. However, the costs of this form of coping can be extremely high as exemplified in C-PTSD and in the kinds of existential alienation that may be part and parcel of survivor's lives. Laub (1992) explained the toll on the development of the self: "The loss of the capacity to be a witness to oneself and thus to witness from the inside is perhaps the true meaning of annihilation, for when one's history is abolished, one's identity ceases to exist as well" (p. 82).

Having examined modes of coping that involved particular kinds of defensive styles and mechanisms the discussion will now move to exploring and describing resilience in child survivors, as this introduces a somewhat different set of considerations.

2.7.12 Resilience in Child Survivors

Resilience can be defined as "a universal capacity which allows a person, group, or community to prevent, minimise or overcome damaging effects of adversities. Resilience may transform or make stronger the lives of those who are resilient" (Greene, 2002, p. 3). Resilience refers to a process that includes positive adaptation in the context of adversity" (Luthar, Cicchetti & Becker, 2000). From these definitions it is apparent that resilience involves two important conditions: severe threat or adversity, and positive adaptation despite the major disruption of the developmental process (Luthar & Zigler, 1991; Masten, Best & Garmezy, 1990; Rutter, 1999; Werner & Smith, 1982, 1992).

Resilience has a multidimensional nature and children may demonstrate resilience in one area while experiencing vulnerability in another facet of their lives. Researchers are cautioned to be specific about an area of resilience that is manifested, rather than making general statements regarding resilience (Luthar et al., 2000). In addition, it is important to understand nodal points of resilience across the life cycle. Research has tended to focus on resilience in children, however, resilience can be attained at any stage in the developmental life cycle (Cicchetti & Tucker, 1994; Luthar, 1999). According to Cook et al. (2017), a resilient child may cope in some domains (for example, academic work) while struggling to cope in other areas. Within the developmental process areas of competency may change when new challenges are faced. The following factors are recognised to be linked to resilience in children and adolescents: positive attachments to competent and supportive adults; the development of the cognitive ability; the capacity to self-regulate and self-soothe; positive self-esteem; capacity for behavioural control; and the ability to act effectively. In addition, the following factors have been associated with resilience: flexible disposition; positive temperament; social cohesiveness; an internal locus of control; external attribution for blame; good coping strategies and problem-solving; degree of mastery and autonomy; special talents; spirituality and creativity (Werner & Smith, 1992). Thus, as with the prior discussion of post-Holocaust adjustment, it is evident that temperamental and personality features, developmental stage, severity of adversity and environmental features, may all play a role in resilience.

According to Mc Farlane and Van der Kolk (2007), secure emotional attachment in childhood serves as a building block in the establishment of resilience as well as serving to provide protection against existential meaninglessness in adulthood. For young children, family

attachments are a mitigating factor against traumatisation, and children are often resilient as long as they have a caregiver who is available on an emotional and physical level. Cook et al. (2005) reiterate that caregiver support is protective factor in nurturing resilience and provides a buffer against the development of PTSD (Cook et al., 2017).

In keeping with earlier descriptions, psychosocial resilience, as defined by Valent (1998), implies "springing back after having been subjected to severe stresses" (p. 30). Valent's (1998) work on resilience was based on his personal treatment of Australian Holocaust survivors. In addition, he himself is a child survivor. He indicated that his clinical and personal experiences resonate with the literature, which reported that being appealing, having good attachments, good social supports, competent interactional skills and raised self-esteem, mitigates against the long-term effects of traumatic situations. According to Valent (1998) child survivors of the Holocaust were by definition resilient, as an estimated 90% of 1.5 million children were killed. Many child survivors cited an inner search, or compulsion to live and a will to survive, as the most important factor in their survival. They used whatever capabilities they had to remain alive.

During the Holocaust children experienced dread, desolation, panic, grief, despair, anger and guilt akin to that experienced by adults (Kestenberg and Brenner, 1986). Like adults, they could also freeze and/or numb their emotions. Children over the age of four years were able to make use of splitting defences and to live in two parallel worlds (Kestenberg & Kerstenberg, 1988). They lived in the current reality while keeping alive an internal world where they fantasised about a reunion with their good parents in a good world. Gampel (1988) saw the inner urge to survive, the ability not to feel, and the ability to keep mental contact with a good object, as the primary means of psychological survival.

Klein (2012) explained that fantasy formation formed a defence against the massive traumatisation of child Holocaust survivors. By using fantasy, children were able to distance themselves from the horror and hopelessness in their external world. This is an interesting observation given Klein's (2012) earlier observation that one of the capacities that became compromised for children in the camps was the ability to develop a fantasy life. Thus, it seems that for those who were able to retain this capacity there was a better likelihood of resilience. In trauma-free periods, hope was an essential resource in helping the victims to tolerate and survive painful experiences. Hope was based on a positive self-evaluation, memories of people

who were loved, and those that represented the safe world of past experience. Experiences of nurturing in the past helped to sustain the child who suffered great loss and trauma, and ego strength based on earlier developmental inputs facilitated survival. It is apparent that children within the camps needed to develop introspective capacities at a stage at which this would not necessarily have been normative and that many of them had to become psychologically precocious in order to subsist.

Wherever possible, children were creative. They played and did drawings in Ghettos and concentration camps. The innocence and hopes expressed in children's games were precious to adults who dared not to hope so openly. According to Valent (1998) child survivors of the Holocaust commemorate the importance of secure attachment, the appeal of spontaneity, and the ability to continue to interact with the environment despite deprivation. In addition, they symbolized the capacity to maintain hope through intense desires to reunite in the future with dearly held memories of past attachment figures. According to Valent (1998) child survivors had a resilience characterised by the will to live where developmental drives, creativity and curiosity were maintained against all the odds. Hass (1995) added that the survivors demonstrated tenacity during the Holocaust and their adaptation to rebuilding their lives was remarkable.

As discussed previously, in the post-war period most survivors' parents did not return, or when they did, were different to the ones remembered (Durst, 2003). Many children returned to hostile anti-Semitic environments. For those who emigrated, adoptive countrymen were indifferent to the past sufferings and encouraged them to forget. Normal grieving processes were inhibited or curtailed. Child survivors in this phase seemed to cope by focusing on the future, repressing memories and feelings, as well as by restricting their thinking. Many suspended any self-reflection for the next three to four decades.

Early professional studies of child survivors tended to be pessimistic. For instance, approximately half of psychiatrically hospitalised child survivors were found to be psychotic, and overall a greater proportion of psychoses was found in younger survivors (Krell, 1985). However, most child survivors belonged to a non-clinical population. Such child survivors worked hard to establish security, and most became financially successful, married, and were devoted parents. Many belonged to helping professions and were altruistic members of society (Kestenberg & Kestenberg, 1988). Nevertheless, most had silently carried a variety of post-

traumatic stress responses such as nightmares, physical symptoms, anxieties and other distressing emotional states, including having disturbing disjointed memories. Most continued silently to desire to belong, to have fuller loving relationships and to enjoy the world with greater humour and optimism (Gampel, 1988).

Valent (1998) also observed that although survivors were able to transcend early sufferings and build productive lives, symptoms of despair existed below the surface. Despite their suffering most child survivors were able to function competently later in the adult world. They were successful in work and often achieved beyond the average. Their passion for bringing up children in normal and loving circumstances and their compassion and community awareness was surprising to an extent, given what they had experienced. Valent (1998) stated that each facet of resilience has a corresponding wound. He noted that the discrepancy between survivors' inner pain and outer high functioning capability pointed to ambiguity in understanding and dealing with trauma impact it also brought into question some of the prior assumptions in the trauma literature concerning the incompatibility of these two types of response. In a similar vein, Shklarov (2013) pointed to the paradoxical existence of good life adjustment and painful emotional memories.

Suppressing memories continued to be the key means of coping with the pain of trauma in post-Holocaust life. Suppression was aided by psychological defences such as negation, denial and repression (Mazor et al., 1990). 'Half knowing' was achieved as a result of the isolation of affect, and depriving the event of meaning, significance and full knowledge (Kestenberg, 1987). This kind of resilience, or defensive style, was shared with siblings, fellow child survivors and parents. The silence between the generations has been referred to as the 'conspiracy of silence' (Danieli, 1985) and was also the term Danieli employed to describe the way in which mental health professionals who worked with survivors failed to acknowledge their suffering and colluded with the societal denial of the Holocaust in many instances.

In discussing resilience, it is important to remember what Chalmers (2015) described as the inappropriateness of attempting to "sweeten the Holocaust" (p. 254). She points out that the testimonies we have about life transcendence post the Holocaust are from survivors, and that emphasizing the overcoming of hardship may occlude full awareness of the tragedy represented in the millions who died. The need to deny trauma and view genocides in a more palatable way is part of the human need to minimise this form of trauma as it is intolerable (Chalmers, 2015;

Herman, 1994). Holocaust research needs to honestly reflect the devastation of the Holocaust, including the cruelty of a genocide that ended in millions of deaths.

The recognition of both vulnerabilities and resilience in child survivors is important. Child survivors of the Holocaust have shown that both the will to survive and psychological adjustments were important. Psychological adjustment included the mental attachment to a good object and the hope of retrieving them, as well as the blunting of emotions and meanings inconsistent with survival. However, for later integrity, these mental processes had to be revisited and assimilated, and past and current responses had to be reconciled.

The fact of child survivors also highlighted higher mental and spiritual levels of resilience, such as illustrating the capacity to develop a unique sense of identity, existential meaning and purpose, despite having suffered extreme degradation, cruelty and loss in earlier life. They demonstrate how creativity can emerge from the resourcefulness developed in traumatic situations and how the life urge can be transformed into investment in the next generation. According to Klein (2012) while the psychological effects of traumatisation have been well described in the literature, patterns of resistance and recovery have been less well articulated. After the Holocaust survivors were able to invest in building families and taking responsibility for other's welfare in the world. He saw this as an important step in revival and renewal after the Holocaust. He said that the ability to hold onto hope and invest in life after the Holocaust depended on a sense of internalised object relations that allowed for a sense of continuity of self, a self that continued to survive despite the Holocaust trauma.

2.7.13 Mediators of Traumatic Stress: Protective and Risk Factors

According to Herman (1992), a supportive response from the people in the survivor's world may mitigate the impact of the traumatic event, and conversely, a negative response may exacerbate the traumatic syndrome. "Having once experienced the sense of total isolation, the survivor is intensely aware of the fragility of all human connections in the face of danger, and fears further abandonment" (Herman, 1992, p. 62). Rutter (1985) proposed that the family could be a protective factor or a risk factor in relation to childhood adversity.

Felsen (2016) indicated that psychosocial support has been found to be crucial in studies on refugees from countries where there is political unrest. This research demonstrated that the

distress of relocation and the acculturation to a new environment significantly contributed to experiences of distress but that this distress could be ameliorated significantly by access to social support (Bolton, 2015; Turner, 2004). Meta-analyses of research on populations exposed to mass trauma conclude that social support is the most important factor in determining adjustment and the amelioration of distress (Norris & Wind, 2009). Last and Klein (1980) noted that within the camps many survivors coped by forming dyads or small groups where they shared food and provided protection for one another. Chalmers (2015), suggested that women and men also formed dyads and this helped them to survive life in the camps. Klein (2012) wrote extensively about the protective factor of forming bonds with other inmates. Common activities such as praying, singing and offering love and hope were important in representing a 'new family' that supported the individual. This was an antidote to the general dehumanisation.

Keilson (1979) spoke of the importance of the post-Holocaust environment in the recovery from trauma. Durst (2002) expressed that the survivors had a need to speak about their traumatic experiences in order to regain a sense of relief and faith in a meaningful world. However, for many years, survivors were met with silence from their new communities and the mental health specialists who did not want to hear their experiences (Durst 2002). The silent response that survivors encountered reinforced their sense of shame, and they felt rejected by their fellow Jews and other citizens in their new environments: "For a survivor to speak about his experiences in the 1950's and 1960's invited humiliation, ridicule, and disbelief" (Durst, 2002, p. 8). For many the opportunity for others to bear witness to their trauma was denied them and the lack of engagement with their history left them feeling isolated and disillusioned. This is in part why subsequent projects to document Holocaust experiences have been viewed as important.

Lurie-Beck (2007), indicated that survivors had vastly different experiences in the way they were received by their communities as emigrants after the Holocaust. Some were shunned in their new countries as people did not want to hear about their Holocaust experiences and there was a kind of collective suppression of the reality and scale of the horror and abuse. Bialystok (2000) described how the Canadian Jewish community did not want to hear about the survivors' experiences and this is echoed by Danieli (1984), who described how the mental health professionals both in Israel and the USA at the time did not acknowledge the trauma that the survivors had endured.

The literature review will now move on to explore aging amongst child survivors.

2.8 Aging Survivors

2.8.1 Introduction to Aging Survivors

In previous sections of this literature review traumatic experiences of child Holocaust survivors were discussed, including some of the longer-term impact of their interment on subsequent adjustment. This section will focus specifically on the long-term impact of trauma over the period of the lifespan and its final consequences in old age since this was a primary area of interest within the present stud.

Dasberg (1987) explained that it takes the time span of at least one generation to stimulate the willingness and motivation to return to massive collective trauma of the form that the Holocaust took. Renewed interest in the Holocaust is a worldwide phenomenon. In the later phases of the adult human life cycle reintegration and reinterpretation of the past and reminiscence comes to the fore. Although denial was adaptive for many years after the Holocaust, survivors may now want to speak out or to attempt to engage with this highly significant period of their lives. Old trauma may resurface, and unfinished emotional business requires resolution. Hassan (2003) argues that Holocaust survivors have a complex relationship with aging. With more available time on their hands, dormant memories emerge – in keeping with Van der Kolk's (2007) observations. Engaging with the process of aging was further complicated by the fact that most Holocaust survivors had no close role model of aging as their parents and older relatives had been killed in the camps. In working with elderly Holocaust survivors in England Hassan noted that despair and hopelessness came into focus as elderly survivors faced old age and their defences weakened. In addition, the added stresses of old age required new efforts to cope not only with past events but also with everyday demands that may be met with depleted reserves.

The psychological lifespan perspective on aging is influenced by Erikson's model of psychosocial development (1965). As outlined previously there are tasks in old age that hold promise for both growth and challenges (Aarts & Op den Velde, 2007). According to Aarts and Op den Velde (2007) memory plays a central role in reflection and reminiscing. Memory gives a sense of continuity across developmental stages and is central in the process of reaching ego

integrity. In addition, memory facilitates the process of giving meaning to past life experiences. Reminiscence is important in the aging process and may carry both positive and negative weight, but recollection is also inherent in post-traumatic symptoms.

According to David (2011), who conducted an extensive study of literature written about Holocaust survivors, early research focused on clinical populations and employed terms such as "survivor syndrome" to describe the population as a whole (Niederland, 1964). Words such as anxiety, guilt, and anhedonia were commonly used to describe the survivor experience (Berger, 1977; Cohen, 1977; Krystal, 1968). In the last two decades, there has been a paradigm shift where aging survivors have become more often described as resilient, and words like strength, mastery, autonomy and integration are used to characterise their psychological adjustment (Bar-Tur & Levy-Shiff, 2000; Lomranz, 2005; Suedfeld et al., 2005). Dasburg (1987) reviewed the literature to examine the basis for this paradigm shift and attributed it to social and developmental changes. He argued that the apparent change in attitudinal stance and representational emphasis was in part due to the accumulation of more evidence based on research conducted with random samples of large survivor communities, as opposed to exclusively clinical samples.

According to Van der Kolk (2007), trauma has a long-term impact over time and it may become the focus of attention in the elderly as their bodies decline and their participation in the external world diminishes. Symptoms of PTSD may worsen as traumatic memory dominates in old age. Joffe et al. (2003) did a systematic study looking at the early impact of trauma on aging in Australian Holocaust survivors and looked at the presence of PTSD in older survivors. Given the timing of their study the interviewees tended to have been in late adolescence or early adulthood during the time of the Holocaust. The present study differed the participants were in childhood or adolescence during the Holocaust, all participants were interned in concentration camps and the focus of the present study did not focus exclusively on PTSD. Joffe et al.'s findings indicated that "the psychological effects of massive trauma are severe and enduring" (2003, p. 46). This confirmed earlier findings (Harel, Kahana & Kahana, 1988; Nadler & Ben -Shushan 1989; Robinson et al., 1990). A prevalence of 39% for PTSD was found amongst aging Australian Holocaust survivors, compared with 48% in the United States (Yehuda et al., 1994) and 35% in Italy (Joffe et al., 2003). Joffe et al.'s (2003) findings showed that survivors suffered from depression, anxiety, intrusive thoughts, insomnia, nightmares, headaches, exhaustion, and dizziness and that they were taking more hypnotics and anxiolytics than the

general population. It appeared that symptoms did not improve with time, and psychological intervention was needed fifty years later, as symptoms appeared to worsen with age. These lessons should be applied to current survivors of other atrocities (Joffe et al., 2003).

In addition to the work of Joffe et al. (2003) and Hassan (2003) there is a considerable body of research indicating that aging Holocaust survivors are vulnerable to psychological distress. Lomranz, Shmotkin, Zechovoy and Rosenberg (1985) compared 44 non-clinical survivors to 33 controls. Findings showed that survivors had a past orientated and more pessimistic attitude to life some 40 years after the Holocaust. Levan and Abramson (1984) researched a random sample of 300 concentration camp survivors and compared them with European born members of the same community, 35 years after the Holocaust. Camp survivors displayed more emotional distress and medical symptoms. They also found that women were more affected than men. Carmil and Carel (1986) found that 40 years after the Holocaust the 150 survivors they had researched suffered more emotional distress and had less satisfaction in life than their matched controls.

Research on child survivors of the Holocaust confirmed these individuals to be the most vulnerable group to lifelong personality disturbances (Dasberg, 1987) suggesting that those who have now entered their seventies and eighties may well be at risk for end of life difficulties. Rees (2002) found that a disproportionate number of Holocaust survivors reside in Israel's mental hospitals, where they have been neglected for decades. There has been a campaign to have survivors treated for Holocaust trauma instead of being diagnosed with psychotic conditions that have been treatment resistant, as currently tends to be the case. Recently, Israeli psychiatrists (Barak, Aizenberg, Szor, Maor & Knobler, 2005) campaigned to treat survivors as victims of trauma rather than as treatment resistant. For example, the introduction of "Testimony Therapy" has helped relieve distress and alleviate depressive symptoms, as doctors listened for the first time to the inmates recounting of experiences in detail. Psychiatrists (Barak et al., 2005) have had to challenge more than just a misdiagnosis made decades ago. They were also perceived to be challenging a Zionist ideology that saw Holocaust victims as, 'weaklings' who had gone, 'like sheep to the slaughter', unlike the strong new Jews Israel's founders helped to create (Barak et al., 2005).

For Holocaust survivors admitted to hospital for depression and anxiety - the roots of which could be traced to their past traumatic experiences (Dasberg, 1987). Research found that

Holocaust survivors are more likely to commit suicide than the general population. All of these observations and findings suggest that aged Holocaust survivors have considerable difficulties to contend with – many of which stem from unresolved post-Holocaust trauma (Barak et al., 2005).

Shklarov (2013) conducted an in-depth study of nine Russian-speaking, child Holocaust survivors. She explored their life experiences and sense of identity. Her participants resided in both Canada and Moscow, and they were interviewed in Russian. She analysed her participant's narratives using grounded theory procedures. She found that as child survivors age they often experience a painful reawakening of their traumatic memories. Her empirical research thus supports other observations that end of life stage may bring traumatic memories very much to the fore, perhaps more especially when these have been repressed for individual and communal reasons.

Kuilman and Suttorp (1989) studied 100 Holocaust survivors in The Netherlands. They found that the majority of their participants developed either late onset or worsening of post-traumatic stress symptoms, during midlife and old age. They studied 100 patients and found that 43% suffered late onset of PTSD as a result of a stressful life event that had taken place one year prior to the worsening of their symptoms. Retraumatising life events can be understood in the context of certain categories, in this instance retirement and children leaving home. Honigman -Cooper (1979) studied concentration camp survivors who were in geriatric homes in the USA and found that survivors suffered from increased vulnerability as they aged. Aarts and Op den Velde (2007) explained that the increase of PTSD symptoms in old age was due to the combination of diminished resilience in combination with stressful life events associated with aging, such as loss of peers and declining health. Such features were understood to lead to decompensation in aging survivors (Cath, 1981; Danieli, 1981; Krystal, 1981). Assael and Givon (1984) found that aging Israeli Holocaust survivors were mentally and emotionally depleted as a result of old age. Shanan and Shahar (1983), having studied aging Holocaust survivors, found that they showed more cognitive impairment when compared with controls, although survivors performed better in coping with current life stress. These study results bring into question the assumption that coping resources and affect regulation necessarily deteriorate in survivors as a result of aging. However, the bulk of research evidence seems to point to increased vulnerability to mental health problems and psychological distress in Holocaust survivors as they enter old age.

Cohen, Brom and Dasberg (2001) compared a non-clinical group of 50 aging child Holocaust survivors with a group of controls. The child survivor group was found to have a high level of post-traumatic stress symptoms, enough to warrant the diagnosis of PTSD in 50% of participants in the group. However, they coped well and did not show significant psychosocial stress when compared to controls. They did not ask for help despite the severity of their symptoms, and they continued to function well despite their suffering. Brom (2001) pointed out that this study showed that although the Holocaust survivor group did not show high levels of psychosocial stress, they were deeply preoccupied with their Holocaust memories, as evidenced by their high score for post-traumatic stress symptoms. Many of the survivors who appeared to be functioning well, would "fulfil the Re-experiencing, Avoidance and Hyperarousal criteria for Post-Traumatic Stress Disorder" (Brom, 2001, p. 1).

Barak (2013) elaborates on what he considers to be a central feature of post–trauma adjustment in survivors that influences aging in a fundamental way. He explains that because survivors have strong dissociative tendencies that they have relied on over extended periods as a result of their traumatic experiences, this may well lead to a failure in integrating memories and emotional experiences. (Barak, 2013) As such, dissociation may complicate the aging process and compromise the survivor's ability to integrate their Holocaust experiences fully, interfering with their capacity to successfully negotiate Erikson's (1965) stage of ego integration (Barak, 2013). Barak (2013) observes that the Holocaust deprived child survivors not only of a normal childhood but also of a peaceful legacy in old age.

It is evident that there are a range of longer-term effects that aging survivors may present with in treatment, be this in psychiatric or less formal settings. According to Kellermann (2001, 2009), the following are characteristics found in older Holocaust survivors who come for treatment: massive repression of traumatic experiences and affect; amnesia; alexithymia; intrusive memories; Holocaust-related traumatic associations; depression; suicidal ideation; a chronic state of mourning; survivor guilt; sleep disturbances and nightmares; problems with self-regulation regarding anger and difficulties in dealing with interpersonal conflicts; excessive anxieties and catastrophic fear of renewed persecution; paranoia, suspiciousness and lack of trust; loneliness and isolation from the community; and a low threshold for coping with stressful situations. In addition, Kellermann observed the somewhat rigid deployment of defence mechanisms and survival strategies that were utilised during the Holocaust. In addition,

based on their research with aging Australian Holocaust survivors, Paratz and Katz (2011) observe that they had a higher risk of dementia as they aged. This suggests an added complication to which survivors may be particularly vulnerable.

Researchers concluded that present diagnostic systems do not adequately capture the complicated picture of the late consequences of the psychic trauma of the Holocaust for those who were children and adolescents in the camps (Cohen et al., 2001; Kellermann, 2001, 2009). It may be that having functioned apparently well in respect of earlier life tasks such as establishing careers and life partnerships the carrying of the burden of their trauma returns to haunt them in a significant way in end of life stages and the colouring of their internal worlds by their Holocaust experiences becomes more evident or visible.

2.8.2 Loss and Depression in Aging Holocaust Survivors

In addition to having to come to terms with and encompass trauma related memories elderly survivors also have to revisit the impact of prior losses at a life stage at which they are increasingly frail. As indicated previously mourning was suppressed after the Holocaust, and most survivors experienced complicated forms of grief that was inhibited in its expression although they did display "emotions such as worry, anger, distrust, sadness, distress and loneliness" (Durst, 2002, p. 7). The impact of loss could emerge in feeling states other than depression or sadness and, in many instances, impacted interpersonal intimacy and relations. Durst (1995) explained that aging survivors suffer from "extended bereavement" (p. 82) where they have no closure for their multiple losses and tend to revisit such experiences.

According to Aarts and Op den Velde (2007), loss and grief are a central feature in old age and Herman (1992) notes that loss of some kind is a part of any trauma. An essential developmental task at this life stage involves the integration and acceptance of loss over a lifetime. This dynamic is amplified in Holocaust survivors who have struggled throughout their life time with themes of bereavement and loss, even if associations to these experiences have been suppressed or repressed. For Holocaust survivors their difficulty in mourning, stems from their severe traumatisation and the catastrophic extent of their losses (Danieli, 1981; Krystal,1981). As indicated previously, in old age new losses may stir up and compound feelings related to old losses. Difficulties with retaining a sense of coherence and meaning also mean that existential, cultural and religious beliefs designed to assist with processing loss may also not be so readily

available to survivors or may lack certainty and credibility (as will be elaborated further in a subsequent section).

According to Krystal (1981), as Holocaust survivors look back and review their lives, repressed memories emerge, and the survivors experience emotional pain. In order for survivors to achieve 'integrity in aging', they need to "work through their losses and problems of guilt and shame" (p. 7). According to Valent (2014), memory plays a central role in the experience of being traumatized. To demonstrate his point, he quotes Wiesel, who says: "Survivors' memories are a psychological and moral vice. To remember smashes the mind; to forget betrays the dead" (p. 3). Valent (2014) observed that survivors are caught in a double bind as they need to remember in order to make meaning of their trauma, however, part of survival involves forgetting. To draw meaning, they needed to feel the weight of their tragedy, fear, despair, shame and guilt and this increased their unwillingness to remember. However, in the final developmental stage of aging remembering becomes essential to the retrospective integration of their lives.

David (2011) suggests that Holocaust survivors move through the adjustments in aging, including illness, relocation, retirement, loss of a spouse, and loss of family and friends as do others but that these alterations in life are complicated by prior related experiences, for example of separation from loved ones or adjustment to new living circumstances. Like others David (1988) also highlights the significance of engagement with earlier losses. Witztum and Malkinson (2009), as previously mentioned, concluded that in the case of Holocaust survivors, trauma and grief exist together, creating the experience of continuous traumatic grief. In some cases, "it would seem that trauma has engulfed the mourning and terror has silenced the sorrow" (p. 138).

According to Laub (1992), when Holocaust survivors experience tragedy in their lives, they experience it as a "second Holocaust, the ultimate victory over their cruel fate, which they have failed to turn around, and the final corroboration of the defeat of their powers to survive and rebuild" (Laub, 1992, p. 650). It is evident that later life losses of peers and difficulties with health and cognition associated with aging might represent this kind of 'tragedy'. There is also awareness of finite time to effect any repair to past difficulties. Laub (1992) explained that survivors who struggle to discuss their experiences are afraid that they do not have the

psychological resources to endure reliving their experiences and this may be particularly so in old age.

After reviewing the research on aging child survivors, Dasberg (2001) observed that coping was the focus after liberation and "the denials, repressions and forgotten injuries as well as the grief for our lost ones remained hidden beneath the surface for many years" (Dasberg, 1991 p. 32). Dasberg pointed to the fact that because of resonances with earlier experiences of deprivation, loss and isolation from supports, aging survivors were at a critical point as they reached Erikson's stage of 'despair and integration'. This stage signalled renewed awareness of their unfinished business from their past and for these reasons survivors often needed geriatric psychiatric evaluation and potentially psychological help for their PTSD. He suggested that mental health workers needed to be alert to such likely difficulties and to be willing to offer survivors psychotherapeutic opportunities (Dasberg, 2001).

In summary, it is evident that there is some disagreement in the literature about Holocaust survivors' ability to reach ego integrity in old age, given the rupture in the self and difficulties in earlier developmental task negotiation as a result of the Holocaust trauma. Trauma disrupts the capacity to symbolise and this may lead to difficulty in reaching ego integration in old age. Based on his observations Dasberg (2001) takes a more pessimistic view, believing that aging Holocaust survivors used defences, such as splitting, in order to cope with their massive trauma and that as a consequence of this survivor's struggle to integrate their traumatic experiences given the entrenchment of this form of defensive engagement. Laub and Auerhahn (1993) described the impact of the massive trauma on the disruption of the self. In keeping with Dasberg they explain how the trauma survivor employs defence mechanisms to allow them to forget their psychic pain. However, this rupture of memory impairs the survivor's identity. On the other hand, survivors such as Frankl (1962) and Klein (2012) were more optimistic in their view of survivors' resilience and ability to preserve a sense of self in order to hold onto hope and find meaning. Although these writers were not referring to reaching ego integrity in old age, they did believe that survivors were able to make meaning despite enduring catastrophic trauma. Valent (1998, 2014), also a child survivor who writes about resilience, shares the more optimistic view.

2.8.3 Research on Aging Survivors: Resilience versus Vulnerability

More than six decades after the Holocaust researchers continue to argue regarding the long-term effect of Holocaust related experiences on survivors (Barel et al., 2010). Some questions that are called into consideration include the following. Do survivors suffer from long-term chronic anxiety and depression (Niederland, 1964) and personality difficulties (Kellermann 2001)? Are the chronic psychiatric difficulties observed in some studies restricted to a small group who are not representative of survivors at large? Do most survivors have functional and successful lives despite the genocide and suffering they endured? (Leon, Butcher, Kleinman, Goldberg & Almagor, 1981). Research in the past two decades has tended to produce more optimistic findings, focusing on survivor resilience (Valent, 1998, 2014). The shift in research has entailed focusing on the coping of survivors as they move into old age. Robinson et al., (1990) found that aging survivors had been successful in their work and family life, despite their mental suffering. In addition, survivors often expressed an immunity to stress, saying that their hardiness was driven by their Holocaust experiences (Robinson et al., 1994).

Lee (1988) a psychotherapist and a Holocaust survivor, explored how survivors were able to resiliently survive their persecution and function well in their new environments. In her research she found that survivors were able to see positive aspects in the world despite their suffering. She found they could use creative fantasy in remembering experiences of warmth and love. From her viewpoint survivors who had experienced loving relationships in their pre-war histories were better able to cope with their trauma and rebuild their lives after liberation, despite difficulties in emigration and in adjusting to a new country, a new language and new social environment. Lee (1988) conducted qualitative research with 13 Holocaust survivors, where their internal resources were the focus of the study. Almost all agreed that their achievements, as well as the achievements of their children and grandchildren, were a source of happiness and satisfaction. Kellermann (2009) agrees that for survivors, the growth and success of their children and grandchildren has been a source of pride and joy. From these findings it can be postulated that after the Holocaust many survivors built their identities around their own new-generation families.

The theory of post-traumatic growth (Calhoun & Tedeschi, 1999) provides an explanation for resilience in the aftermath of significantly traumatic experiences, capturing the idea that trauma may not only be psychologically damaging but may also serve as a positive catalyst for personal

transformation. According to Calhoun and Tedeschi (1999), “post traumatic growth is the tendency on the part of some individuals to report changes in perception of self, philosophy of life, and relationship with others in the aftermath of events that are considered traumatic in the extreme” (Calhoun & Tedeschi, 1999, p. 321). According to Calhoun and Tedeschi (1999), developing a sense of meaning and understanding is part of positive adaptation. In the case of Holocaust survivors, an attempt to make meaning of their survival could contribute to successful adaptation, and from some of the research previously cited it is evident that some survivors were able to achieve this. This dovetails with Erikson’s (1982) emphasis on the importance of generativity in aging.

Isserman, Hollander-Goldfein & Horwitz (2017) used qualitative research to explore the coping styles of ninety-five Holocaust survivors and their families to examine how they coped, adapted and rebuilt their lives after the Holocaust. The study was conducted under the Transcending Trauma Project (TTP) and was conducted in Philadelphia in the U.S.A. The research team looked at family dynamics and early attachment, the impact of the war, meaning making, resilience and beliefs. The narratives were analysed using grounded theory, and the findings indicated that adaptive coping mechanisms utilised by survivors during the war continued to be evident as they aged. The TTP identified that the quality of early family relationships was one of the key elements that underpinned resilience in the aging survivor. Isserman et al.’s (2017) research demonstrated that positive family of origin attachments help to create adults who hold positive beliefs about themselves. The opposite was true for negative family of origin relationships, where adult children described problems in coping during their adult lives (Hollander-Goldfein, Isserman & Goldenberg, 2012). Attachment theorists have noted that in a supportive family of origin, caregivers create secure children who develop stable adult personalities (Ricks, 1985). These early attachments appear to continue to shape well-being and resilience even for older adults (Hollander-Goldfein et al., 2012). Children with a positive sense of self may have been able to access emotional resources that enabled them to employ productive, focused coping abilities. Paris (2000) presented a biopsychological stress-diathesis model of post-traumatic stress to explain resilience in aging survivors, also suggesting that when survivors had a pre-war positive experience with their family this served as a protective factor against the development of PTSD. “In other words, survivors may have established secure relationships with their attachment figures, which in turn may have served as a buffer against the atrocities they have endured, enabling their proper functioning after the Holocaust” (Barel et al., 2010, p. 679).

According to Kellermann (2001), Holocaust survivors differ from one another in a multitude of ways, including developmental history, nature of traumatic war experiences and post-war acculturation and adjustment. The most striking difference lies in how they differ regarding vulnerability and resilience. Although leaning towards a pessimistic view as discussed earlier, Dasberg's (1987) review of the literature suggested a mixed picture of post-war adjustment. He described the more resilient survivors as 'hardening', with the connotation that adjustment was at the expense of a full emotional life. Dasberg (1987) maintained that survivors emotionally constricted to avert dealing fully with trauma and mourning. An intrapsychic understanding suggests that under severe circumstances the employment of core defence mechanisms, specifically repression of negative childhood experiences, may facilitate long-term adaption (Sigal & Weinfeld, 2001). As previously mentioned, Dasberg (1987, 2001) suggested that survivors who coped well used splitting as a defence to cope with their inner turmoil and adapt in the outside world. In alternative language, what Dasberg (2001) refers to as "splitting" may be more clearly understood as repression, suppression or compartmentalisation.

Some empirical support for the idea that under the kinds of circumstances faced by children within the Holocaust the subsequent employment of repression related defences may be constructive comes from research on aging survivors conducted in Australia (Joffe et al., 2003). One hundred Holocaust survivors were compared to controls on measures relating to PTSD, brief psychiatric rating scales and impact of events scales. Survivors displayed worse scoring on all psychological measures when compared to controls. However, the groups were equal in social and instrumental functioning. Thus, despite their vulnerability to mental health conditions survivors appeared as functional in carrying out the tasks of everyday life as the controls.

Although Joffe et al. (2003) found positive adjustment in areas of life for the survivors they assessed, other studies do not support their findings. Amir and Lev-Wiesel (2003) compared a group of 43 aging child survivors with 44 non-survivors living in Israel. PTSD symptoms were measured, as well as subjective quality of life and psychological stress. Results demonstrated that child survivors had higher PTSD scores, higher anxiety, depression, anger, somatisation, and lower social, psychological and physical well-being scores when compared to the control group. The results suggested that the psychological damage of the Holocaust is enduring (Amir & Lev- Wiesel, 2003). Thus, in this instance mental health difficulties went along with other

forms of problematic life adjustment. It is probable that the two sets of difficulties were inter-related as longer-term consequences of Holocaust trauma exposure.

Barel et al. (2010) conducted a meta analytic study looking at the long-term physical, psychiatric and psychosocial consequences of their experiences in the camps for Holocaust survivors. In 71 samples from worldwide research on Holocaust survivors, 12,746 participants were compared with non-Holocaust survivors on psychological well-being, post-traumatic stress symptoms, cognitive functioning and physical health. Holocaust survivors showed more post-traumatic stress symptoms and were generally less well-adjusted when compared to controls. However, the Holocaust survivors showed remarkable resilience in their general functioning such as in enjoying good health, and in the ability to manage general stress and in their cognitive functioning. "The coexistence of stress related symptoms and good adaptation in some areas of functioning may be explained by the unique characteristics of the symptoms of Holocaust survivors who combine resilience with good defence mechanisms" (Barel et al., 2010, p. 677). This seems an important overview of the research findings to date and the conclusions appear to lean towards the recognition that defence mechanisms that might be understood as maladaptive in more 'normal' contexts proved to be adaptive to Holocaust survivors in their post-war adjustment.

Barel et al. (2010) go on to elaborate that their findings reflect the dynamic employment of defence mechanisms that Holocaust survivors used during and after the war. The successful use of defence mechanisms, such as denial and suppression, may have enabled survivors to successfully repress their traumatic experiences in uncontaining conditions (Shanan & Shachar, 1983). Mazor et al. (1990) proposed that the employment of these kinds of defence mechanisms facilitated a process whereby Holocaust survivors were able to focus on good adaptation when rebuilding their lives. Barel et al. (2010) suggested that in the process of building families and achieving in their lives, child survivors further reinforced their protective mechanisms. Rutter (2012) suggested that self-esteem and competency are constructed in childhood and adolescence. However, they are open to being reconstructed during adulthood through supportive interpersonal relationships and productivity. Barel et al. (2010) suggest that by building their lives in a positive manner, survivors built their "acquired self-protective mechanisms" (p. 692) that served to protect them against "dysfunction in several domains" (p. 692).

Certain specific personality characteristics may be associated with resilience in Holocaust survivors (Ayalon, 2005; Barel et al., 2010). Helmreich (1992) found ten qualities in Holocaust survivors that may have enabled them to function in an adaptive manner, despite the trauma experienced. The qualities included optimism, tenacity, flexibility, intelligence, assertiveness, distancing ability, group consciousness, integration of the knowledge that they survived, courage and finding meaning. It will be evident that these kinds of qualities would also contribute positively to the building of a sense of integrity in later life. Helmreich's (1992) analysis indicated that survivors who led successful lives demonstrated more of these qualities, although not all qualities were found in every survivor. Barel et al. (2010) explained that the traumatic experiences inflicted during the Holocaust were from strangers, and not the survivors' own parents or others to whom they were attached. Hence, these actions may not have undermined basic trust in the way that caretaker inflicted abuse has been shown to do, producing highly ambivalent internal working models (Bakermans-Kranenburg, Van IJendoorn & Juffer, 2003).

Fridman, Bakersman-Kranenburg, Sagi-Schwartz and Van IJendoorn, (2011) used a case study method comparing 32 elderly Holocaust survivors and 33 elderly non-Holocaust survivors living in Israel. Fridman et al. (2011) presented their findings in an Eriksonian (1982) developmental framework and argued that it was clear that the Holocaust experiences destroyed the trajectory of normal psychological development., The obstacles in the process of developing ego integrity and accepting and integrating life experiences led to a sense of depression or despair in many survivors as they struggled to draw upon more positive than negative life memories and experiences. Fridman et al. (2011) observed that dissociative propensities appeared to fragment the memory of painful experiences and prevented adequate processing of traumatic memories in their sample. This led to symptoms of derealisation, depersonalisation and even possible hallucinations. Thus, in their study it appeared that the over-use of dissociative defensive styles produced particular kinds of difficulties in end of life stages even if these defences had been adaptive at earlier points in life.

The discussion above illustrates that it has been unequivocally demonstrated that survivors suffer from symptoms of post-traumatic stress, decades after the Holocaust (Barel et al., 2010; Cohen et al., 2001). However, the findings regarding apparently good adaptation and resilient functioning are understood differently by different theorists and groups of researchers. Whilst some theorists affirmed the resilience of survivors and explain their resilience to be a capacity

that developed from early good enough attachment (Klein 2012; Valent; 1998) and particular kinds of personality features and aptitudes, other writers explained survivors' adaptation and life success to be a function of employment of strong defences such as splitting (Dasberg, 2001), depersonalisation and dissociation (Herman, 1992; Laub & Auerhahn, 1993; Wardi, 1992). These defences, that may broadly be understood as entailing a form of compartmentalisation, enabled coping both within the camps and war-torn environments as well as in subsequent environments where there was some appreciation that trauma associations could not be entertained either because of limited personal capacities or the absence of external supports.

The debate in the literature regarding aging survivors as resilient versus vulnerable continues. Kellermann (2009) offers a way of reconciling this debate by presenting the concept of "paradoxical integration" (p. 34) to describe the way in which survivors as a group are both vulnerable and resilient. This concept includes both the aspects of victimhood and survival, severe traumatisation and post traumatic growth. In Kellermann's (2009) terms – paradoxical integration is inclusive of both the legacy of courage and the trauma of victimisation. The literature review will now look at the aging survivor's capacity to make meaning in Erikson's (1965) stage of integrity versus despair.

2.8.4 The Critical Issue of Ego Integrity and Meaning

According to Erikson (1965), acceptance of one's life story, with positive and the negative experiences, facilitates the process of ego integration. To assign meaning to one's life trajectory involves the individual being able to accept both the negative and positive experiences, which allows for accepting and enduring the inevitable losses associated with aging. With the acceptance of one's life story, the individual is able to look back retrospectively and find a sense of satisfaction in the final stage (Aarts & Op den Velde, 2007; Erikson, 1965).

For McFarlane and Van der Kolk (2007) attachment in childhood is understood to offer a basis for protection against existential meaninglessness in adulthood. According to Klein (2012), a strong ideological or religious identification was helpful in coping and providing survivors with meaning, purpose and hope for the future. Mc Farlane and Van der Kolk (2007) agree that religion universalises suffering and offers a larger context for this suffering, enabling traumatised individuals to connect more with their experience of suffering. McFarlane and Van der Kolk (2007) noted that victims usually emerge from a trauma feeling that the suffering they

endured was meaningless, feeling overwhelmed with loss, anger and betrayal. The sense of meaninglessness in the face of trauma is a painful experience, as victims feel abandoned by a God and betrayed by man. “Usually suffering does not bring an increased sense of love and meaning: rather it results in loneliness and the disintegration of belief” (p. 26).

Many Holocaust trauma survivors felt psychologically unsupported by their families and communities after the trauma had happened. In addition, they felt blamed for their own suffering in some respects and reported that this left deeper scars than the traumatic event (Danieli, 1986; Durst, 2003; Lifton, 1979). They carried a sense of shame and disgust about not being able to protect themselves against the perpetrators, despite their survival. As such, the experience of shame and feeling unsupported by their communities became part of the traumatic experience. (Durst, 2002).

According to Hass (1995) many survivors who lived successfully did not forget the Holocaust. Rather, they found a sense of meaning in living to tell the story of what they endured and witnessed. Des Pres (1976) suggested that motivation to survive was to speak out and “to let the world know” (Des Pres, 1973, p. 671). Laub (1992) quoted a Holocaust survivor who said: “We wanted to survive so as to live one day after Hitler, in order to be able to tell our story” (p. 78). Hass (1995) made the following comment about resilient survivors: “There are those among them who have much to teach us about survival and successful coping under unbelievable circumstances” (p. 73).

Klein (2012) explained that after the confrontation with death, the search for meaning was a defence against the threat of robotisation and fragmentation as a result of Holocaust trauma. He observed that the search for meaning was important in the search for survival and the process of recovery after the Holocaust. Victor Frankl a young doctor from Austria at the time of the Holocaust wrote about his experiences in Auschwitz in his famous book *Man’s Search for Meaning* (1962). He draws attention to the importance of finding meaning as an avenue of survival. He described his experiences on a death march and wrote of how he clung to his wife’s image and the hope of finding her after the Holocaust. Frankl (1962) described that in the contemplation of his beloved wife he was able to endure suffering. “The truth - that love is the ultimate and the highest goal to which man must aspire. The salvation of man is through love and in love” (Frankl, 1962, p. 56-57). Frankl argued that even in the desperate place of the

Holocaust, humankind is able to find meaning in suffering, by choosing to engage in certain behaviour even in dire circumstances.

Although Klein (2012) and Frankl (1962) wrote from different psychological perspectives, both gave credence to attachment as a core foundation that helped survivors cope and survive terrible ordeals. Frankl (1962) named the longing for an attachment figure as a driving force behind the will to survive and understood loving attachments as imbuing life with meaning. Klein (2012), coming from a Winnicottian perspective, emphasised the core expression of hope as a guiding factor in survival and revival after the Holocaust. While Frankl (1962) does not offer a developmental theory, Klein (2012) proposes that early, pre-Holocaust positive attachments enabled survivors to have a sense of ego mastery. This enabled them to hold onto a sense of self that was not lost during the Holocaust. After the Holocaust, the internalisation of early positive attachments enabled the survivors to hold onto a sense of hope in the revival and the building of their lives. From the experience of positive attachments, a sense of self developed which was able to survive the destruction. One was able to find meaning in suffering by then re-building one's life after the Holocaust (Frankl, 1962). In part this meaning was derived from creating new attachments such as to partners or offspring, however, this also left survivors vulnerable to renewed loss of attachments in later life stages.

For aging survivors who had become parents the eventual separation from children and their leaving home is coloured for survivors by their tainted past of being deserted and forcefully separated from their own parents. The emptiness which emerges may become filled with the threat of abandonment and an experience of 'no object'. The departure of children from the home or even the country may mean that there is no longer a distraction from their own trauma. Some may feel that they are losing their families for the second time, because of such emigration. In the South African context where rather high proportions of adult children emigrate, as is the case in a number of Jewish families over the last three decades, the survivor's feelings of loss may be reactivated. Nevertheless, on balance it seemed that having children brought increased life meaning for survivors even if this left them vulnerable to the pain associated with inevitable separations.

Ultimately it seems that attempting to engage as ethically as possible with what life brought both within the camps and in life thereafter was what was important to many survivors in the establishment of meaning. For Klein (2012), accepting responsibility for one's behaviour was

a way in which, for him, meaning could be gleaned from suffering. According to Klein (2012), "Paradoxically, the experience of the Holocaust offers a glimpse of hope for the triumph of life over death and destruction" (p. 31). Some of the ways in which meaning is derived relate centrally to hope and to creativity as is elaborated further.

2.8.4.1 Hope and Creativity

According to Nedelmann (as cited in Klein, 2012), Klein understood Holocaust survivors from a perspective of "meaningful life experiences rather than psychic damage" (p. 13). In keeping with some of the earlier discussion, Klein (2012) commented that the literature was saturated with works on the psychopathology of survivors. According to Klein (1992), signs of recovery and renewal were signs of hope, and without hope, there was no way forward. He told his German colleagues that hope is hardly mentioned as an analytic theme and maintained that it was critical that therapists find hope in themselves and in their patients. Hope is an important part of ego organization in coping with active hopeless feelings in painful states. Hope is regarded as the condensation of the total reservoir of internal good objects and fantasies projected onto the future, using relevant experiences from the past and actual fragments of external information, in the service of psychic survival (Klein, 1974, p. 300). Erikson (1965) also emphasised the importance of hope in the life cycle, beginning as part of the establishment of trust in infancy; and hope is critical in the process of developing wisdom and ego integration in old age.

The formation of new 'family networks' to provide both physical and psychological succour in the camps has been mentioned already. Common experiences such as praying, singing and conveying universal and personal strivings for hope and love, were important group activities, antidoting dehumanisation and supporting the self, and the ego ideal, in attaining mastery over trauma (Klein, 1983). Klein (2012) explained that universally, Holocaust survivors identified with Kiddush Hashem (sanctification of God) as it gave meaning to their Holocaust experience and also instilled hope for the passing of torment and the possibility of something better.

In the tradition of his Winnicottian influence, Klein (2012) said: "Creativity was a form of dealing with human losses, the loss of love, the anticipation of one's own death, and most important a way of preserving an image of God in one's self" (p. 25). According to Witztum and Malkinson (2009) a creative process can become a means through which meaning is

constructed, in the face of loss. The creative process can be used as a medium through which to express emptiness and grief and yet to generate something new out of this. Pollock (1978; 1982) studied the life and work of many gifted artists and found that creativity may be an attempt to cope with grief, through reparation.

According to Giberovitch (as cited in Hassan, 2015), aging Holocaust survivors are able to find a sense of meaning when they share their experiences in a public forum, educating others about the Holocaust and in this sense becoming 'creative' in their narration and depiction of material for the absorption by others. Positive psychologists, as well as gerontologists, are interested in how creativity and artistic expression may contribute towards resilience in aging survivors more generally (Corley, 2010).

2.8.4.2 Wisdom

According to Aarts and Op den Velde (2007) there is a parallel trajectory in the developmental task of aging and recovering from trauma. Both processes involve finding meaning in loss. Aging involves an acceptance of one's life experiences, while recovery from trauma requires a level of acceptance that events took place as they did. Both the aging process and recovering from trauma require re-establishing self-coherence and self-continuity leading to a better sense of ego integration.

According to Erikson (1965), the developmental task of old age involves some sense of gleaning wisdom in achieving a sense of ego integration. Trauma theorists including Krystal (1968) and Herman (1992), considered the shattering of the self to be the most damaging phenomenon in trauma survivors. Ulman and Brothers (1988), who were influenced by Kohution and Object Relations theories, postulated that trauma causes a shattering of the self, leading to a split in 'good' and 'bad' self-representations. The focus of recovery is the integration of the self and the re-establishment of coherent self-other representations in trauma survivors (Krystal, 1988; Ulman and Brothers, 1988). Laufer (1988), who studied Vietnam veterans, argued that the splitting of the self is a result of the rupture between a pre-traumatic, traumatic and post-traumatic self. He said that the rupture in the self was caused by the wish to deny the trauma. An attempt was made to fuse the pre-traumatic and the post-traumatic self by bypassing rather than integrating the traumatized self and this left the self-damaged and struggling to function optimally. The traumatic self is regarded with fear and dread, shame and

rage. In order to recover from trauma, integration of these different life experiences is required, a challenging but necessary task. Recovery can be achieved when traumatic affects and memories are acknowledged, and the loss and mourning of the pre-traumatic self can be experienced (Aarts & Op den Velde, 2007; Herman, 2004; Laufer, 1988). Krystal (1981) said that aging Holocaust survivors need to process repressed memories as part of their life review, which involves working through the pain of loss, guilt and shame in order to reach "integrity in aging" (p. 187).

For Eagle, (2013) the attainment of a sense of meaning is possible after a trauma when there is a capacity to assimilate both good and bad aspects of objects.

> It has been suggested that it is only in the transcending of damage and loss that human beings can develop a true sense of resilience and hope. This way of thinking resonates with some notion of what is achieved in the resolution of the depressive position as understood by Melanie Klein (1935). Coming to terms with the trauma may indeed offer an archetypal opportunity to recognize the inter-relationship between the good and bad objects and the necessity for repair and restoration in response to psychic damage. (Eagle, 2013, p. 135).

For Kellermann (2001), who has vast clinical experience in working with survivors in Israel, there is a possibility for Holocaust survivors to find a sense of meaning in terms of finding a positive reason for their survival that replaces guilt. For this process to happen, it is essential that the Holocaust trauma is integrated in some way. "Naturally resolution of the Holocaust trauma is never complete. There will always remain a considerable amount of anger, sorrow, fear and yearning for another reality" (p. 6). However, Kellermann (2001) seems to have thought that finding meaning in their suffering is possible for Holocaust survivors. Religion is a well-recognised form in which individuals attempt to make meaning. Thus, integration in several spheres intrapsychic, cognitive and existential is part of developing wisdom.

2.8.5 Holocaust Survivors' Engagement with God and Religion

Much of what is written about the impact of the Holocaust on the spiritual lives of survivors is based on survivors who were religious. Little has been written on Holocaust survivors who were atheists at the outset. Nevertheless, survivors who were not religious prior to the Holocaust still experienced a change in their world view and meaning making beliefs having lost trust in

a benign world. However, most of the research on Holocaust survivors describes the loss of trust in a benign God. Eli Wiesel (1974) described his experience as a fifteen-year-old boy in Auschwitz:

> Some talked of God, of his mysterious ways, of sins of the Jewish people, and of their future deliverance. But I had ceased to pray. How I sympathized with Job! I did not deny God's existence, but I doubted His absolute justice (p. 53).

The victim of severe trauma of interpersonal origin has a change in his or her sense of self, loses trust in humankind and ultimately questions their sense of faith or systems of meaning. According to Janoff-Bulman (1985), the experience of trauma destroys the survivors' assumptions of safety in the world and challenges a sense of justice and faith in a benevolent creator, leaving many survivors feeling bitter and abandoned by whatever God they previously believed in. Wiesel (1974) described attending a New Year (Rosh Hashanah) service in Auschwitz where he felt angry and alienated:

> My eyes were open and I was terribly alone - terribly alone in a world without God and without man. Without love or mercy… I stood amid that praying congregation, observing it like a stranger (p. 74-75).

According to Klein (2012) Holocaust survivors came to have an ambivalent relationship to God. He quoted a survivor to demonstrate his point: "I either hate God or deny His existence because He let me go through such horrifying experiences or I trust in Him because he performed a miracle in allowing me to survive" (p. 157-158). Klein himself described his ambivalence towards God when he described survivors in the following way: "They are monuments to man's destructive power untamed by centuries of European civilisation. But they are, as well, symbols of rebirth and of man's efforts to preserve within himself an image of God" (Klein 2012, p. 31). Greif (2005) describes the loss of faith in one of the Sonderkommando survivors he interviewed, Ya'akov Silberberg. This participant said he was a devout Jew before the Holocaust but had lost his faith in God as a result of his work in the Sonnderkommando. He said, "If all the trees in the world became pens and all the oceans turned into rivers of ink, one could not write down and fully document what happened in the Holocaust" (p. 311). He continued:

> If this German could take a baby from its mother, grab it by the leg and smash its head against the wall - then faith has lost its value. Seeing something like that, the sight of the baby with its head smashed in, broke me up and destroyed the faith I had (Greif, 2005, p. 330).

In these kinds of quotations, it is evident how intensely camp inmates had to grapple with issues of faith and meaning as a consequence of the extreme cruelty and depravity they witnessed. Lassley (2015) quoted a phrase that was found, carved into the wall of a prison cell at Mauthausen concentration camp, in Austria; "*Wenn es einen Gott gibt mub er mich um Verzeihung bitten*". Translated it means: "If there is a God, He will have to beg my forgiveness"- author unknown (p. 1). For Lassley (2015), this quote serves as a metaphor for the way in which religious, Jewish Holocaust survivors were confronted by an extreme test in their faith. According to Lassley (2015), a central core of Judaism is that God is omnipotent and omnibenevolent. In his view, many survivors felt "If He were omnipotent, He would have been able to stop the atrocities. And if He were omnibenevolent how could he have stood by while these atrocities occurred" (p. 1). He says that every survivor emerged from the Holocaust with a different spiritual perspective, some found a renewed faith and others abandoned their faith in God. However, many became atheist Jews, where they renounced their faith but remained culturally identified.

Juni (2015) described the way in which Holocaust survivors view God as a father figure who let them down. He believed that it is helpful for trauma victims to face their pain on this level. He described the dynamics and interpreted the defence mechanisms related to the sense of abandonment by potent figures evidenced by survivors in the following ways: "I was punished for my sins and misdeeds. God is righteous and I deserved what I received" (Juni 2015, p. 158). Juni (2015) understood this position as justifying God's actions and accepting culpability. In this way, the survivor identifies with the aggressor. "The Holocaust was a punishment for the sins of the Jewish nation" (Juni, 2005, p. 158). Juni (2015) interpreted this as a rationalisation whereby the survivor accepts the punishment as part of a group, rather than feeling personally attacked. "God does not micromanage world events. People have free will to harm others (Juni, 2005, p. 158). Juni (2015) explained that this contradicts the Jewish view of God being omnipotent and is an example of splitting. "A mortal cannot judge and evaluate God's ways. Our intellect and knowledge are minimal compared to his infinite attributes". Juni (2015) maintained that the way in which God's wisdom is defended to circumvent personal reactions

to adversity, is a manifestation of intellectualisation. “Rather than focus on the hardships and pain I suffered, I choose to focus on God’s beneficence, grace, and kindness in saving me”. In Juni’s (2015) view, this manner of thinking blocks negative feelings while focusing on positive feelings and is an example of reaction formation (Juni, 2015, p. 158). From Juni’s various formulations it is evident that there were different ways of attempting to reconcile what was witnessed during the Holocaust with the idea of a God who existed and was present and that people might vacillate in adopting different positions.

Juni (2015) makes the point that defence mechanisms are not curative, they allow disturbing experiences to recede from consciousness to facilitate effective functioning. However, the underlying dynamics remain and will influence personality, relationships and self-concept on a covert level. From his clinical knowledge from working with Holocaust survivors and their children, Juni (2015) argues that object relationships can be extended from a human dimension, to include the relationship one has with God. “We have found consistently that the subjective phenomenological relationship one has with God parallels, and is an extension of, the relationship one has with significant others - particularly parents” (p. 170). For example, in his experience with religious patients Freud’s (1910) observation that “belief in an omnipotent and caring God is a developmental continuation of the all-superhuman archetype of the father in the child’s psyche” (Juni, 2015, p. 170) was reinforced. Juni (2015) said that the growing child transfers the notion of an infallible parent, onto an omnipotent and omnibenevolent God figure whom they then can later feel has betrayed them. Their sense of anger and disappointment can be likened to children who feel a sense of anger at a parent, whom they feel has betrayed their trust by failing to protect them from the viciousness of others (Juni, 2015).

Holocaust survivors were “left with a disturbed sense of theistic object relations. God was no longer trustworthy to interact with them predictably” (Juni, 2015, p. 171) since without warning, trauma could strike, and God be absent, relegated to the role of *Hester Panim* (hiding his face) (Besdin, 1993). Just as one cannot trust a parent who has betrayed this trust, “trust of God as the kind father thus becomes precarious, at best” (Juni, 2016, p. 171). Juni (2015) suggested that there are religious Holocaust survivors who feel a sense of “betrayal by the very God whom one has relied upon for sustenance and protection” since early childhood (p. 171). Where “feelings of neglect and abuse” prevail (p. 172) Juni (2015) stated that this psychodynamic applies for both adults and children - but that the damage is more serious in the

case of children, as they are at a vulnerable developmental stage in which internal object relational dynamics become disrupted by the failure of protective objects.

As mentioned previously, Laub and Auerhahn (1989) said that "failed empathy" (p. 1) is the central experience of Holocaust survivors. They were referring to the rupture between the self and the 'other'. However, the above writers have explained how this rupture may extend to the survivor's spiritual relationship with God. From this perspective, the destruction and rupture of the trauma begin with the self and extends to interpersonal and spiritual relationships (Herman, 1992).

In summary, this literature review has looked at post-traumatic stress in aging child survivors, as well as the affective impacts of trauma. Complex Post Traumatic Stress (Herman, 1992) seems to be a helpful model to describe the impact of trauma on child survivors. Although Herman (1992) primarily used C-TSD to describe survivors of domestic and sexual abuse, she also includes Holocaust survivors owing to their ongoing experience of cruelty in captivity. As previously noted, Kellermann (2001, 2009) acknowledged that C-TDS is a helpful model for understanding child Holocaust survivors. A difference should be noted when comparing child Holocaust survivors to child survivors of domestic abuse as many child survivors of the Holocaust had good parental attachment. In contrast, child survivors of domestic abuse have fragmented attachment as their tormentors are often family members. The debate around resilience versus vulnerability in child survivors was presented as well as their ongoing struggle with PTSD and catastrophic bereavement and the likelihood that such features of experiences become exacerbated in old age was signalled. Kellermann (2009) highlighted "paradoxical integration" (p. 34) where survivors may be viewed as showing both resilience and vulnerability as they age.

Numerous studies show that a high proportion of survivors suffer from PTSD and related symptoms, despite in many instances displaying good adaptive functioning in terms of life tasks. The employment of key defences was highlighted as a central issue in resilient child survivors, who appeared to largely compartmentalise significant past and current experiences in the service of coping. This form of coping has been largely viewed as adaptive and should arguably not be pathologised as it facilitated survival. In contrast, vulnerable child survivors suffered with chronic PTSD and depression and seemed unable to compartmentalise their trauma. However, it is apparent that both groups may become more vulnerable to distress as

aging re-evokes past memories and produces new losses of various kinds. As child survivors reach old age, they have a final opportunity to review their life process and attain a sense of meaning regarding their trauma. However, the process of meaning making is particularly complex for this population who are forced to integrate the reality of having lived through one of the greatest tragedies of humankind, of human origin, and inflicted upon them because of a particular cultural identity. The grappling with existential issues is thus profound for many and previous defensive strategies may become inappropriate, inadequate and even compromising of the capacity to engage with the task of ego integrity versus despair.

3 METHOD

3.1 Introduction

This study embodies theory driven, exploratory and descriptive research as it aims to describe the experience of aging child Holocaust survivors within a particular theoretical paradigm. A qualitative research design was used, more specifically employing a multiple case study method and utilizing thematic content analysis to interpret the data. According to Long and Eagle (2009):

> Good qualitative research involves the assimilation of 'rich data' whereby informants elaborate on a subject of interest and disclose material that may be viewed as 'difficult', conflicted, exposing, intriguing or surprising. In a sense, one could argue that it is that which is being repressed or suppressed by the individual or by society that is of particular interest to qualitative researchers. For those holding a hermeneutic ethic, the aim of qualitative research is to 'uncover' or make visible that which is not transparent" (Long & Eagle, 2009, p. 24).

Based on this kind of perspective of the aims of conducting in-depth qualitative research, qualitative research methods were chosen to explore the experiences of Holocaust survivors who had been interned in concentration camps during their childhood and/or adolescence. In addition, this research aimed to elaborate the present experiences of aging child Holocaust survivors within the context of Erikson's (1965) eighth stage of psychosocial development, 'Integrity versus Despair'.

3.2 The Relevance of Qualitative Research Methodology

Throughout its history clinical psychology has on the one hand been wedded to quantitative research methods, drawing on a largely positivist epistemology; yet on the other hand, similarities between the kinds of analysis undertaken in qualitative research and the judgments practitioners used in understanding clinical material were also noted (Walsh-Bowers, 2002). Qualitative research has provided a response to the need for a contextual social science that speaks from the perspective of those being researched. This contrasts with a positivist approach

that has tended to swallow individual voices in the quest for universal explanations (Kelly, 1999). Qualitative research aims to provide "rich or thick descriptive accounts of the phenomenon under investigation while quantitative research is more concerned with counting occurrences" (Eatough & Smith, 2008, p. 1). Qualitative research is generally theory driven. According to Neuman (1997), qualitative research is focused on describing a phenomenon in an in-depth manner, rather than proving something about it. Qualitative researchers create new theory and concepts by combining empirical evidence and abstract concepts. Instead of testing a hypothesis, a qualitative analyst will demonstrate that a theory, generalisation or interpretation is possible (Neuman, 1997).

Qualitative research methodologists have also challenged the epistemological assumption that quantitative research is value free: "In contrast, qualitative research argues that personal values are an integral part of research, arguing that no research can be truly objective or free of research influence" (Langa, 2012, p. 101). In response to the notion of research influence, reflexivity is a term that captures the idea that knowledge is constructed between the researcher and the participant (Hunt, 1989) and influenced by the researcher's identity, ideology, values, interests and beliefs, whether consciously or unconsciously.

Within the present study, a qualitative research methodology was selected. This decision was partly influenced by the small number of remaining Holocaust survivors who were interned in concentration camps during their childhood and/or adolescent years who were/are still alive in the world, and in South Africa in particular. In addition, the focus of the study was primarily clinical in nature, seeking to document individual histories from a developmental perspective with a particular focus on the apparent impact of experiences surrounding the Holocaust on the mental health and internal and relational worlds of the survivors. As such, a retrospective view was taken examining people's lives both during the event and over the past several decades since the Holocaust ended. A multiple case study approach was used, including a "life history approach" that explored participants' childhoods before the Holocaust, their traumatic experiences during the Holocaust, and the rebuilding of their life after liberation. In addition, participants were questioned about their life at present and how they were coping with aging. This information was gathered through a series of interviews with each participant as will be described further. After the interviews were transcribed, main themes and sub themes were extrapolated from the data. using thematic content analysis. An interpretivist approach was used to understand the psychological dynamics of each case and the similarities and differences across cases were explored. Thus, both intra- and across-case analyses were conducted.

Employment of qualitative methodologies enabled the in-depth understanding of the life experiences of the nine Holocaust survivors who were interviewed in the study.

3.3 Location of the Research within Qualitative Methodology

In providing some background to the research approach employed in this study certain philosophical debates concerning epistemology and ontology will be briefly discussed. Qualitative methodology has emerged as a movement that has brought an interpretive influence to social science epistemology (Rabinow & Sullivan, 1979), contributing to 'contextually located' research, which is less concerned with universal patterns of human behavior and more concerned with making sense of subjective aspects of human experience (Kelly, 2006).

3.3.1 Realism and Constructionism

Within the qualitative research paradigm two central perspectives are entertained that can be viewed as differing in the degree to which they embrace a realist, as opposed to a social constructionist, view of the world (Banister, Burman, Parker, Taylor & Tindall, 1994). This research aims to understand how Holocaust survivors experienced their worlds and adopts a largely 'realist' perspective, for example in assuming that accounts given by participants reflect aspects of their 'real' or factual life circumstances. The social constructivist approach places greater emphasis on how individuals construct meaning in their social world, including for example, what discourses they draw upon to explain their experiences and how they seek to position themselves in their accounts. This form of investigation is not the focus of the present study, although some elements of such an approach to data analysis will be evident where these appeared salient. "In some sense a constructivist approach can be construed as interested in "surface" as opposed to hermeneutic or interpretive traditions which are interested in depth" (Eagle, 1998, p. 191). In addition, the realistic interpretive approach emphasizes the understanding of phenomena within their context, in an empathic manner, whilst social constructionism involves a more distanced and skeptical approach (Kelly, 2006). Given the nature of the population being researched and the clinically oriented focus of the study a more experience near approach was considered preferable.

Hermeneutics refers to the theory (Eatough & Smith, 2008) or "business" of interpretation (Miller & Crabtree, 1992, p. 110) and has its origins in a structuralist understanding of the

world. Interpretation involves the process of linking surface manifestation to underlying phenomena. According to Eagle (1998), much clinical research is based within this specific interpretive tradition. Within interpretive research, looking for differences is given the same importance as looking for commonalities (Kelly, 2006). By this means, we come to understand what is distinctive about individual cases or contexts as well as coming to appreciate processes that may reflect commonalities across cases. The present research is located within a psychodynamic theoretical perspective and employed psychodynamic and related constructs to comment on 'underlying' phenomena where appropriate. Thus, the hermeneutic approach to the data was informed by this particular theoretical approach.

3.3.2 The Psychodynamic Approach to Qualitative Research

The guiding epistemology of the present research was that the data could legitimately be read through a broadly psychoanalytic or psychodynamic lens (*psychodynamic* approaches being viewed as aligned with but more broadly encompassing than *psychoanalytic* research traditions). According to Frosh and Young (2008), "psychoanalytic interpretive strategies throw light on conscious and unconscious processes, including emotional investments and fantasy, which can enrich the interpretive understanding brought to bear on personal narratives arising out of interview situations" (p. 110). For psychoanalytic researcher's communication is mediated by relational dynamics and will also reflect psychic structures that organize the individual's internal world. From this perspective, how external events and social events are acknowledged, understood and conveyed, is necessarily influenced by the individual's internal world. Individuals express themselves based on internal and relational dynamics, resulting in forms and patterns of communication that will differ from individual to individual. A psychoanalytic interpretation of a text will, for example, interpret themes that are indicative of anxieties, defenses and attachment behavior that may have begun in infancy and been repeated throughout the life of the individual.

Hillel Klein (1983) suggests that the psychodynamics which give rise to the emotional characteristics of survivors are historically and psychologically unique and argues that any effort to compare them to other population groups can only serve to blur distinctions and what may be unique to each group. Klein (1983) contends that psychoanalytic insights may deepen the understanding of the specific conflicts and psychological defenses utilised, as well as the meaning of life during and after the Holocaust. In his research with survivors, Klein (1983,

2012) found that the Holocaust remains with survivors in their conscious and unconscious life, as evidenced in dreams, memories, discussions and writings. Klein (1983, 2012) argues that it is essential to explore individual survivor's memories and experiences of their pre-Holocaust past, family and personality, as well as their subsequent experiences. Survivors have psycho-historic identities as individuals and belong to diverse social groups in which specific value systems and cherished traditions abounded. In addition, traditional defenses, that are transmuted from one generation to another, characterized and influenced their experience of the Holocaust as well as their later adaptation to life as survivors. The period of early history, as emphasized in psychodynamic formulations, is crucial in shaping later development, adjustment and individual ways of functioning. The research with Holocaust survivors should seek to do justice with regard to offering credible interpretations with regard to life events and experiences. However, it is also recognized that there may be some commonalities of experience and in this respect cross-case analyses may also be usefully undertaken to complement 'within case' analysis.

Erikson's' (1982) 'Psychosocial Approach' looks at the development of the ego in relation to social reality as discussed in the literature review and can be viewed as broadly psychodynamic in orientation. Concepts articulated in Erikson's' lifecycle approach (1982) were drawn upon to examine the developmental disruption that took place in each of the participant's lives as a result of the Holocaust, as well as to elaborate some of the long-term effects of the trauma. However, it will be apparent that psychoanalytic and psychodynamic analyses of the interview data drew upon theory beyond that advanced by Erikson (1982).

3.3.3 The Interpretive Phenomenological Approach to Qualitative Research

The aim of interpretive phenomenological analysis is to explore how research participants make sense of their personal and social worlds and informed the analytic stance within the research endeavor. The main emphasis of this approach is to examine the meanings that particular events and experiences hold for participants (Smith & Osborn, 2008). The emphasis of phenomenology lies in its examination of the participant's lived experience. It attempts to explore the individual's personal experience, perceptions and account of an event, as opposed to producing an objective account of an event (Langa, 2012). An interpretive phenomenological approach, combines empathic hermeneutics and questioning hermeneutics. This approach

acknowledges the importance of the researcher's role in the process in that the researcher attempts to 'get close' to the participant's world and is involved together with them in a process of interpretive activity. "The word 'understanding' captures two aspects of interpretation: understanding, in the sense of identifying or empathizing with, and understanding, as in trying to make sense of" (Smith & Osborn, 2008, p. 54). Allowing for both aspects leads to a richer analysis of the research data and does justice to the understanding of the research participants. Thus, in interpretive phenomenological analysis, two stages of interpretation are involved: firstly, the participants are encouraged to make sense of their world and secondly, the researcher is invested in making sense of the participants trying to make sense of their world. In this instance the interview accounts were viewed as offering a picture of how participants retrospectively attempted to capture, describe and make sense of their experiences during and surrounding the Holocaust and how this significant life experience had impacted upon their lives. This approach to data collection and analysis was viewed as compatible with the psychoanalytic interpretive stance in that it was this theoretical framework that informed the interviewer's sense-making process.

A distinctive feature of the interpretative phenomenological approach is its detailed interpretive account of the cases used for research. According to this approach, a small number of cases or subjects of investigation is sufficient to produce a suitably penetrating analysis. Thus, in simple terms, one may fruitfully sacrifice breadth for depth. This approach seemed appropriate to examine the participants' existential understandings of the impact of the Holocaust on their life trajectories including their engagement with ego integration versus despair.

3.4 The Case Study Method

Historically both psychological and psychiatric case histories have been used in clinical research to gain a better understanding of patients, as well as to formulate appropriate treatment approaches. The case study method is an important means by which theory can be generated and illustrated and can be employed to demonstrate how different aspects of an individual's life are inter-connected (McLeod, 2001).

Bromley (1986) defines a case study as "the way we describe and analyze a person's behavior and psychological characteristics in relation to a set of circumstances. It is essentially a reconstruction and interpretation of a major episode in an individual's life" (p. 3). According to

Yin (2009), the case study method has been stereotyped as the "weak sibling" among social science methods as it has been viewed as having insufficient scientific rigor and provides little basis for scientific generalization (p. 10). However, Yin (2009) argues that the case study method is the "preferred strategy when 'how' or 'why' questions are being posed, and when the focus is on a contemporary phenomenon within a real-life context" (p. 13). In addition, the case study method is appropriate and useful when the researcher's goal is to expand and enrich existing theory, rather than to enumerate statistical generalizations.

The case study research method refers to the use of a descriptive, exploratory research approach that is used to generate an in-depth analysis of a person, group or event (Christensen, 1994; Yin, 2009). Case study research generally employs a single case design but can also be based on a multiple case design where replication in addition to sampling, is the criterion for inclusion. The case study method is based on the idiographic approach. This means that the focus is on the individual case without reference to a comparison group (McLeod, 2008), although in multiple case study designs some element of similarity across cases is often investigated. According to Bromley (1986), the scientific character of the idiographic approach is derived from the fact that abstract concepts are applied enabling the researcher to reach a deep understanding of individual cases. The aim of the idiographic approach is to deepen knowledge about human nature. The case study approach views each individual as unique and as acting in a unique context, in which the assumption of general laws of human behavior is not necessarily desirable or possible. The case study method emphasizes the complexity of the individual and often serves as a starting point from which ideas or principals may be generated for subsequent theory building (Gerdes, 1988).

The present research utilized a multiple case design. This has advantages over a single case design as the approach is considered to be more compelling and robust (Yin, 2009). The replication of cases is not seen as having a sampling logic but rather as paralleling the replication used in multiple experiments. According to Yin (2009), each case must be selected so that it predicts similar results or produces contrary results for predictable reasons. Yin (2009) states, "the ability to conduct six to ten case studies is analogous to conducting six to ten experiments on a related topic" (p. 53). The case study method emphasizes the use of multiple sources of evidence, including interviews, observations, records, physical artifacts and participant observation. This research followed a case history methodology adopting a chronological narrative structure in the gathering of information concerning events over time,

although this structure was not rigidly adhered to as participants themselves sometimes took the discussion into different life periods or stages. It will also be evident that the initial phases of the interviews were more present than past history focused in order to allow for some rapport building before moving into discussion of more difficult material. The interview was formulated from a retrospective life history perspective as will be further elaborated in a subsequent section. According to Bromley (1986):

> A life history approach is a scientific reconstruction and interpretation, based on the evidence available, of the major formative and critical episodes in a person's life. A life history is based on subjective data (subjective evidence) and objective data (observation, factual records, testimony) (p. 8).

In the case of the present study the emphasis was upon subjective data in keeping with the interpretive phenomenological approach adopted.

3.5 Thematic Content Analysis

Content analysis is defined as "any research technique for making inferences by systematically and objectively identifying specified characteristics within a text" (Stone, Dunphy, Smith & Ogilvie 1969, p. 5). Content analysis is applied to the examination of texts, including interviews, speeches and films. The procedures entailed within content analysis are designed to reduce and categorize large volumes of material into more meaningful units, from which interpretations can be made (Eagle, 1998). Thematic content analysis is the term used to describe an interpretive application of a method, where the focus of analysis is on the thematic content. This content is identified, categorized and systematically scrutinized (Banister, Burman, Parker, Taylor & Tindall, 1994; Berg, 1995). This method of organizing and describing data enables the researcher to interpret aspects of the data in relation to the research topic (Boyatzis, 1998).

According to Braun and Clarke (2008), thematic analysis is widely used in psychology, yet it has not been methodologically structured or properly acknowledged until relatively recently. Thematic analysis entails a systematic search across a data set to find repeated patterns of meaning. It is flexible in that it is not dependent on theory and epistemology; therefore, it can be applied across a range of theoretical approaches. In addition, it is a useful research tool that

can potentially provide a rich and complex account of data. Thematic analysis can be employed as a realist methodology that reports on experiences and texts as representing the reality of participants. Alternatively, it can be employed as a constructionist method that examines a range of discourses operating in a society. For the purpose of this study, a realist epistemology together with a psychodynamically inflected analytic approach was used to generate findings from the data that spoke to the original research aims.

Thematic content analysis was a helpful methodology as it facilitated the identification of major themes both within and across the nine case histories, the latter enabling the researcher to crystallize major themes that were common to all the participants. A theme captures a critical meaning of the data in relation to the research question and represents a pattern of responses, or meanings, within the research. Existing theory and research findings generally create some awareness for the researcher of themes that may potentially emerge in the data, although there is also a need to remain open to emergent ideas. Theoretically led thematic analysis drives the construction of themes and the processing of the data in a largely inductive manner. The epistemological and theoretical perspective of the researcher informs the way in which the researcher conceptualizes the meaning of the data and influences the sorting of material into key themes (Braun & Clarke, 2008). As will have been evident from the discussion thus far the analysis was influenced by interrelated aspects of developmental, psychodynamic and clinical theory.

Thematic content analysis falls under the umbrella of interpretive analysis. Thematic analysis involves immersion which means becoming familiar with a phenomenon, carefully reflecting on it and then attempting to capture an interpretation in writing. According to Kelly (1999), it is not enough to look only for commonalities across research material. In interpretive research, one looks for differences across cases and gives them the same priority as commonalities. A key principle of interpretive analysis is to stay close to the data and to interpret it from a position of empathic understanding. According to Geertz (1973), an anthropologist, the purpose of interpretive analysis is to provide “thick description” (p. 139), i.e., a thorough description of the characteristics, processes, transactions and contexts that constitute the phenomenon being studied; as well as of the researcher’s role in constructing this description.

3.6 The Research Question

Within qualitative research the questions that inform the research are often exploratory and open-ended (Eagle, 1998) and tend to be phrased per the defining interest of the researcher, usually led by theoretical and/or empirical observations. In the case of the present research, the broad aim of the study was defined as follows:

To explore Holocaust-related experiences of traumatization, loss and adjustment in elderly child survivors living in South Africa.

Within this overarching aim four constituent aims were identified:
1. To provide a retrospective consideration of the Holocaust experiences of child survivors with a focus on developmental disruptions and impact on subsequent life trajectories
2. To identify and explore the effects of the Holocaust on the mental health and well-being of survivors with a particular focus on features of complex post-traumatic stress
3. To examine what forms of coping and defense survivors employed to negotiate their life circumstances and the possible impact of such adaptations
4. To explore how aging Holocaust survivors negotiate the life stage of integrity versus despair with specific reference to cultural identity, spirituality and current life circumstances in South Africa

3.7 The Participants

3.7.1 Terminology

Within qualitative research, there is a resistance to using specific scientific language regarding the individuals from whom the data is collected (Eagle, 1998). The term "subject" is viewed as "representing a hierarchical relationship between the researcher and the researched, objectifying the participants, privileging the researcher's management and interpretation of human experience and denying the commonality of humanity" (Eagle, 1998, p. 206). From this perspective, it is a convention within qualitative research to use terms such as informant, participant and interviewee to describe the 'subjects' of the study (Banister et al., 1994). The researcher has chosen to use the word participants in the present study since it was recognized that in many ways the participants were more knowledgeable regarding the Holocaust than the

researcher. They were thus viewed as co-constructors and co-creators of the project in many respects.

In considering the sensitive topic of Holocaust survivors the term "subject" is likely to be particularly offensive given the way in which survivors were dehumanized and involuntarily used for scientific experiments. For this reason, it was especially important that participants did not feel objectified in the research process. Awareness of this history informed engagement with the participants throughout the study. However, it is acknowledged that the research process inevitably involves a hierarchical relationship which was reinforced by the participants' knowledge that the researcher was a practicing clinical psychologist.

3.7.2 Participant Grouping

Within the present research, the intention was to study a relatively homogenous group in order to focus on trends and similarities, although diversity of response was also of interest. Since the aim of the study was to glean in-depth information from participants it was decided that rich data from a smaller number of participants was appropriate to the study aims. There were also issues with availability of potential participants given the relatively small number of living Holocaust survivors in South Africa, as mentioned previously. This study was based on a group of nine participants. An attempt was made to control for homogeneity in the group in several respects as elaborated below.

3.7.3 Criteria for Inclusion as Participants

The participants of the research comprised of five female and four male child Holocaust survivors, nine participants in total, all of whom meet the following criteria:

1. The participants were fourteen years old, or younger, when the Holocaust began in 1939. This ensured that all the participants were children or adolescents when the Holocaust ended in 1945.
2. The participants were interned in concentration camps at some stage during the Holocaust. Since this study focused on trauma, the experience of being imprisoned in a concentration camp meant that all participants were subjected to somewhat similar traumatic conditions.
3. At the time of the interview the participants lived in South Africa and had been living in South Africa since World War II.

4. The participants were psychologically lucid and had good verbal skills, in order to relate their story. (For example, if a person had been diagnosed with Dementia they would have been excluded from the study.) Since the participants were all elderly individuals (generally in their late seventies or eighties) it was considered important to ensure that they were lucid enough to provide reliable data.

3.7.4 Identifying and Recruiting Participants

At the outset of the study I met with the director of the Holocaust and Genocide Museum who introduced me to a Holocaust survivor who is the head of the South African Holocaust Survivors Association. Both parties agreed to help recommend possible participants and four initial candidates were identified via this channel. Despite the assistance of these individuals and organizations it proved very difficult to find participants who met the inclusion criteria and the search was extended beyond Johannesburg via contact with The Jewish Board of Deputies in Cape Town. Two possible participants were suggested, one of whom was assessed to be too emotionally fragile to be asked to participate and the other of whom was included in the study. As the interviewing process began, a further four participants were suggested by the two initial contact persons and ten participants were thus deemed suitable and were willing to make themselves available to participate in the study.

Each potential candidate was contacted telephonically and their permission to participate in the study was requested. Only one respondent declined at this point. The other nine candidates agreed to be interviewed with an awareness of the aims of the study. However, of the nine participants, only eight were able to complete the full interview process. One respondent told me that she had never spoken about her story but would try to do so. I met with the candidate three times. After beginning the interview process, and discussing her early life before the Holocaust, this participant said she was unable to speak further. She reported that simply discussing her family background had triggered nightmares and a feeling of ‘dread’ regarding telling her story. I assured her that she would not be pressurised to continue with the process if she found it too difficult. Aspects of the case material from this ninth person are included in the study since it appeared that her engagement with the interview process offered a salient illustration of how difficult it can be to talk about Holocaust trauma even after many decades have passed. The participant was also eager to have the material she had shared included in the

research write-up. All nine respondents had choice regarding where the interviews would take place and eight elected to be interviewed at their home and one at my office.

3.8 Data Collection

The qualitative data was collected by means of semi structured, face to face interviews. In order to prepare for the interviews, I obtained permission to watch the Spielberg Testimonial Videos. In these interviews, participants were asked to tell their story to a trained journalist. Most of the prospective informants for the study were interviewed as part of this documentary that was undertaken during the 1980s. Information from the relevant videos was transcribed to provide some background information on the histories of survivors. This information proved to be important in cueing relevant areas of questioning, particularly regarding the participants' experience of loss and trauma. In addition to the interviews, all participants voluntarily showed me pictures of themselves shortly after the Holocaust ended. and one participant sang a song and one recited a poem. The significance of this data will be reflected upon and discussed in the findings section of the thesis.

3.8.1 The Semi-Structured Interview

The semi-structured interviews were conducted face-to-face by me as the researcher. The interviews took several hours and required ongoing contact over a period of weeks. Interviews provide the following advantages for data collection:

- Interviews can provide access to subjective meaning
- They permit investigation of complex phenomena
- The contact encourages reflexivity in the research process, and;
- They represent an approach to conducting research *with* rather than *on* people, an important consideration in clinically sensitive areas (Banister et al., 1994). Although the interactional component influences the data collecting process, which is addressed through reflexivity, face-to-face contact allows for direct observation of non-verbal cues in the participant and "facilitates greater intimacy in the interview context" (Eagle, 1998, p. 212).

All of these features of face-to-face interviewing were deemed relevant to the study.

3.8.2 Interview Content and Structure

With the guidance of the research supervisors of this study and based to some extent in the related literature, a structured interview format was compiled. This structured interview format was helpful in covering all the areas that needed to be addressed with participants. In addition, some of the participants spoke tangentially and the interview schedule was the tool with which it was possible to re-establish focus within the interviews. As was anticipated the participants spoke about very traumatic material. From this perspective the structured interview also served to contain both parties and to pace the interview. The interview schedule can be seen in APPENDIX 3. The purpose of this discussion is to highlight relevant aspects of the schedule and to demonstrate how it was helpful in collecting data.

To begin each set of interviews biographical information was collected. Initially, the interview focused on the participants' present life: *"Tell me about your present life*", including soliciting information about work, health and family life. This gave me an opportunity to connect with the participants on a more 'social' or 'surface' level. This also provided the opportunity for the participant to get accustomed to me before moving towards elaboration of traumatic material. The next section began with: "*When did you first begin to talk about the Holocaust?".* This was a gentle move towards focusing the interview on the Holocaust and served to probe the extent to which the participants were able to verbalize their Holocaust experiences. This question also gave some indication of the participants' psychological defense style, particularly with regard to Holocaust related experiences

In accordance with psychodynamic theory, Hillel Klein (2012) stated that the individual's early childhoods and personality features, prior to the Holocaust, were critical in understanding the impact of traumatic experiences and recovery after the Holocaust. As the present research was informed by psychodynamic theory, the third section of the interview focused on pre-Holocaust life. The main question was: "*Please describe your family life before the Holocaust began?".* In this section, probes focused on early attachments to parents and siblings, as well as possible traumas in pre-Holocaust life. This section began to structure the case study and developmental history of each participant. From this material in each interview, I was able to locate respondents within Erikson's (1965) Life Cycle Approach as well as to comprehend aspects of their early attachments, aspects of personality make-up and features of early life that might have contributed to resilience. This insight helped to guide exploration of later aspects, such as

experiences of trauma and capacity to build relationships after the Holocaust. These issues will be discussed further in the findings and discussion section.

The fourth section explored "Exposure to Trauma and Loss During the Holocaust". The main question was: "*Tell me about your experiences prior to and in the concentration camp/s?".* Primary probes aimed to elicit themes related to loss, traumatic experiences, cruelty experienced and witnessed, significant relationships in the camps and survival strategies. This section of the interview focused on the nature, intensity and duration of the Holocaust related trauma, including the loss of parental and family relationships and existential questions raised for survivors in relation to what they had been compelled to endure, comprehend and engage.

Section five focused on life after liberation: "*Please tell me about your experiences when your camp was liberated?".* The literature points to the fact that this was a very vulnerable time for many survivors (Gutterman & Shalev, 2008)) as it was a period when most inmates were sick and weak and also when many first came to realise that their families were dead. It thus seemed appropriate to enquire about the participants' experiences of this time.

The sixth section examined emigration to South Africa after the war*: "What did you experience as a new emigrant in South Africa after the war".* According to previous research, including that of Klein (2012), the way in which the new country offered support and stability was an important predictor of adjustment and revival after the Holocaust. The seventh section, explored building a life after the Holocaust: "*Please tell me about your experiences in building a new life in South Africa".* This part of the interview focused particularly on adult functioning. This section explored relationships with spouses and children, with the aim of eliciting data that would indicate the participant's capacity to make close relationships; as well as unconscious patterns such as the 'compulsion to repeat the trauma' within close relationships. Some of the Holocaust survivors in this study were also the children of parents who survived the Holocaust and appeared to carrying aspects of their parents' experience, in addition to their own. This was also true of those who had lost parents during the war.

The eighth section looked at psychiatric history and explored whether the participant had consulted a psychiatrist or psychologist over the course of their lives. This was included to see not only whether participants had developed severe or diagnosable mental health problems but also whether psychotherapy or medication had perhaps been a mitigating factor in overcoming

the trauma of the Holocaust. Participants were asked about their experiences related to possible post-traumatic stress symptoms and complicated bereavement.

The ninth section explored any exposure to crime and to emigration of family members as these were considered to be features of living in South Africa that might have particular resonance for Holocaust survivors. For example, it was considered useful to assess whether exposure to criminal violence may have re-triggered traumatic experiences from the Holocaust. In addition, it was important for the purposes of the research to establish whether the emigration of family members had evoked separation, loss and mourning experiences previously associated with the Holocaust.

Section ten examined the aging experience. Participants were asked: *"How have you coped with getting older?".* Probes included a retrospective view of how they had been affected by the Holocaust over the long-term. This section focused on Erikson's (1965) stage of 'Integrity vs. Despair' and aimed at locating the participants on this developmental continuum.

The final question explored the participants' experience of the interview. This was important so as to encourage the participants to reflect on the interview process. It also helped to get a sense of the participants' transference experience towards the research process.

Prior to conducting the interviews, the head of the South African Holocaust Survivors Association, Mr. Krausz also suggested relevant probes and questions that helped to further refine the interview schedule. His insight and collaboration added depth and richness to the research and assisted in establishing a participant sensitive atmosphere in the interviews.

The interviews were conducted over a three-and-a-half-year period, from December 2005 to May 2009. I interviewed all participants and the material was audio-recorded. During the interview process, the participants were seen on a weekly or bi-weekly basis. Each interview took between two to three hours, with occasional breaks during each session. I carefully monitored the fatigue levels of the participants and ensured that enough time was given to help them complete their story to a particular point of closure in each interview session. I travelled to Cape Town and completed the interview with the two participants located there over a week. In this case both interviews were four hours long for one participant and six hours long for the other participant. Once the participants began to speak, it was difficult to stop them and one

participant gave 30 hours of recorded interviews. Most of the participants provided between nine and twelve hours of recorded material. The minimum period of interview material for any participant was six hours. It is thus evident that rich and extensive material was collected during the data collection phase and also that the repeated series of interviews allowed for a degree of trust to be built up between both parties. It was also possible to revisit issues and to clarify material within this kind of extended contact period.

Together with a research assistant, a graduate student at the time, I transcribed the interviews. The material was transcribed verbatim and included pauses, silences, overlaps and interruptions in speech; emphasising emotive language, including crying. This method is in accordance with the recommendation for psychological interview transcription (Banister et al., 1994). In keeping with qualitative research practices, where significant, both the researcher and the participants' speech were recorded in the written transcripts (Eagle, 1998). As the principle researcher I also checked the assistant's transcribed texts for accuracy (full texts are available for scrutiny upon request). As might be imagined both the interview and transcription processes proved enormously taxing to me as the researcher and to my research assistant, as the content of the material was often profoundly disturbing. The vicarious traumatization entailed in engaging closely with the material in part accounts for the time elapsed since the conducting of the interviews and writing up of the findings and this issue will be returned to in the reflexive section of the thesis as is was deemed worthy of in-depth commentary.

3.9 Data Analysis

The data analysis took place in two inter-related phases. Firstly, after the transcripts were read and an initial thematic content analysis was completed, each case was written up in a case history format with emphasis on both descriptive and interpretive material that was categorized according to a set of generic headings derived from what had emerged as significant in the interviews in response to the interview schedule (see below). The second phase of analysis involved a more deeply interpretive approach and consisted of the generation of common themes *across* case histories, highlighting points of difference and similarity. The actual approach to analysis is described further below.

3.9.1 Conducting the Thematic Content Analysis

Categories were constructed according to themes that emerged in the qualitative data and based on the theoretical constructs covered in the literature review. A process of refinement of thematic categories took place over time as is consistent with such approaches. According to Braun and Clarke (2008) thematic analysis needs to be a rigorous in order to establish itself as a respected research methodology. Six phases of thematic analysis are outlined as a guide to researchers. The researcher followed these guidelines to complete the thematic analysis in the present study:

1. Familiarisation with the data. I immersed myself in the material in order to become familiar with the data. The data was read, re-read and any analytic observations were noted.
2. Generating initial codes. This involved coding interesting features of the data and collating the data relevant to each code. Coding depended to some extent on the research questions, which meant that the analysis was to a large extent 'theory driven'. Coding was done manually and relevant themes were highlighted with relevant notes written in the margin of the text. Attention was paid to the emotional overtones that were evident.
3. Searching for themes. At this stage the codes were collated into themes and sub-themes, with several iterations of this process until the best fit was found. Both supervisors of the thesis read most of the transcribed material and also assisted with theme derivation.
4. Reviewing themes. This step involved checking that the themes accurately reflected the coded extracts.
5. Defining and naming themes. At this stage of the analytic process the essence of each theme was identified and appropriate thematic titles were allocated. According to Braun and Clarke (2008), the researcher needs to ask: "What does this theme mean? What are implications of this theme? What conditions are likely to have given rise to it? What is the overall story of the different themes and what do they reveal about the topic?" (p. 94) With these kinds of questions in mind the transcripts were summarised and each theme was written next to a page number in the transcript so as to access supporting data in the form of quotations and observations at the time of writing up the theme. My two supervisors were also involved at this stage of the project and assisted in refining the analysis and making decisions as to what thematic material should be given greatest prominence. As might be imagined, with the very large volume of data generated for analysis the analytic and interpretive process was lengthy and some careful decisions needed to be made about how to structure material and what to foreground. In general,

considerable weight was given to material that was affectively loaded for participants and material that recurred across interviews. As has already been acknowledged the analysis was also located within existing theory and in relation to the research questions that initially framed the study.

6. Producing the report. At this stage, each case history was written up in the form of a within case analysis and then core cross-case themes were highlighted and elaborated. To ensure academic rigor, I returned to the transcripts and read them again to extract relevant quotes to illustrate each theme. Braun and Clarke (2008) suggest that a good balance between analytic narrative and illustrative extracts should be provided and attempts were made to strike this balance.

3.9.2 Analysis in Respect of the Case Study Method

As a component of the overall thematic analysis individual case analyses were conducted to condense the data and to provide a backdrop against which to consider the cross-case analysis, as described previously. Given that this first phase of the analysis involved a form of within case narrative history collation and interpretation it is considered useful to locate this aspect of the analysis specifically within case study methods. According to Bromley (1986) a written case study should be drawn up after a content analysis has been conducted. Each case study should ideally include the elements listed below (although these may be subject to change depending upon the particular phenomenon of interest being researched):

- The identity of the participant including biographical information
- The life history and present circumstances including any pertinent incidents or life events
- The psychological attributes of the participant, including his/her characteristic reactions, expressive behavior and self-image
- The participants' social life and family relationships
- The relationship between the participant and the investigator carrying out the case study
- The ethical issues governing the case study (p. 27)

In this instance most of these guiding parameters were included in each case history although the psychological attributes aspect was less emphasized and greater weight was given to Holocaust related experiences and apparent subsequent mental health and adjustment. The case study headings were derived out of considered discussion with both supervisors with the aim

of doing justice to the most relevant content pertaining to child Holocaust survivors' experiences and life trajectories. After the initial content analysis was completed the case studies were written up under the following headings for this specific thesis:

- Overview and introduction including biographical information
- Memories of early parenting
- Childhood/Adolescent Experiences During the Holocaust
- Traumatic Experiences and Recollections
- Key Losses
- Developmental Disruptions as understood within the framework of Erikson's Life Cycle theory
- Present Life Difficulties Associated with Past Traumas
- Adult Capacity to Build and Sustain Relationships
- Indicators of Resilience to Trauma
- Main Themes in the Case Study.
- Psychological Defenses
- Experiences of Integrity/Wisdom on Old Age
- Process related observations.

3.10 Reflexivity

Within qualitative research reflexivity refers to the researcher's contribution to the construction of meaning in the research process and the acknowledgement of the researcher's subjective approach to conducting research. According to Parker (2005) "Subjectivity is viewed by psychoanalysis and qualitative research not as a problem but as a resource" (p. 117). In psychoanalytic thinking, countertransference may be employed as the related term used to describe the researcher's interpretation and analysis of the data, as well as his or her emotional reaction to the research participants, although it is recognized that the term countertransference is generally employed largely within the clinical consulting room (Parker, 2005).

According to Hollway and Jefferson (2000), psychodynamically orientated qualitative research can ground interpretive claims through the analysis of the countertransference. They used triangulation in their illustration of the relevance of countertransference deployment in research analyses, both researchers describing their different countertransference responses to the same case. This is a method of checking the researcher's responses to participants and what these

responses may signify. Within the present study, the responses of the research assistant and those of the supervisors were employed to interrogate and triangulate possible countertransference responses. It was evident that reactions to the participants and the material and personal allegiances to particular cultural and ideological positions were significant in conducting, analyzing and the writing up of this research and the issue of reflexivity and countertransference is therefore addressed in some depth.

Reflexivity in qualitative research is defined as the researcher's critical reflection on the intersubjective space between the researcher and the participants. (Berger, 2015). Included in this are the values and personal history of the researcher and its impact on the research. The distance and engagement of the researcher can be monitored through awareness of the reflexivity. The factors that influence the reflexivity include the researchers shared experiences with the participants, the journey from the position of outsider to insider in the course of the study, and the familiarity with what is being studied (Berger, 2015). The subjective experience of the researcher is used to give the research a deeper texture and to help her to understand her impact on the research process. According to Brom (1998) "there is a process between client-therapist, interviewer- interviewee and author reader relations where there is no such thing as not being engaged." (Brom, 1998, p. 6). Tauber (1998) states that when listening to the experiences of Holocaust survivors, "the therapist adopts the role of witness to the extremes of horror and cruelty that humanity is capable of" (Tauber, 1998, p. 25).

Eagle (2013) quotes Rosenblum (2009) who suggests that the analyst plays three kinds of roles in relation to listening to the client: "The authenticating witness, the sanctuary provider, and the experience sharing companion" (p. 135). Eagle (2013) explains that the "process of therapeutic sharing and empathic engagement facilitates a process of healing where the survivor begins to build a reparative and protective good object, in their internal world" (p. 135). The therapist helps in her role as 'authenticating witness' by encouraging reality testing and the processing of meaning. From a classical Freudian stand point, the expression of affects and fantasies allows a catharsis that facilitates a process of cognitive coherence, restoring a sense of continuity in remembering the traumatic experience,

Eagle (2013) states that listening to trauma survivors can be emotionally taxing for the therapist. The process involves the therapist being open to receiving unbearable affects and thoughts, including projective identifications, this entails that the therapist is a container for powerful feelings of despair, terror, anxiety, helplessness, anger, humiliation and helplessness. Herman (1992) concurs with Eagle (2013) and says that listening to a trauma survivor involves hearing unbearable traumatic material and the listener becomes a witness. Long & Eagle (2009) argue that the researcher who is also a clinician listens with a clinical attunement. In addition, Long & Eagle (2009) comment about Testimonial therapy and the unconscious or conscious need of participants in certain kind of research areas to use the research interview in the service of therapeutic goals.

According to Long & Eagle (2009), when the qualitative researcher is also a psychotherapist, he/she may hold a function as a "researcher-clinician, as a listener, as an interviewer as an interpreter and as a container" (p. 20). In the process of qualitative research, the clinically attuned interviewer is likely to access deeper material that may have been supressed by participants. Long & Eagle (2009) argue that an attuned listener who makes empathic reflections is likely to form a trusting bond with the participant where emotionally sensitive material is elicited and this adds to the emotional intensity of the qualitative research.

According to Gerson (2009) over the past decades psychanalysts have worked with Holocaust survivors including Bergman (1985), Kestenberg (1993) and Laub (1992, 2005) who agree that bearing witness to the unbearable, gives meaning to both life and death, and the longing for an empathic witness could give the survivor a sense that life may have a bearable meaning. Gerson (2009) quotes a patient who said "I would be entirely hopeless, if I couldn't be truly hopeless with you" (p. 1354).

According to Laub (1992):

> The testimony to the trauma thus includes its hearer, who is, so to speak, the blank screen on which the event comes to be inscribed for the first time. By extension, the listener to the trauma becomes the participant and a co-owner of the traumatic event through his very listening, he comes to partially experience trauma in himself (Laub, 1992, p. 57).

According to Laub (1992) trauma survivor's live with both memories from their history as well as the continuation of traumatic memories that have no closure and continue to haunt their present lives, where they remain trapped in the memory and the enactment. For Laub (1992) a therapeutic process of "constructing a narrative, reconstructing history, and essentially re-externalizing the event- has to be set in motion" (p. 69) and offers a hope of liberation for the survivor of his entrapment in the story and reclaiming his past history.

Long and Eagle (2009) says that it possible within the context of sensitive research, that the participant projects traumatic material into the researcher who serves as a container for unbearable experiences. Projective identification may take place, where the researcher has to hold and experience unbearable feelings that are unconsciously projected by the research participant. In Long and Eagle's (2009) opinion, the clinically trainer researcher needs to be aware of the transference and countertransference issues that may emerge in the process of data collection and analysis, as well as the possibility of projective identification, as part of the reflexivity process. In addition, the deep understanding of this process may add to the richness of the research data (Long & Eagle, 2009). "The interactional nature of the exchanges as well as the experience of having something being projected into the interviewer leads us to prefer the term 'projective identification' to the term "countertransference'. (Long & Eagle, 2009, p. 38). In the case of Holocaust survivors who have been severely traumatised there is a likelihood of these dynamics developing

For these researchers, the awareness of the researcher is important in regulating her own experiences of receiving the conscious and unconscious communication of the participant, and processing her responses to ensure that she treats the participant ethically.

> It is therefore necessary both ethically and methodologically, to undertake an analysis of countertransference and /or projective identification with a reflexive awareness of the interactional nature of the exchange and of what the researcher may bring to the interpretation (Long & Eagle, 2009, p. 41).

Laub (1992) worked both as a psychoanalyst of Holocaust survivors and also as the interviewer of Holocaust survivors for the Testimony Project at Yale. In his understanding the role of analyst and the role of interviewer, while they have essential differences, are also very similar in impact and dynamics.

For Laub (1992) the contract between the interviewer and the participant was:

> For this time, throughout the duration of the testimony, I'll be with you all the way, as much as I can. I want to go wherever you go, and I'll hold and protect you along this journey. Then at the end of this journey I shall leave you. (Laub, 1992, p. 70).

In his understanding the interviewer is involved in the process:

> For the testimonial process to take place their needs to be a bonding, the intimate and total presence of an *other* -in the position of one who hears. Testimonies are not monologues; they cannot take place in solitude. The witnesses are talking to somebody; somebody they have been waiting for, for a long time (Laub, 1992, p. 70-71).

In Laub's (1992) understanding there is a big emotional investment in the interview as there is harsh destructiveness, death, loss and hopelessness that is revealed, that "there has to be an abundance of emotional holding and of emotional investment in the encounter, to keep alive the witnessing narration." (p. 71). As part of the process the listener is impacted by the trauma and faced with the existential questions raised by the Holocaust. Issues around death and the meaning of life are raised as well as around love, loss, helplessness, and our ultimate aloneness as human beings. Because this material is so intense and overwhelming, Laub (1992) cautions that the interviewer may become defensive in the following way: paralysed in the face of the huge suffering. Angry at the victim who tells an overwhelming story, withdrawing and numbing. Admiration and fearing of the survivor in a way causes a distance to avoid the emotional engagement of hearing and knowing. Distancing by intellectualising and finally being emotionally overwhelmed and drowning in the story.

Laub (1992) acknowledges that sometimes the defences are engendered by the defences of the trauma survivor. This may happen on a conscious level or by unconscious means through projective identification. In his understanding of the resilience of survivors, Laub (1992) states that although they have been materially and professionally successful and built bonded family lives, at their core survivors are deeply wounded "a fragility, a woundedness that defies all healing" (Laub 1992, p. 73). He understands their relentless need to build and create is a desperate attempt to undo the destruction that they witnessed and experienced. For Felman and Laub (1992) the act of giving testimony is a process of facing loss and mourning. "It is the

realisation that lost ones are not coming back" (p. 92) and in listening to testimony the listener becomes a witness to the grief of the survivor (Felman & Laub, 1992).

3.11 Reliability

Reliability is generally concerned with the consistency and replicability of findings: "Replication in qualitative research has more to do with re-interpreting the findings from a difference standpoint or exploring the same issues in different contexts rather than expecting or desiring consistent accounts" (Banister et al., 1994, p. 143). In the case of this study, the main check of reliability took the form of a co-coding/interpretation of data by a briefed clinician/researcher. From the discussion above, it is clear that interpretation is always somewhat subjective. Within the present study, the graduate research assistant, who assisted with the transcription of the tapes, also acted as a coder and interpreter of the thematic material. I met with her on nine occasions (at the completion of each case transcription) to discuss the case and the main themes that emerged. In addition, the co-rater read each case study summary, and gave particular attention to the section that identified predominant themes related to each case. In most cases there was agreement regarding the analysis of the case and where this was not the case there was discussion until agreement could be reached. In addition, as mentioned previously, the case transcriptions were read by and discussed with both supervisors who also gave useful input regarding the predominant themes. The supervisors thus also served as additional co-raters of the present research.

3.12 Validity

Validity is the degree to which an instrument measures what it sets out to measure. In qualitative research validity tends to be dependent on the interpreter and the interpretation process: "It becomes largely a quality of the knower, in relation to his or her data and enhanced by different vantage points and forms of knowing" (Marshal cited in Banister et al., 1994 p. 143). In this study, validity has been kept in mind in terms of the coherence of the interpretation, the relationship of the analysis to the existing theory and the ability to substantiate findings with illustrative case material. According to Frosh and Young (2008): "No interpretation is sacred, there are no full and absolute truths: but some are more reasonable and persuasive than others" (p. 118). They continue that some interpretations are more valid on theoretical grounds and logic, as well as the conclusions they draw. In general, there was an attempt to remain close to

the data in the interpretation of material and to convey conclusions with as much theoretical and data-driven substantiation as possible.

3.13 Ethical Considerations

According to Brinkman and Kvale (2008), qualitative research gives the researcher access to human experience, as it describes intimate aspects of people's worlds. The human interaction in qualitative research affects both researchers and participants and may affect our understanding of the human condition. Consequently, qualitative research is saturated with ethical issues.

It was recognized that this research would in all likelihood be very personally demanding for participants – even if they perhaps wished to be able to give some form of testimony concerning their Holocaust experiences. The procedures for approaching subjects and ensuring informed consent were consequently very carefully formulated. Clinical psychological research into human experience requires observation of the basic principles of confidentiality, or protection of identity, and free choice concerning participation. According to Durrheim and Terre blanche (1999) informed consent is an ethical requirement for all research studies. However, researching sensitive topics requires special ethical caution, especially if disclosure of the material may be threatening to participants concerned. Participants need to be fully informed about the research process, giving them a chance to consider possible ramifications.

A consent form was drawn up attempting to address all of these relevant issues and participants were asked to sign it (see APPENDIX 4). Confidentiality was assured, for example by use of pseudonyms in the write-up, although given the specificity of their life histories it is likely that some participants might be recognizable to themselves and close others. In addition, 'thick disguise' (Winship, 2007) was used to protect the confidentiality of some of the participants to ensure that their story would not be recognized. Many of the participants in this study had already chosen to give life testimony accounts to be placed on public record and some had never spoken publicly about their experiences. According to Mr. Krausz most of the respondents had been involved in giving public lectures about their experiences and some of the participants have published books about their personal Holocaust stories. There was some anticipation that in having become accustomed to sharing their experiences on a regular basis the participants

might have developed a degree of hardiness that would render them less vulnerable to being traumatised by taking part in a research interview.

In addition, participants were told that they had the option of withdrawing from the study at any point and that any wish of this kind would be respected. If in response to the interview process participants felt that they might need psychotherapeutic support then it was made clear that an appropriate referral would be made based on a considered discussion of implications and options. None of the participants requested referral for counseling. In every case a follow-up interview was conducted a week after the research interviews had been completed to see how the participant was coping, as well as to assess whether counseling was necessary and an additional follow up phone call was made one month later to assess any possible longer-term effects.

Permission from the relevant university ethics committee was sought to ensure that all relevant concerns had been addressed (see APPENDIX 5). I also contacted a respected Israeli academic and clinician experienced in working with Holocaust survivors and asked this person to read the proposal and the questionnaire. He indicated that he felt that the interview schedule was appropriate and encouraged the use of probing questions in order to communicate to survivors that the extent of their trauma was/is bearable for others to hear. This feedback was encouraging given considerable anxiety about retraumatization of participants prior to beginning the interviews.

According to Long & Eagle (2009):

> The qualitative researcher who is also a psychotherapist is both enabled and potentially limited by the fact that the researcher's therapeutic skills inevitably contribute to the research process. In the context of sensitive research this may raise unanticipated ethical dilemmas (p. 21).

Long and Eagle (2009) identified four areas where ethical issues may arise when the therapist's role interacts with his/her role as researcher: "These include the researcher-clinician as listener, as interviewer, as interpreter, and as container" (p. 21). Within the present research, I faced difficulties that resonated with those raised by Long and Eagle. In my role as listener I faced the task of listening to very disturbing and traumatic material. There were many times during

which I needed to take breaks from the research and frequently needed trauma debriefing in clinical as opposed to purely research supervision. I faced an ethical dilemma in my role as "intervener" most particularly when I interviewed a survivor who I assessed to be clinically depressed. As a researcher, it was not my role to make an intervention, however, my role as a clinician took precedence and I suggested that the participant consult a psychiatrist to assess her depression. The respondent indicated that she had been prescribed anti-depressants that she had been reluctant to take for fear of becoming addicted. Psychoeducation around this was offered and with her permission the participant's social worker was contacted and informed that the participant might need extra support and counseling.

As clinician-researcher I also faced an ethical dilemma as an interpreter, as one of the participants reported that he engaged in potentially dangerous and aggressive behaviors that I understood to represent some sort of enactment of unresolved trauma. Based on the information he had shared in his interviews I interpreted to him that it was likely that that he was in a process of a repetition of the trauma, hoping for a different result. This clinical interpretation was made as it was clear that he was putting himself at risk. I also invited him to think more realistically about the possible negative consequences of his behavior for himself and others and he subsequently related that he had stopped this behavior. Within a strict research role, this interpretation and therapeutic intervention should not have been made. However, as a researcher who also carries a clinical psychologist identity, after consulting with one of my supervisors I deemed that this to be an appropriate and ethical intervention. Had I not been a registered clinical psychologist I would have attempted to make a referral to a relevant registered practitioner. In this instance the relationship of trust built up over the interviews appeared to assist in engaging with the implications of this behavior.

Long and Eagle (2009) use the concept of the clinician-researcher as a container to describe the way in which research respondents may project unwanted emotions onto the researcher that require 'digestion'. The researcher may experience projective identifications that can be understood as evoking countertransferential responses. This is particularly likely to be the case with sensitive and affectively loaded interview content and became a critical issue in this study in engaging with Holocaust survivors who almost inevitably carried complex trauma as a result of their experiences. There were many instances in which it felt as if I was being required to receive and contain powerful affects of various kinds and debriefing as well as supervision was required throughout the project as will be further discussed.

During the research it was noted that no social work services were available in South Africa that were specifically designed for Holocaust survivors, I approached Jewish Social Services about this gap in the system and was sent to AMCHA in Israel for a week of training. AMCHA is an organization, with offices throughout Israel, that offers psychosocial services to Holocaust survivors and the second generation. I met Israeli psychologists and social workers and received input and training on how to work therapeutically with survivors. This training helped to prepare me for interviewing survivors in the present study and in providing optimal containment where possible.

When I returned from Israel I offered training seminars to psychologists and social workers, working within the Jewish Social Services in both Johannesburg and Cape Town. This training focused on working therapeutically with survivors and second-generation individuals. In addition, I helped to set up the "Friendship Forum" which was a monthly social club intended for survivors to be run by Jewish Social Services. This project was taken over by the Holocaust and Genocide museum and is called the Holocaust Group. The group of 25 survivors meets monthly. Thus, I aimed to set up ongoing support structures for survivors beyond the supports provided during the interview process.

One of the benefits of this study is that it focuses on the long-term effects of trauma on children with some emphasis on resilience, through this elaborating on aspects of the developmental negotiation of tasks of old age. Thus, the study aimed to present the participants as survivors rather than as purely victims and may contribute to other research and interventions with aging populations who have suffered mass trauma.

4 FINDINGS AND DISCUSSION

4.1 Introduction

This chapter will discuss the findings of the present research and link them to relevant theory concerning trauma and aspects of aging in child Holocaust survivors. Initially, each participant will be introduced within the context of a case history and a *within case* analysis will be offered. Each case history will be formulated within a psychodynamic framework and will be discussed with reference to Holocaust trauma and developmental disruption within childhood and adolescence. Each participant's life trajectory after the Holocaust will be traced and the specific impact of the Holocaust trauma on each case will be extrapolated as far as is possible from the material available. Since this research concerns itself with the impact of the Holocaust on aging child survivors, special focus is given to the long-term consequences of trauma and loss, as well as its impact on the negotiation of Erikson's (1965) stage of Integrity versus Despair. The focus will subsequently move to discussing themes of trauma that were extrapolated from the testimony that represent *across case* commonalities and differences. The discussion will move to exploring and explaining the findings as they appeared to emerge as significant in the data related to trauma in aging child survivors in relation to core theoretical constructs including complex traumatic stress, resilience, coping related defences, and traumatic bereavement. The conducting of interviews and analysis of material pertaining to each case was coloured by traumatic transference and countertransference, and this will be explored and explained as part of the dimension of reflexivity as it is relevant in this qualitative research project dealing with sensitive and compelling life histories. Finally, key conclusions and interpretation of the findings will be distilled and discussed.

Each child survivor was interviewed over an extended period and conveyed life history material that was of significance to them. Each case is summarized against a common set of sub-headings that includes general background information, early parenting and attachment experiences, traumatic experiences and recollections, developmental disruptions, and features or symptoms of complex traumatic stress. All the material in italics represents directly quoted material from the interviews with research participants. In addition, each person's apparent functioning within the stage of Integrity versus Despair (Erikson, 1965) is discussed.

4.2 Case Summary: Helene

Helene, a child survivor from Germany, was seventy-two years old at the time of being interviewed. She was born in 1933 in Germany in a town near to the French border. Her family spoke German at home and they identified themselves as proud Germans. Although they were observant Jews, they did not speak Yiddish. Helene was six years old when the Holocaust began and twelve when it ended. She and her family were captured by the Nazis and sent to concentration camps in France. She spent three and a half months in Gurs concentration camp and six months in Rivesaltes concentration camp together with her parents. The camp commander at Rivesaltes agreed that some Jewish children were to be released to French and Jewish authorities. In an attempt to save Helene's life, her parents sent her away. Helene left with a group of Jewish children and spent time at two children's homes that were established to look after Jewish refugee children in France.

Helene's extended family in France collected her from the children's home after a period. However, when conditions became dangerous for Jews, they organised for her to go into hiding in a Catholic convent in Brive. She spent two years at the convent until the end of the war. The nuns taught her catechism every night and she lived as a Catholic child under a false identity. After liberation, her French relatives collected her and she lived with them for six months. After the Holocaust, she was reunited with her grandmother. They immigrated to South Africa where she lived with her aunt, uncle and cousins. Helene's parents were killed in Auschwitz; however, she was not told about this until years later. She reported that her South African family was very kind to her and she adjusted well to her environment at school. In addition, she had managed to develop friendships. As such, her environment post-liberation was supportive, and this proved to be a mitigating factor in ameliorating the impact of the losses and trauma related experiences in keeping with Keilson's (1979) observations. She got married at eighteen years old and gave birth to her first child when she turned nineteen.

At the time of the interview, Helene was widowed after fifty years of marriage. She had two children and lived in Cape Town. She reported that she suffered from osteoporosis, which according to her doctors was a result of malnutrition in her early years during the Holocaust. She described herself as a person who was socially active and enjoyed her hobbies. Helene was involved in volunteer work in her community and reported that she had never suffered from

anxiety or depression. She was interviewed on two occasions and five and a half hours of material was recorded.

4.2.1 Memories of Early Parenting

Helene reported that she was an only child who felt loved and cherished by her parents, who were a happily married couple. She described how she was very spoiled and indulged by her mother who did everything for her. Helene described her parents as *wonderful people and devoted parents*. Her memory of her father was that he created a sense of security, and this left her feeling *looked after and cared for*. *Life before the Holocaust was filled with happy memories…that being loved and indulged gave me great strength, which allowed me to be down to earth. It gave me the strength to face life and not focus on negatives*. This latter comment indicated that Helene had some awareness that her history of secure early attachments was instrumental in building her resilience. The importance of secure and positive early attachment for managing subsequent stressors was discussed in the literature (Isserman, 2013; Klein, 2012).

Helene said she felt *adored* by her grandparents and extended family. Her older cousin Maud was an important role model for her. Although Maud was eleven years older than her, Helene described her as *her best friend*. It was Maud who fetched her from the children's home in France, and it was Maud's family with whom she lived for six months after the war ended. Helene said she was devastated when Maud passed away years later. She explained that Maud was the only person who made her feel loved and special in the same manner that her mother had loved her. Her relationship with this older cousin seemed to be a further protective factor in building her resilience.

4.2.2 Traumatic Experiences and Recollections

Helene remembered Kristallnacht, in November 1939, as her first experience of terror. Her father and grandfather were captured by the Nazis and taken to Dachau concentration camp along with the other men from her town. After her father's release, he was not permitted to work, and she was not sure how the family coped financially. In 1940 the Jews of her province were ordered to gather in a hall. She reported that she and her parents were sent to Camp de Gurs in the French Pyrenees Mountains. She remembered being cold, hungry and sick with diphtheria. Many young children died of diphtheria at that time and she felt that she was *lucky*

to survive. She and her young cousin helped to take care of his baby brother who died, and she reported that she was very upset by this incident. Helene explained that because of the cold and the hunger many babies and children died. She remembered a woman whose baby had died: *This woman lost her mind, and I remember her running from barrack to barrack, and digging in the mud, looking for her baby*. Helene said that this image remained with her and left her feeling disturbed and very sad for this woman who she saw as *mad with grief.*

Helene reported that after a period in Camp de Gurs she and her parents were sent to camp Rivesaltes, in France. When she arrived there, she recollected that she and her cousin walked into a barrack that was filled with corpses. She remembered feeling horrified and afraid and running from this sight. She said the food was inedible, and she had to go to the infirmary as a result of stomach problems. Thus, part of Helene's early memory of trauma impact was of somatic or physical problems. Her encounters with death at a young age also clearly stood out for her.

At some point a concession was made for Jewish children who were released from the camp and Helene was subsequently handed over to French Jewish authorities. When she said goodbye to her parents, she remembered her mother giving her a purse that she had made for her. *I remember my father saying, 'always pray, and everything will be ok'. I don't remember my mother saying a word. As an adult now, I think she was incapable of speaking because it was so hard for her to say goodbye. What can a mother say if she knows that there is a good chance she will not see her child again? My grandmother told my aunt that it took a lot of persuasion from everybody for my mother to give permission for me to go. I remember my father waving his handkerchief as far as he could see me. I didn't cry. I didn't know I would never see them again.* Helene was seven years old at that time.

Helene remembered that a twelve-year-old girl named Claire became *like a surrogate mother* to her when she was sent to a children's rehabilitation home near Marseilles. She remembered collecting crusts of bread to send to her parents. This indicated that she "held her parents in mind" and attempted to take care of them by saving her bread to feed them at a later date. She said that she received a letter from her parents to say they were being sent to another place. The place they were sent to was Auschwitz, where they died.

Helene said that being in the children's home was very difficult emotionally for the following reasons: *My parents made me feel that nobody was as wonderful as I was, nobody was prettier or more intelligent than I was. In the children's home, there were children who were prettier and cleverer than me, and it gave me a dreadful complex… being one of forty children made me feel that I was nobody special and actually not good enough… this was a big complex I carried to my fifties and sixties. That my parents made a mistake that I was just ordinary so I lost a lot of confidence, and after that, I never felt special.* This comment suggests that Helene experienced the separation from her parents as injurious to her identity and sense of self, in part because of some apparent idealization on their part that did not have time to transform into a more realistic form of relating and also because the transition away from them to a world of peers was forced rather than scaffolded. The sudden absence of previously available parental mirroring left her feeling dislocated and negatively affected her self-esteem. Her parents did not explain why she was being sent away, nor did they come and collect her. This worsened her sense of abandonment and her feeling of being unworthy. This absence of a 'good enough mother' (Winnicott, 1965), despite positive early attachment makes it difficult for a child to hold onto a positive sense of self. The rupture of the attachment broke Helene's sense of self-other continuity and she struggled to hold onto her parents as good internal objects. This is consistent with what is described in trauma survivors who experience a traumatic loss as a rupture in relation to their attachment objects leading to a lack of trust and a fragmentation of a cohesive sense of self. (Auerhahn & Laub, 1993; Eagle, 2013; Herman, 1992). It seems that parental attempts to protect Helene from the magnitude of terror and threats the family faced left her vulnerable to interpreting events in terms of her own more personal developmental issues and crises.

Helene, who had never undergone therapy, had the insight to realise that this dynamic related to her early experiences had affected her self-esteem and sense of worth. As described by Dasberg (2001), Helene had aspects of child survivor syndrome. She had experienced a multitude of traumas. For example, she was deprived of her childhood, uprooted from her community, permanently separated from her loving parents, and felt alone and afraid at seven years old. It is possible that Helene felt an unconscious sense of anger at her parents for sending her away as she had no idea why or how they failed to fetch her. This may have caused her to feel rejected by them and perhaps she assumed that it was because she was not good enough or not loved enough. According to Fraiberg (1959) early to middle childhood is a magical age where children feel all powerful and blame themselves when they are faced with difficulties.

We could also argue that Helen demonstrated Fairbairn's (1952) 'moral defence'. This is a tendency for abused, neglected or abandoned children to internalise a sense of badness in order to keep the objects to whom they are attached, pristine. This defence might have been operative in allowing the abandoned Helene to retain a sense of attachment to her absent parents.

Helene reported that her feeling of not being 'good enough' was prevalent in her relationship with her husband and her children. This suggests that the psychological injury sustained in relation to her separation and loss of her parents may have affected all her subsequent relationships. She continuously questioned her worth and her lovability despite her adult awareness of what had transpired. The feeling of not being special enough persisted into her sixties, demonstrating that her sense of not being worthy was a theme that coloured her sense of worth throughout her life.

When Helene's cousin Maud fetched her from the children's home her family arranged for her to be taken into a Catholic convent where she lived in hiding with nuns for a year and a half. *My friend Claire was no longer with me, and I was truly alone and felt I didn't belong anywhere… As an adult, I did a writing course and was asked to describe myself as a child... I saw myself all alone in a grey garden shed, and I was dreadfully sad.* This quote demonstrates how abandoned, alone and desolate Helene felt as she had to cope as a young child in a strange place without family or friends. However, unlike many others, Helene received a formal education and was taught Catechism in secret every night so that she would be word perfect the next day. She said that the nuns saved her life. She enjoyed mass and felt comforted in the church. The routines of the environment created some sense of containment for her with recognition that this required conforming to the expectations of others. *I am fearful of authority, I listen, I do, I follow the rules, and I'm obedient. I have learned to merge into a crowd and never stand out. This was how I survived in the convent. I had to fit in.* This reflective observation demonstrates what Kellermann (2001) meant when he said that child survivors became compliant. Helen's identity development appears to have been foreclosed in important respects in the name of adaptation.

When the war ended, Helene's cousin Maud fetched her from the convent, and she lived with her aunt, uncle, and cousins for two years. She said that she used to go to the train station and wait in the hope that her parents would return. Her uncles in South Africa offered to take care of her and she consequently travelled to Cape Town with her grandmother. She was told of her

parent's death years after she arrived in South Africa, as the Red Cross notified her family that they had died in Auschwitz. *I could never bear to think about it. If I saw pictures of skeletal people in Auschwitz, I looked away. I avoided all books and films about the Holocaust, and as a teenager, I never got depressed and tried to fit in and be normal. If I got sad, I would read or listen to music. Reading was my refuge. I never considered myself an orphan because I regarded my aunt and uncle as surrogate parents… I never mourned my parents the pain was unbearable…I had friends, but I always felt lonely, I always smiled, but the smile was a mask that hid my pain.* This set of comments demonstrates how Helene used suppression and avoidance to bury her grief and conceal her feelings of loss and abandonment from her new caretakers and points to an underlying sense of pain and anxiety that had to be kept at bay at all costs, both for the sake of her sanity and for the sake of those who had taken her in. As she describes it, Helene, lived with an inner sense of loneliness, diminished self-esteem, and identity problems, despite her reparative environment. This is consistent with Dasberg's (2001) description of survivors hiding their vulnerability in an attempt to appear normal.

During the interviews for the research Helene became very tearful and sobbed inconsolably as she described her grief surrounding the loss of her parents. She also sobbed when she spoke of their suffering in Auschwitz: *I have never allowed myself to think about it until now! They must have been hungry and cold, living in that hellhole. I cannot bear to think of them as walking skeletons or fighting for their last breath in the gas chambers… I cannot come to terms with their suffering they must have felt pain! I feel so sad and angry that they died in Auschwitz!*

Helene spoke in detail about her sense of loss and how much she had loved and missed her parents. She said that she had never allowed herself to mourn them. While she felt slightly detached in her relationship with her children as a result of her trauma, she said that being a mother was *sometimes a rewarding but also a boring experience that left me feeling empty*. She said she was the happiest reading a book. It seemed that she struggled to attach securely to her children. Perhaps her attachment was muted because she held back – fearing that if she allowed herself to be too close she would not cope with any future separation or loss. This perhaps was as a result of her childhood loss and trauma and the development of a somewhat 'false self' persona who adapted at the cost of emotional authenticity. Initially she felt abandoned by her parents and behaved as if her aunt and uncle had become her (substitute) parents. Her 'loving memory' of her mother and father only came later with her adult understanding of their

situation. In addition, she felt a sense of survivor guilt that she had been rescued while her parents had perished at Auschwitz.

4.2.3 Developmental Disruption

Helene described an early history where she established strong, loving attachments with her parent figures. Her early experiences of feeling loved suggest that her object relationships were secure and her parents met her need for positive mirroring. She has demonstrated resilience and resourcefulness in many respects throughout her life, and this can perhaps be accounted for by the early sense of trust that was established in relation to her parents.

Helene described her parents in idealised terms, which is consistent with her developmental age at the time. In separating from them at the age of seven, she held onto this idealised view despite feeling they had let her go. Subsequently, she was unable to separate and individuate from them and achieve a more integrated view of her parents with some ambivalence, as is typical for an older child. Her separation from her parents came at the latency stage related to what Erikson referred to as requiring resolution of Industry vs. Inferiority (Erikson, 1982). Helene was affected in many ways. Her sudden loss of positive mirroring from her parents made her feel inadequate and inferior, and as a result, she felt that she had lost confidence in herself and her sense of a solid self or identity became compromised. Her experience of separation and her difference at the convent, coupled with her fear for her survival, led to her attempt to fit in and become unobtrusive as a means of survival. Kellermann (2001) has described that child survivors did their best to fit in and placate new caretakers, in the process perhaps relinquishing aspects of drive and individuality. The cost of survival meant the relinquishing of authentic experiences of the self.

When Helene moved to South Africa she had to adjust to a new family, learn English and adapt to a new culture at thirteen years old. She reported that she adapted successfully. Her aunt and uncle were very warm and she coped well at school. She found that she could make friends easily. Helene described her environment post-liberation as supportive. However, the changes and adjustments left restricted opportunity for her to mourn. Helene said that she never cried during or after the Holocaust and her grandmother never wanted to discuss the war with her. She said that the first time she cried was when she had her first child. Her ego defences helped her to avoid thinking about her parents and she expressed that her resilience and resourcefulness

helped her to adapt. However, a close examination of her narrative account reveals that while she had friends, she felt lonely. This suggests that because of her unresolved mourning she was unable to fully bond with her peer group, an essential developmental task of adolescence (Erikson, 1982). In addition, owing to the loss and dislocation she endured, her choice to marry and have a baby in her late adolescence was perhaps related to a wish to re-create a family for herself. This is reflected by Laub (1998) who explained that often survivors married and had children in an attempt to re-establish their lost self, in the context of a family. However, this early leap into adulthood left Helene with limited time to develop a stable sense of self and may have left her with a foreclosed identity. She spoke of her struggle with postnatal depression and her difficulty in bonding with her baby, perhaps also in part as a result of her unresolved grief. It seemed that in becoming a parent the absence of her biological parents became more salient and real to her.

Helene said she was afraid of further loss and she felt that her eldest child bore the brunt of her Holocaust trauma as she struggled to bond with her. In her description of her husband, she said that although they had a peaceful relationship she often wondered if he loved her. Helene sometimes worried that he had had an affair. She said that she knew she was not the *love of his life* and knew of another woman who she thought he loved more deeply. She said it upset her that he treated her like a sister and not like a lover. He took her for granted and never gave her compliments, which distressed her. From an Eriksonian (1965) perspective, developmental disruption as a child and teenager appears to have affected her sense of identity development and her capacity to develop intimate relationships. Helene openly admitted that insecurity plagued her relationships with her family. Most significantly, her avoidance of the mourning of her parents in adolescence and adulthood meant that it appeared that considerable psychic energy was invested in defending and protecting her from unbearable pain and repressing her grief. This is likely to have restricted her range of affect more generally. It appears that this had consequences for her attachments with her husband and her children. It is possible that the defences that protected her from her emotional pain regarding mourning also prevented her from establishing deep attachments to her children. Her issues of loss and postnatal depression will receive further attention in the discussion chapter of across case themes.

4.2.4 Mental Health Impacts

In the process of the research interview, Helene identified the following features as characteristic of herself, several of which could be viewed as indicative of complex traumatic stress. Helene described a sense of helplessness and survivor guilt. She described her frequent experience of feeling utterly alone. She said that her relationships were disrupted as a result of her Holocaust trauma and she felt isolated and distrustful of others. Her alteration in meaning was seen in her loss of sustained faith. She expressed a deep sense of despair in her unresolved grief regarding her parent's death in Auschwitz. However, Helene reported that she had not suffered from clinical depression, other than a brief period of post-natal depression with her first child.

4.2.5 Experience of Aging: Integrity versus Despair

Helene was in good health at the time of the interview. She walks and meditates which she reported calms her, indicating that she has some capacity to self-soothe and self-regulate. She reported that reading had been a haven for her all her life. It is a 'place' where she says she can escape her thoughts and feelings, indicating some effective avoidance defence mechanisms. It seems that reading became her primary refuge or flight into fantasy as a retreat from an overly burdensome world.

Helene indicated that she struggled with her first child as a result of her Holocaust experiences, and she said that she *was not a perfect mother*. However, she felt she taught her children to *have integrity… I always believed in making love, not war*. She acknowledged that although her marriage was stable, she had insecurities in relation to her marriage. Her testimony indicated that she had a capacity to self-reflect and the theme of her yearning for mirroring seemed to influence the way that she related to her husband. She nursed him after he had a stroke and her devotion to looking after him indicated that she had a capacity to express her caring in instrumental ways.

As a widow Helene was socially active and had good relationships with her friends. She did the Lifeline training course to qualify as a lay counsellor and was the leader of the Jewish Woman's Charity Group. She also volunteered at a local library twice a week. She said that she was proud of her marriage and proud of her children. Helene said: *I have had a full life, I have my*

children and my friends around me, this wonderful flat to live in, I have been treated well by life, even in difficult times. She said that she was grateful for her health and that as she aged her memories of the Holocaust did not intrude into her daily life. She was able to *block* them. When asked about her feelings about dying she said that she looks forward to seeing her parents and her late husband in the afterlife. She stated that she was *ambivalent about God* and that she rarely prayed. Of her Holocaust experience, she said: *I found good people wherever I went. It gave me hope for humanity that there were more good people than bad*. She said she never discussed the Holocaust with her children as she was afraid to upset them.

Helene seemed to have attained a good level of ego integrity as she was able to reflect on both the positive and the negative of her life's journey with a level of acceptance and appreciation for "a life well lived" (Erikson, 1973). In addition, she had reinvigorated, in her adult years, her sense of self that had been foreclosed owing to the trauma she experienced. One could argue that she coped well by compartmentalizing her grief and mourning. However, she had the ego strength to do this and was able to live an enjoyable life holding onto what was good. *As one gets older one becomes more as they were. If you were a misery when you were younger, then you become more of a misery when you get older. Everything is magnified. I get irritable quicker. As I have matured, I am less afraid to say what I think. I always wanted to fit in and be the same as others. As an old lady (smiling) this is not so important to me anymore*. It seemed that in her old age Helene was able to individuate and form a sense of self and no longer needed to placate others.

4.2.6 Process Observations

The research interview was conducted over a two-day period in Helene's apartment. During the first interview she cried continuously for hours. Loud, inconsolable sobs were evoked when she began to speak about her parents. I felt that I was sitting with a seven-year-old child who was crying for her parents. I was aware that this was an outpouring of grief and mourning that Helene had avoided and repressed for sixty years. Eagle and Long (2009) mention the tension between the researcher and clinician's roles within particular kinds of research. In this instance it helped me to be informed by my clinical knowledge of working with trauma and grief. Although I adopted an empathic stance and reflected how difficult it was for Helene to be in so much evident pain I did not try to reassure or shut down the ongoing crying by distracting her

or offering physical comfort. After some time, Helene became more composed and made it clear that she was prepared to continue and she did not want to stop the interview process.

As I listened to and watched the sobbing that continued for most of the initial three-hour interview, I remembered the words of Herman (1992) who said that trauma work involves bearing witness to unbearable grief and trauma. I realised that Helene needed to experience a containing presence to bear her grief with her. This experience was reminiscent of what Eagle (2013) described as a reverie, whereby Helene needed me to hear her distress and understand that it was the outpouring of a child and adult's grief that had been repressed for several decades. The following day she cried much less and expressed gratitude for my having given her the space to cry. She said it was a great relief to begin to finally mourn her parents. I offered to refer Helene for follow-up therapy. Helene declined, saying she had no need as she felt a great sense of relief that she could finally experience her grief. By the end of the interview process she had stopped crying and chose to read her own poem about the coming of age of an older woman *who lives by her own rules*, instead of feeling like she is obliged to conform to conventional norms. Perhaps this was Helene's way of laying claim to her sense of individuation at this stage of ego integration.

Helene said*: Yesterday I cried in front of you because the whole thing about my parents hit hard. I cried when my husband died but never like I cried with you, yesterday. I have never told anyone but you. I could never bear to think of it, and I am not strong enough to face it, so what I am saying is that you helped me tremendously. I had to face it one day, I faced it, and it's dreadfully painful (crying).*
Researcher*: I can see.*
Helene*: I have never cried the way I am crying now, to think that a woman like my mother had to live in such horrible conditions, and my father who was a businessman had to be reduced to that. They were stripped of their dignity, the thought of that is unbearable! (crying).*

In these words, explains her pain around viewing her caretakers as helpless and humiliated. Her difficulty in facing this was perhaps because she needed to preserve them as undamaged introjects in order to protect her internal world, as well as her view of them. By preserving her parents as undamaged internal objects, and repressing her grief, Helene was able to survive psychologically. It was also likely that she no longer needed to retain her parental introjects in the same way as she moved in the phase of her later life.

I contacted Helene in the week following the interviews to check-in with her. She said that she was feeling relieved and was still happy to have spoken to me. Contact was made three weeks later. Helene said she was able to cry on her own and that this did not overwhelm or scare her. A few months later she wrote me a note to say thank you, writing that she was finally free to mourn her parents.

Over the two long sessions, one can perhaps argue that a positive transference had developed. In keeping with what Eagle (2013) suggests, the establishment of a positive transference may enable the patient to recreate an inner container that was broken by traumatic experiences. The process of giving testimony seemed to have developed Helene's ego strength, where she was subsequently better able to experience her grief without feeling overwhelmed and fragmented. From Laub's (1992) perspective, Helene appeared to have had an experience of being empathically held in the interview process. It is also likely that Helene agreed to be interviewed in part because she was seeking an opportunity to better resolve the issues from her past and that this, together with her increasing capacity to reflect back on life, made her more receptive of me as a helpful 'object' in this respect.

4.3 Case Summary: Dave

Dave was a child survivor from Holland who was seventy-five years old at the time of the research interview. He was nine years old when the Holocaust began and fourteen when it ended. After the Germans had invaded Holland, as a member of a Jewish family, he was captured and moved with his parents and younger sister to Westerbork transit camp. After a period of time, his father was sent to Buchenwald concentration camp, where he died. Dave, his mother, and sister were sent to Ravensbruck women's concentration camp. At the age of thirteen Dave was separated from his mother and sister and sent to Ravensbruck men's camp. Finally, he was sent to Sachsenhausen concentration camp from where he was liberated. During the Holocaust he spent a total of two and a half years in the four different concentration camps. When he returned alone to Holland he heard that his mother and younger sister had survived the Holocaust. After the family had been reunited they immigrated to South Africa as he had relatives living in the country.

At the time of the interview Dave lived with his wife to whom he had been married for forty-four years. Although he was retired, he worked part-time and was in good physical health. He had previously been diagnosed with both depression and PTSD by a psychiatrist and had been medicated with anti-depressants for the previous 20 years. Fifteen years before the interviews took place he attended weekly therapy for a period of six months.

Dave began by saying, *when I tell my story I am not speaking for myself, I am speaking for one and a half million children who died,* suggesting that he identified with others who perished. He spends his free time giving talks at schools and working in Holocaust education. The interviews took place at Dave's home and he was interviewed twice a week over a period of a month and thirty hours of material was recorded.

4.3.1 Memories of Early Parenting

Dave reported that he came from a happy family and that his parents were loving and supportive of one another. He said he was closely attached to his mother, however, he remembered being a somewhat *difficult child* who gave his mother a *hard time*. He remembered that sometimes he was naughty and she would shout at him. He reported that he was not bonded to his father: *I didn't love him and I didn't hate him*. However, he remembered his father as being *honest, charitable, and having integrity*. He said that he had a caring relationship with his sister who was six years younger. He described himself as an adventurous boy who rode his bicycle and had both Jewish and non-Jewish friends. Dave reported that he had not experienced any anti-Semitism prior to the war.

4.3.2 Traumatic Experiences and Recollections

Dave said that his first traumatic memory was of his town burning: *The fire was coming towards us, and we had to evacuate as the houses could go up in flames.* After the family had left the house, it was burnt completely. He remembered seeing his whole city burning. He remembered being horrified when he saw the Nazis beating Jews in the streets and he was frightened by the air raid bombardments. These made a very loud noise and happened nightly. He reported that his family moved to a new house and one evening when they were having dinner a Dutch policeman broke a window and opened the kitchen door. He proceeded to march through the house and told his father to open the front door for a German soldier. The German soldier told

them that they had fifteen minutes to pack a suitcase and get out of the house. Dave said that he and his family were shocked and afraid but followed the orders. They were put on a train and sent to Westerbork transit camp. Dave described his experience as a nine-year-old boy, witnessing his parents as fearful and helpless and as impotent to protect him or themselves.

Dave lived in Westerbork transit camp with his family and many hundreds of Jewish people who had been captured by the Nazis. He said that every Thursday morning a train filled with one thousand people would leave Westerbork for the Auschwitz or Sobibor death camps. He had his Bar Mitzvah in Westerbork and his father gave him his watch as a present. When he was told that his father was going to be sent to Buchenwald concentration camp, he slipped the watch into his father's back pocket as a gesture of goodwill. For years afterwards up to the time of the interview he reported that he was tormented by guilt, wondering whether his father had been upset or angry when he found it. He wanted his father to understand that it was a *gift of love* and hoped that his father would not have felt that Dave had rejected his gift. Dave explained that until the present he had no closure on this issue and said that he always became very sad when telling this story. This indicates unresolved mourning and guilt, as described in the literature as common amongst Holocaust survivors. (Dasberg, 2001; Durst, 1995; Kellermann, 2001; Wardi, 1992).

Dave's uncle told him that his father died a 'Musselman' (this was a concentration camp term used to describe a prisoner on the verge of death) in Buchenwald. *I was told that my father was so thin that he had so little flesh on his body, and he was so weak that the Germans did not bother to take him to work anymore*. He reported that he felt very sad and angry that his father had died in this manner, stripped of his dignity. As an adult, looking back retrospectively, he said he had a deep empathy for his father's pain and helplessness regarding not being able to protect his wife and children.

Dave was thirteen years old when he arrived at Ravensbruck women's camp. A group of European non-Jewish women prisoners who saw him and the group of twenty children who were with him and the women started to cry. The women said: '*You are not the first children here. They were sent to Auschwitz.' I realised then that I am a Jew and am headed for a gas chamber*. He explained that he empathised with his mother's pain as she watched helplessly as her children starved and suffered from cold during the Holocaust years. He said his mother was a very loving woman and he was constantly with her as she was responsible for looking after a

group of twenty children in the camp, including him. She would tell them stories and teach them poetry and he admired her creativity and her compassion. She taught him *stone walls do not a prison make* and to resist becoming demoralised, instilling that he was in control of how he reacted to his circumstances. Dave's attachment to his mother appears to have been a source of comfort, despite the adverse circumstances and was a protective factor for him, as described in the literature review was often the case (Klein, 2012; McFarlane, 1988, 2007; Rutter, 1985; Valent, 1998).

Dave said that the non-Jewish Polish women prisoners were particularly cruel and anti-Semitic. They used to swear at him and the other children, calling them *cursed Jews*. He said that many women died of sickness and starvation and he was surrounded by death. He described how he had vivid recollections of the sounds and sight of women screaming as they were beaten with sticks. Weakened, cold and starving, women often got sick with typhus and dysentery. He himself became gravely ill and a German SS woman, who was in charge of his barrack, fed him extra food that saved his life. It was apparent that he experienced both prejudice and compassion from the adults around him and also that he was prematurely exposed to witnessing intense suffering and death.

When he turned fourteen, Dave was separated from his mother and sent to the men's camp. He remembered that this separation was very difficult for him as he was not certain he would see his mother and sister again. At the men's camp he was beaten daily and forced to work. His mother arranged to visit him two months after his departure and when she saw him she hugged and kissed him. He said, *seeing her, after being separated for a month or two was devastating, it felt like a wound had been torn open! The separation meant I had to break the dependence of a child on his mother. I did not see her again until after the war ended*. This comment clearly demonstrates how painfully Dave experienced the separation from his mother to be and how he anticipated her loss as he was surrounded by people who were dying or dead. It appears that he attempted to cope with the awareness of the possibility of permanent separation and absence by 'forgetting' his attachments or mentally detaching. Seeing his mother in person ruptured this defence temporarily but it seems he returned to a defence of treating their loss as if it has already taken place in anticipation of this likelihood.

The transition to the men's camp represented the loss of his childhood as Dave found himself alone and unprotected at fourteen. The loss of childhood is a theme described by Dasberg (2001)

in his conceptualisation of child survivor syndrome. Dave described ongoing PTSD after the trauma he endured during this period. He stayed at Ravensbruck men's camp for six months where he received violent beatings daily: *There were thirteen Jewish boys, including myself, and eighty gypsy boys and men, the gypsies beat and humiliated me and the other Jewish boys daily*. He reported that the older (Roma) gypsies encouraged the younger ones to attack the Jewish boys and that the gypsies swore at and stole from them. Consequently, his experiences were persecutory and humiliating. *After reporting this to the camp guard the gypsies launched a 'revenge attack', and twelve of them beat me up with a spade and I was very afraid and was knocked unconscious*. It is clear that Dave was the victim of abuse and humiliation at the hands of fellow inmates and this experience had a long-term impact as the trauma disrupted the development of trust and engagement with others in adolescence (Herman, 1992). He said that according to a neuropsychological assessment, he had a short-term memory problem due to the blows he sustained to the head. The frequency with which he was knocked unconscious, both by the gypsies and barrack leaders in the concentration camps, clearly had contributed to this problem. Not only did Dave use the defence of dissociation to cope with the level of inescapable trauma he was exposed to, but also the physical trauma he sustained was so severe that it caused some permanent neurological damage.

In addition to being severely beaten Dave reported that he was deeply traumatised as a result of witnessing the floggings and torture of other inmates. *There was a flogging block to which the victim was tied, and I remember seeing the victims writhe in pain and scream horribly. We were surrounded by sadists; the guards the gypsies, and the Kapos were all bent on inflicting pain and humiliation*. He reported that when seeing a guard beat up a child, he realised that he and other children were viewed as vermin, that Nazis had no compassion and were determined to destroy them. One can well appreciate that Dave felt dehumanised and feared for his life and that dissociation was an understandable defence, although it is apparent that he retained some capacity for empathy in his description of being disturbed by others' distress.

Dave said that at Sachsenhausen concentration camp it was so cold that inmates held onto each other in a *spoon position* during the night for warmth and sometimes he woke up holding a corpse. He explained that he became emotionally numb as a result of this trauma and a dead body became *like a sack of potatoes* to him. Dave's description of emotional numbness is similar to the descriptions of the dissociation of the Sonderkommando that was highlighted by Greif (2005). Both Dave and the men who were described by Greif (2005) became so

disconnected from the horror of managing dead bodies that emotional numbness, as described by Herman (1992) and Wardi (1992), was a means of surviving this form of daily life.

As the allies approached, Dave was taken out of the camp on a forced evacuation or 'death march' that lasted for two weeks. He said that the hunger and the cold were unbearable. The Germans shot a man next to him and he knew that if he protested he would be shot too. He said that the death march was his worst experience during the Holocaust because he witnessed so many executions. He felt horrified by them. In addition, he was weak, starving, and constantly under threat of being shot. Of the hundred men on the death march, only fifty survived. After they had been liberated the allies gave him and his nine young friends potatoes. They got oil and made fried chips. Eight of these ten boys died as their starved bodies could not tolerate the food. These kinds of descriptions brought home the reality of the level of life threat experienced and it was apparent that Dave had anticipated and almost accepted the likelihood of his own death.

As an early adolescent Dave was forced to fend for himself in an environment characterized by harrowing cruelty. During this time in his life he reported that he became detached from people and had remained that way until the present time. Dave's description of his forced "independence and detachment" suggests he used the narcissistically oriented defence of complete self-reliance to cope with the painful loss of parental care and environmental attack. The detachment he describes seems to be concordant with a form of dissociation, as described in the literature to be common amongst survivors (Herman, 1992; Laub & Auerhahn, 1983; Wardi, 1992). When Dave returned to the Netherlands after the war, he was surprised to hear from family friends that his mother and sister had survived and were living in England

Dave was pained, not only about the loss of his father, but also of the sixteen members of his extended family who were gassed at Auschwitz and Sobibor. He described his horror and fear regarding the death in the gas chambers in great detail during the interviews He cried as he described how *Lithuanian and Latvian Jews were stripped and shot dead 'en masse' by the German Einsatzgruppen (mobile killing units) in forests* and identified strongly with these victims. He said that if he had been a father at that time, he would have held his wife and his child so that they could have died at the same time so as to spare them the anguish of witnessing each other's deaths. Although Dave spoke in a largely detached tone throughout most of the interviews this was the first time during interviewing that he expressed visible sadness. In a

sense he seemed able to empathize more easily with these somewhat once removed atrocities than to engage with the affect associated with his own direct experiences.

Dave spent a long time giving a detailed description of the gas chambers at Auschwitz. For the past decade, he had visited schools where he showed slides and spoke about the gas chambers. He brought his pictures of Auschwitz and explained the death process in great detail in his interviews. *Just think of the horror and terror of these poor people, standing there naked with their children and suddenly realising this is not a shower, it's a gas chamber*! Dave constantly perseverated about the deaths at Auschwitz, which could be understood to be one indication of his PTSD. It was apparent that he was very invested in others' appreciating the full horror of the Holocaust and bearing witness to this.

4.3.3 Developmental Disruption

Dave reported that in early childhood he came from a stable and loving home where he was closely attached to his mother. His lack of attachment to his father was noted, however, he described his father with respect and admiration. When the Holocaust began he was in the latency stage, described by Erikson (1977) as the Industry vs. Inferiority stage. His primary school years were disrupted with the burning of his home at the beginning of the war. The family's eviction from their home was his first experience of his parents' inability to protect him.

According to Erikson (1977) the core developmental task during adolescence is Identity versus Role Confusion. Dave's adolescent years were fraught with loss and trauma. Part of adolescent male identity includes developing a sense of physical strength, autonomy and the capacity to be competent. He was constantly humiliated with being weak, defeated and a 'masculine failure' It is possible that his experience of severe beatings and humiliation, in addition to catastrophic loss at that time, led to the construction of a detached style defence mechanism. This could have contributed to the manifestation of depression later in his life. During the war, Dave was developing his identity as a boy or young man. He was the victim of continual, violent beatings and reported that he felt humiliated and violated. In addition, hunger, illness, and degradation added to his sense of helplessness and impotent rage. He witnessed executions and feared for his life. These experiences led to the development of PTSD (Herman, 1992; Van der

Kolk, 2007) and disrupted his capacity to form a stable adolescent identity (Erikson, 1982). He seems to have experienced himself as 'already dead' at times although he fought to survive.

Dave said that when he arrived in South Africa at fourteen years old nobody asked him about his experiences during the Holocaust and he did not discuss his experiences even with his mother. His extended family was not supportive of his mother or himself. School was difficult as he did not relate well to his peer group. When he tried to discuss his Holocaust experiences at school the other Jewish boys *shut him up*. Consequently, he became angry and socially isolated. He said that he involved himself in solitary activities such as hiking outdoors, which he enjoyed. Another severe trauma occurred when he visited Israel during the early fifties. He became involved in a fight with a group of young men who beat him to the point of being hospitalised for a couple of days. He reported that this experience was particularly traumatic as he had been beaten up in Israel, by Jews, which left him feeling betrayed and enraged. It is possible that this experience brought back memories of prior beatings and exacerbated his PTSD.

Despite Dave's difficulties with adjusting in South Africa, his resilience prevailed. He was able to work and marry. His capacity to re-attach was activated, and he reported that he shared a loving and fulfilling relationship with his wife. However, Dave said that she was the only person to whom he was attached. This positive, nurturing relationship indicated that despite his PTSD, he was able to make a good object choice, probably based on his secure early attachment to his mother (Klein, 2012).

4.3.4 Mental Health Impacts

Dave reported that he suffered from depression and PTSD. Periodic alterations in consciousness included preoccupation with his traumatic experiences, and he spoke incessantly about his experiences and the death of his family at Auschwitz. He described dissociative episodes including depersonalisation and derealisation. In addition, Dave ruminatively focused on his Holocaust trauma and had PTSD symptoms, demonstrating reexperiencing and mood instability some seventy years post his liberation. He described a sense of survivor guilt and the sense of stigma associated with his identity during adolescence appeared to have stayed with him. He remained preoccupied with understanding why the Holocaust happened and the Nazi motivation for killing Jews. As a consequence of his traumatic experiences, Dave withdrew

socially and was persistently distrustful of people over the course of his lifetime. His lack of faith in God and humankind suggested that his Holocaust trauma had permanently altered his system of meaning. In addition, he expressed a sense of despair regarding his lost childhood and his unresolved grief regarding the loss of his father and the manner of his dying. A psychiatrist had prescribed both medication and psychotherapy for his depression and his PTSD.

4.3.5 Experience of Aging: Integrity versus Despair

At the time of the interview, Dave was in excellent health and was fit and active, however, he continued to take anti-depressant medication. Dave represented the kind of survivor described by Kellermann (2001), who observed that survivors often had a dual diagnosis of PTSD and depression. Dave worked part-time and volunteered to speak about his Holocaust experiences at schools. He also read extensively about the Holocaust. He told me that in the years following the Holocaust he took up shooting and martial arts to gain a sense of masculine competence. He admitted to placing himself in dangerous situations where he walked around in unsafe areas at unsafe times carrying a loaded gun. He explained that he would rather die than be humiliated again. Dave seemed to be attempting to gain a sense of retrospective mastery over the victimization he endured during the Holocaust. His risk-taking behaviour indicated that over sixty years later he remained deeply scarred by his experiences. Dave was still *fighting* as an old man.

Dave was insightful and had a deeply philosophical worldview. He said that as he ages, he is more appreciative of what life offers. He explained that although he still suffered and was angry at times, *there is more joy than anger, I enjoy life*. He spoke of the deep love that he felt for his wife and said that the love had grown and developed over time. From this perspective, it appeared that Dave had elements of ego integration, such as appreciation for his present life and marital bond, however he was consumed with despair regarding his trauma and loss as a result of the Holocaust.

Towards the end of the interview, Dave asked if he could sing a song. He chose to sing ‘Ani Maámin’ which means ‘I believe’. That Dave chose to sing this specific song was significant in that he defines himself as an atheist. Despite his atheism, he marked the conclusion of his final interview with a song about faith and God.

4.3.6 Process Observations

After thirty hours of recorded interviews, Dave was keen to continue. When I asked him to reflect on the interviews it was apparent that Dave perhaps held me in an idealised transference relation, as both a listener and someone whom he implored to hear his story.

Researcher*: Dave what has your experience talking about the Holocaust been like?*
Dave*: Good. If it adds value, it's worthwhile. I enjoy discussing this thing with you.*
Researcher*: What has been beneficial for you?*
Dave*: Have you heard about the ancient mariner syndrome?*
Researcher*: No.*
Dave*: It's a story about a sailor who survives a lot of horrific experiences and eventually he is the only one who survives from the whole crew. As an old man, he looks around a table until he can find someone who can listen to his story, and by hook or by crook he must tell the story; he practically forces the other person to listen to his story. I hope you didn't feel forced.*
Researcher*: No.*
Dave: *He had this compulsion and obsession to talk. I have been inflicting my story on you*.

It seemed that while Dave was aware that his trauma narrative had been a burden on me he was also powerfully in need of a validating audience and appreciative of the research time devoted to him.

He continued to say that because I was a professional, he could tell his story to me without worrying that he would upset me. At points during the interview process I became anxious about Dave's well-being and worried that his reported behaviour might be dangerous to him. I felt confronted with an ethical dilemma as I understood that Dave was putting his life in danger apparently in a form of repetition compulsion related to camp trauma but it was not necessarily my role as researcher to take up this issue. He had not asked me to engage him as a clinical professional or therapist. Nevertheless, my clinical understanding became ethically more important to me than adopting a non-interventionist stance as a researcher. In addition, his wife approached me in Dave's presence and spoke of her fear for his safety. I consulted with one of my research supervisors, who is also a clinician, and after this challenged Dave about his potentially self-destructive behaviour, offering an interpretation concerning his compulsion to

repeat the trauma. I explained that his actions had potentially dangerous consequences for himself and his wife. After initially resisting the interpretation, Dave acknowledged that he knew that his actions were dangerous. The recognition that his wife would be heartbroken should something happen to him appeared to shift his self-endangering stance.

I offered to refer Dave for therapy, which he refused. I stayed in touch with him and we met eight months after the interview process was completed. The plan was to see how he was coping and reopen the possibility of referring him for therapy. When I asked how he had been since the interviews, he reported that he had stopped his dangerous behaviour, much to his wife's relief. I think Dave was so unconsciously trapped in this act of repetition compulsion that it did not occur to him that it could also hurt his wife. He said that the interviews had helped, that he was feeling good and that he would be prepared to receive therapy if it would help the research. I explained that although he had helped with the research the therapy was not for my benefit but rather for his own benefit. He said that he was coping well and did not feel he needed therapy at this point. I observed that he appeared to be doing well and that therefore referring him for therapy was perhaps not necessary. I have retained contact with Dave through various forums as will be further elaborated in the reflexivity section.

4.4 Case Summary: Miriam

Miriam was born in Latvia. She was eighty years old at the time of the research interview. Miriam was twelve years old when the Holocaust started and sixteen when it ended. Soon after the Holocaust began her father was taken to prison and killed by the Germans. Miriam and her mother were initially moved to the Dvinsk Ghetto and later to Keiserwald concentration camp, near Riga. After their time in Keiserwald she and her mother were imprisoned in Stutthoff concentration camp for three months. They then moved to Sophienwalde labour camp, a subcamp of Stutthoff. After a treacherous death march the Russian Army finally liberated them. At the end of the war Miriam and her mother worked for a year for the Russians who liberated the camps, after which they then spent a year in Paris. They then emigrated to South Africa, moving to Johannesburg because her mother had family who lived there.

Miriam reported that her extended family was very supportive of her and her mother, however, no one asked about or discussed the Holocaust. Although she and her mother remained close she stated that they never discussed what they had endured. Miriam studied and obtained a

school leaving qualification. After this she got married and had four children. She was interviewed once a week at her home over a period of five weeks. Miriam was interviewed for a total of eight hours and was very engaging and seemed ready and willing to tell her story. On closer examination she presented as having very strong psychological defences. She did not become visibly sad or anxious during her interviews and said that she had never suffered from depression. She told her story in a detached manner as if she was a storyteller describing the narrative of another person. This indicated that perhaps Miriam had developed and sustained rigid defences in relation to managing the impact of the Holocaust period in her life. Her flat affect suggested that there was evidence of her using dissociation as a way of coping with catastrophic trauma and loss, in accordance with Herman's (1992) observations about coping with extreme and prolonged trauma exposure.

4.4.1 Memories of Early Parenting

Miriam said that she had memories of a very happy childhood. She was the only child born into an affluent family and described both parents in glowing terms as educated and culturally sophisticated. Her father worked in his business and he remained at home with her while her mother, who was involved in arts and culture, frequently travelled around Europe. Her father was said to be *a very kind man*, and she described her mother as *a very cultured and dynamic woman*. She was very proud of her mother. She had clear memories of her early childhood and spoke of ballet lessons, which she loved. She enthusiastically showed me pictures of her ballet class when she was six years old. She reported that from the age of two her beloved Latvian nanny Natasha looked after her. Natasha was a devoted nanny who slept in Miriam's room and taught her how to sew and knit. She reported that her nanny was *like a mother to me*. Miriam used to accompany her to church and spent many hours with her. She reported that her nanny risked her life for her during the Holocaust, keeping her in hiding for two months and bringing Miriam and her mother food. Miriam describes her childhood as happy and secure. On closer observation it seemed that her nanny was a very important nurturing object who cared for her in place of her mother, who was somewhat absent owing to her travelling. It was evident that Miriam had felt well supported and loved and had introjected primarily positive object relationships with all three significant caregivers.

4.4.2 Traumatic Experiences and Recollections

Miriam reported that her first traumatic memory was of running away from the fires caused by bombings. Houses were ablaze, and Miriam and her family ran frightened through a tunnel of fire. She described how sick patients from the nearby hospital were begging for help, shouting and crawling on all fours. As they were also running from the fire themselves, she and her mother were unable to help them. She reported that this image profoundly distressed her throughout her life. Miriam's father and uncle were sent to prison. Her mother had gone to visit her father and found that the prison was empty aside from a large pile of men's clothes. She remembered that her mother had returned home shaken and whispered - *they are all gone, murdered in cold blood!* She reported that she and her mother were so afraid for their survival that they were unable to process their loss and mourn properly for her father. Ghetto selections took place frequently and people were shot and buried in mass graves by the Einsatzgruppen (mobile killing units). Miriam said she constantly lived with the threat of death. She reported that she had witnessed the hanging of an older girl whom she knew well. Her crime was that she had hidden her yellow star from view. Her dead body was left to stand for a week and this image was a fearful warning for all to see.

Miriam said that during the time they lived in the Ghetto she was constantly afraid of being separated from her mother who she depended upon for survival. *I was covered in boils, and I would scratch the lice, my burning skin hung from my bones. When my mother was taken from the ghetto to town to work, I was left alone and sick, a child of twelve years old. I spent the days without her, and she returned to sleep in the Ghetto at night. I lived in fear that my mother would not return*. At one point when her mother did not return for three nights, she was terrified that she would not see her again. She said that when her mother returned, she was beaten up and bruised: *Her face was so swollen I didn't recognise her! She said, 'Miriam it's me your mother!'. Her mother reported that the Germans took a book and put it on her head and beat her. They kept her in a dungeon and tortured her for three days. A German soldier kicked and humiliated her and made her kiss his feet!* She said that she was constantly afraid that her mother would not survive, and this incident was particularly terrifying.

Miriam reported that her nanny made continuous efforts to help them during the Holocaust period: *My nanny risked her life to bring us bread and got my mother's permission to christen me with holy water in the hope that it would save me. Although I didn't pray, I believe that I*

survived the Holocaust because my nanny, who was a religious Catholic, prayed for me. Miriam went to hide at her nanny's home as her mother feared that she would be killed in the Ghetto during the day while she was at work. Miriam reported that after two months she returned to the ghetto because people were suspicious that her nanny was hiding her and it became unsafe. When Miriam returned, the ghetto had been 'liquidated', and she said that she witnessed a horrific scene of carnage that never left her memory.

Miriam and her mother were then transferred to Citadel, a military camp across the town in Dvinsk. Miriam reported that she used to sew dolls and clothing for the Germans, a skill she had learned from her nanny. She and her mother spent nine months in Citadel. She reported that they were later moved to Keiserwald concentration camp, in Riga, where Miriam became very sick and weak. Her mother and other inmates helped to nurse her. Hunger and the cold were extreme yet she was made to work very hard in the rain and cold. She reported that she and her mother were then taken to Stutthof concentration camp. Miriam said that this was a *terrifying experience* as will be described in more detail later in this discussion.

Miriam said that every day someone would commit suicide by touching the electric fence, which became a normal way of life. Miriam described her concentration camp experience in the following way: *The cruelty was in the way they gathered us and counted us, you stood there in the cold, hungry and it's raining, and they kept you standing for no reason and counted you for no reason, you had nowhere to run too, there was no reason to keep counting! Cruelty was there all the time the whole thing was cruel! Then someone grabbed a potato from your soup! People slept with a piece of bread under their bunk… the hunger we experienced, this is something that normal people could never understand!*

Miriam said that because she was small and weak she was constantly afraid of being *selected for death*. She reported that her mother often stuffed her bra in order to make Miriam look older and nourished. At Sophienwald camp Miriam witnessed a woman being shot as she grabbed a potato from a nearby cart. She reported that she was constantly afraid and traumatised by severe hunger, cold and lice. Towards the end of the war she and her mother were taken on a death march overnight for twenty kilometres in the snow, without food or water. When morning came, they could barely move as the Germans drove them into a barn. The next morning the Russians liberated them. She said, *my mother was an amazing, outstanding woman, she constantly looked after me, and she saved my life. I was lucky I had her with me.*

Miriam lost her father in the first months of the war, as well as her cousin Hannah, who was like a sister to her. In addition, her aunts, uncles and extended family were also murdered. She reported feeling devastated as a result of her separation from her nanny, Natasha, who was *a second mother*. This woman did not have children of her own and was devoted to caring for Miriam. In recent years, Miriam and her family honoured Natasha at Yad Vashem, in Israel, as a righteous gentile who put her life at risk to save Miriam.

4.4.3 Developmental Disruption

Miriam said her childhood was very happy, and her parents were described in positive and perhaps even idealised ways. It is significant that she commented on being very attached to her nanny. She seems to have internalised Natasha as an alternative nurturing object. Her frequent separations from her mother from the age of two may have left Miriam anxiously attached, however, her nanny was constantly with her and seemed to be a secure maternal substitute. The sharp contrast between her privileged and protected life before the war and the extent to which she was overwhelmed by trauma, deprivation and physical suffering during the Holocaust was apparent in her narrative.

Miriam was an adolescent in the stage of Identity versus Role Confusion during the time of the Holocaust. In early adolescence, Miriam lost her father and experienced fear and suffering. Both she and her mother were unable to properly mourn his loss as their survival was at risk. Miriam reported that for a period of five years she was constantly fearful of her own death and experienced extreme fear of losing her mother. Her mother cared for and protected her, which was a significant factor in building her resilience. However, she was frequently sick and depended on her mother for survival. Living under the constant threat of this loss may have exacerbated her anxious attachment to her mother. Miriam had to struggle for survival and had no time to form an identity or bond with her peer group, instead she remained with her mother who she retained as a primary attachment object in the camps. While being with her mother added to her resilience, she remained intensely over-attached to her mother. This enmeshment or traumatic bonding was clearly as a result of the trauma they endured together. From her narrative, it is understood that Miriam idealised her mother to a degree and considered her a *saviour*. However, she may have sacrificed her own identity formation in the service of this intense attachment. The loss of her nanny was very traumatic, as she had been a stable caretaker

who had devoted her life to looking after Miriam. As with her father's loss, she was unable to process the separation from and loss of this primary caretaker, as she was focused on her own survival.

During adolescence, Miriam endured humiliation and intrusive bodily attacks, such as injections to the breast and pubic hair examinations for lice, with a stick. She described her initial feeling of humiliation but reported that she later disassociated as a way of coping. Her intense suffering from lice, eczema, cold, and hunger was described in great detail. This seemed to have been experienced as a powerful, visceral/physical trauma. It is possible that Miriam's extreme anxiety about losing her mother and dying herself, in combination with her physical suffering, led to dissociation as a way of coping. She reported as an adult that she never became depressed and is not *emotional*. It is likely that she used powerful psychological defences to disconnect from her loss, humiliation, and sense of imminent life threat.

Miriam reported that she had good familial and social support when she arrived in South Africa and this helped her to adjust to life in a new country. As explained by Keilson (1979), a facilitating environment after the Holocaust was a mitigating factor. She married in her early twenties. Miriam reported that she suffered from nightmares for many decades. The themes of her nightmare always involved running away from the Germans. It is interesting that despite her conscious attempts to move on from or repress her traumatic experiences they emerged in this intrusive form.

4.4.4 Mental Health Impacts

Miriam suffered from severe nightmares for decades after the Holocaust ended, a symptom that would be seen as falling under the intrusion cluster of PTSD, and it is evident that this symptom was chronic. Additionally, during her time in the camps she coped by using depersonalisation and derealisation and there was some indication that these defences may have become somewhat entrenched. Her flat affect was remarkable, and she avoided expression of any emotional vulnerability. She told me in a hostile tone of voice that no one could understand the Holocaust unless he or she had been there. This suggested her experience of feeling different from others and of having been indelibly changed or marked in some way. Extending upon this, she described her alienation from religion and her loss of faith in people and God.

4.4.5 Experience of Aging: Integrity versus Despair

At the time of the interview Miriam was in good health and said she was content with her life. She said that her husband, to whom she had been married for over fifty years, was very kind to her, and her children were a source of pride. She was proud that her children are supportive of one another and do not fight. In this respect she seemed to find it important that her children had not been contaminated by her experience and were generative in their own right.

She said that she never got depressed and kept herself busy with sewing, reading, making jewellery, gardening, and baking. Clearly, her capacity to engage productively and to distract herself with activities and channelling her creativity was her way of coping. She spoke publicly about her story fairly frequently and was acknowledged by her community for her bravery in this respect. When asked whether her memories of the Holocaust became worse as she aged, she said that they were always with her but did not get worse. It seems that her defence mechanism of dissociation, that appeared to largely successfully block her emotional engagement with her trauma, continued to function well in her old age. In addition to dissociation, Miriam seemed to use compartmentalisation as a defence mechanism to cope with her trauma as she was able to talk about her experiences without this apparently intruding into her everyday functionality. She seemed to idealise her mother who had saved her life and said many times that her mother was an outstanding woman. It appeared that she had successfully repressed all her negative emotions in the service of survival. According to Dasberg (2001), this level of repressing unmanageable trauma was commonly found in child survivors. It was evident that Miriam had underlying hostility towards religious leaders and her hostility also emerged in relation to me indicating that at particular times she used hostility to cope with her vulnerability.

During the interviews at her house, Miriam would offer tea and an elaborate assortment of biscuits that she had baked, of which she was very proud. She said that all her clothes were hand-made as her nanny had taught her to sew. Keeping busy helped her to cope, and the skills she had in this regard were thanks to her nanny. At the end of her interview, Miriam asked if she could show me her jewellery and explained that she had made a living for many years designing handmade jewellery. Miriam was very proud of her work and recounted that she had used her creativity as a way of coping. It seemed that not only had Miriam used creativity as a way of distracting herself from her pain but also that this was perhaps a concrete means of

holding onto her internalised good object, as it was her nanny who had fostered her creative skills. Although Miriam was able to express gratitude and pride about her achievements, as well as attain a great level of satisfaction from her life, it was clear that she blocked aspects of her emotional life associated with traumatic experiences. She struggled to process her Holocaust trauma because of her rather rigid defensive style (Herman, 1992; Dasberg, 2001). Nevertheless, it is important to acknowledge her generative capacity and her retention of good object introjects from her childhood throughout her life

4.4.6 Process Observations

Despite being apparently comfortable to take part in the research, the interview process with Miriam was rather complex, as illustrated, for example, by the following exchange.
Miriam: *No one can understand the horror unless they have been there. Even you can never understand! (Said with apparent aggression)*
Researcher: *I agree Miriam, I cannot understand, I was not there.*

During the interview process I felt Miriam's anger and recognized her communication to perhaps be a projection or displacement of hostile feelings. My psychological training helped me to decide that it was best to acknowledge rather than explore her communication, particular given the context. In addition, I thought it was important to validate that no one could understand Miriam's experience. She was an adult who had been very wounded by her reality.

Miriam continued to invite me for tea after the interviews were over. She also showed curiosity about my life and attempted to befriend me, becoming angry if a long period of time elapsed without hearing from me. She would call me and say in an aggressive tone of voice, *Where have you been? Come for tea*! I tried to be as sensitive and tactful as possible in responding to her need but also in setting boundaries. I wondered if in some respects I had become a replica transference object of the nanny that Miriam was so fond of. This impression was to some extent reinforced as Miriam treated me as if I were at her beck and call and as if she was somehow entitled to my attention (as a child might feel towards a caretaker). Perhaps as a result of her distrust she became very controlling of her objects. It felt as if having told me her story, Miriam needed to hold onto the relationship. I felt guilty about setting what I perceived to be a necessary boundary in terms of ongoing extra-research contact and tried to do so as gently as possible. However, Miriam's anger was an indication of her dissatisfaction suggestive of unmet

need for a mirror and a listener in the present. It seemed that Miriam had invested in herself in the research by telling her story in detail and this meant that perhaps it was difficult for her to let go of the gratifying contact with someone who was empathically engaged. Despite raising this possibility Miriam said she did not want to see a therapist. She kept in touch with me telephonically for over a year but this contact ceased after she later suffered a stroke.

4.5 Case Summary: Lenna

Lenna was a child survivor born in Hungary. She was eight years old when the Holocaust began and thirteen years old at the end of the war. She was imprisoned at Auschwitz for a year and was moved to Bergen-Belsen where she was captive for three months before liberation. Her entire family was killed, except for her aunt. After the war ended, she went to live on a kibbutz in Israel. After meeting her husband in her early twenties, she immigrated to South Africa and had two children. She worked as a teacher for many years before starting her own business, which became a very successful company.

At the time of the interview Lenna was in good health and was a healthy seventy-seven-year-old woman. She worked full-time and lived with her husband. Both of her daughters lived overseas, and she was planning to emigrate from South Africa so that she could be close to them and her grandchildren. Lenna agreed to meet me but warned me that she had struggled to tell her story and had almost never spoken about her Holocaust experiences: *I have never spoken about what I went through or what happened in the camps, I am not sure I will be able to cope, the difficulty is expressing it verbally and then hearing it out loud is too traumatic.* Despite her anxiety Lenna nevertheless chose to go ahead with the interviews with the mutual understanding that she could terminate the process at any point.

Lenna said that several years ago she had experienced emotional difficulties related to relationship problems and consulted a psychologist. However, she found it difficult to speak about her issues and ended the therapy. She met with me for three sessions that lasted over an hour per session and spoke about her early history. She said that the dread of discussing her Holocaust experiences had activated nightmares and she felt unable to continue the interview process. I thanked her for her willingness to make herself available for the research project despite her initial misgivings and she indicated that she was comfortable for her data to be included in the research thesis.

4.5.1 Memories of Early Parenting

Lenna reported that her parents were married for many years before she was born. Her father contracted tuberculosis shortly before she was born and when she was ten months old her mother gave birth to her younger brother. At this time her father her became very ill, and as a result, she and her younger brother went to live with her grand-aunt when she was four years old. This aunt was her grandfather's sister and she and her husband did not have children of their own. Lenna described them as kind and loving people. She and her brother lived with the couple during the week and returned to their parents' house on the weekend. This living arrangement minimised the risk of the children contracting their father's disease. In addition, their mother worked full-time as the family struggled financially and her mother looked after her sick husband at night. Lenna did not have any memories before the age of four and said she does not recollect ever having felt sad to say goodbye to her mother as her great-aunt was a good parent figure. She said that she did not remember receiving affection from her parent figures and sometimes this left her doubting her lovability. She has memories of being nurtured and cared for by her aunt: *I don't remember being hugged by my parents, it upsets me, but I don't remember… I remember everything about my aunt, she was very kind and nice… I remember the food she would pack in my lunch and that she would walk me to school.*

Lenna reported that her father's illness was traumatic for her and her brother as they were not allowed to approach him or touch him for fear that he was contagious: *We used to have a board between the kitchen and the bedroom. We would stand on a chair and look over the board and talk to him like that; we would never go in the room. I used to stand outside the door and talk to him.* Lenna said that her father was a refined man who loved poetry and music and she felt attached to him despite the physical separation. When he was in the hospital, they were allowed closer contact although she and her brother had to wear masks for protection. She reported that her father died when she was seven years old. A week before he died, she remembers that he did not speak much, but he blessed Lenna and her brother. No one told Lenna directly that he had died. She remembered that her aunt said it was time to go and when she walked outside and saw her father's coffin, she then realised that he had died. *It's difficult to say how I felt as a child. I would imagine that his death traumatised me. I used to imagine that my father was talking to me after he died.* After her father's death, she and her brother returned home to live with their mother and it is likely that the renewed separation, this time from her great-aunt, may have been difficult. She reported that she and her brother were always very close. It is

interesting that Lenna chose to spend a considerable portion of the interview time talking about this pre-war period. This may have been in part because this early period in her life also held difficult or traumatic memories and was illustrative of a childhood that may have left her vulnerable, even prior to the Holocaust period. However, it may also be that it was easier to talk about this time than her camp experiences, as she suggested.

4.5.2 Traumatic Experiences and Recollections

A year after her father died the Holocaust began. Lenna was eight years old at the time. The Jews in Hungary were protected until 1944. However, in 1944 she was captured and sent to Auschwitz concentration camp for a year. Thereafter, she was moved to Bergen-Belsen where she spent three months before being liberated. At this time, she was very sick and was taken to Sweden by the Red Cross. She said: *I don't think anyone who went through the camps like Auschwitz, Bergen-Belsen or Majdanek is normal. I don't believe you can be normal! You live with the memories and the people you lost, and what you experienced, it's there with you all the time, so how can you be normal? It's not something that is finished and gone, and you get on with your life. So, you build yourself a way of life; you try to act normal, you laugh, you dance you go to movies and theatre. I have it all in front of my eyes, and it's hard to forget!* This comment illustrates rather vividly what Dasberg (2001) says is the parallel existence that many survivors experience. Part of them is stuck in their camp experience, whilst they function as if 'untouched' in their present lives. Unlike some of the other participants Lenna would not describe her experiences in the camps in any detail, however it is evident from the statement just cited that she experienced death and horror of a similar magnitude to that described by others and her reference to her sickness indicates that she also suffered physically.

Despite her lack of elaboration of her camp experiences Lenna mentioned that she had visited Auschwitz three times after the Holocaust ended and felt a sense of comfort there. She expresses intense feelings of survivor guilt in relation to her younger brother who died in Auschwitz. As indicated previously she also lost multiple other family members, including her mother and the grand-aunt who had looked after her as a child. Unlike some of the other survivors interviewed it is evident that Lenna had no sustained relationship with anyone in the camps or pre-and post the Holocaust. *I was liberated from Auschwitz. I was twelve and alone*. This isolation may have contributed to her fragility in approaching Holocaust related recollections as it is apparent that she did not have anyone to share the burden of the experience at the time or subsequently.

4.5.3 Developmental Disruption

Lenna's capacity to have developed basic trust in the first year of life is questionable. Her father was sick with Tuberculosis before she was born, and so it is possible that her mother's anxiety regarding her father's illness distracted her from bonding with Lenna as a baby. In addition, Lenna was displaced by the birth of her brother born ten months after her. By the time she was four years old, there was anxiety that the children could contract Tuberculosis from their father. For this reason, the children were sent to live with their great-aunt and uncle, returning home only on weekends. This was a major developmental disruption at Erikson's (1982) stage of Guilt vs. Initiative. According to Fraiberg (1959) children are renowned for "magical thinking" at this age and are egocentric. During this stage, children often feel guilty and blame themselves for difficulties in their environment. It is possible that Lenna unconsciously blamed herself for her father's illness and that she understood the move to her aunt as a rejection and punishment by her mother, despite her positive experience of care in her new home. Her capacity for resilience is demonstrated by how she adjusted to her environment. She also, fortunately, was able to bond with her aunt. Lenna seemed to develop a narcissistically oriented self-reliant defence as a way of coping, as she knew she could not rely on her heavily burdened mother or her sick father. This self-reliance seemed to continue after the Holocaust as she reported that she never discussed her feelings or her Holocaust experiences with anyone.

Lenna's father's death was remembered traumatically, where there appears to have been little or no preparation for or mediation of the experience from the adults around her. While she had no memory of affection from her parents and sometimes wondered if she was loved she remembers that her aunt cared about her. It seems the separation from her parents at an early age compromised her capacity to form a secure bond with them. One could argue that her sense of being burdensome and her susceptibility to loss was established before the Holocaust in relation to her father's death and her mother's preoccupation with caring for her father. The Holocaust trauma seemed to exacerbate this and translated into an intense experience of survivor guilt in relation to her younger brother and cousins who perished.

During the Holocaust, Lenna missed out on a primary school education and never thereafter completed her education. According to Erikson (1982), the latency stage involves the core negotiation of Industry vs. Inferiority. Despite her successful business, Lenna felt she had missed out on her education and reported that she had low self-esteem in this regard. *As far as*

education is concerned, I never had the chance or the opportunity. I am very sensitive about people saying to me 'What do you know you never had an education, you think you know everything, you are stupid'. That affects me very badly. This comment illustrates Lenna's sense of inferiority, even though she was able to build a large and successful business. She demonstrates that developmental disruption at this stage of life may well leave its mark on personality development in later life.

Lenna was thirteen when the war ended. Her entrance into adolescence was heralded by experiences of being orphaned and sick. Her entire family had been killed. Her search for an identity was eclipsed by her intense grief for her mother, brother, and extended family. She reported that going to a kibbutz in Israel helped to provide a peer group that became important for her. Klein (2012) demonstrated in his research that the close-knit community of a kibbutz seemed to provide survivors with a 'safe haven', where they had a sense of belonging. It mitigated against the sense of isolation experienced by survivors, especially those who had lost immediate and extended family. This mirrored Lenna's experience and she said that her kibbutz experience helped her to cope after the Holocaust.

4.5.4 Mental Health Impacts

Although Lenna was unable to complete the interview process, it was clear from what she had said that she was suffering from various symptoms of complex traumatic stress. It was evident that she had persistent dysphoria and she described her inhibited anger in relation to family members. It was also evident that despite a motivation to participate Lenna could not modulate or regulate the powerful affects evoked in talking about her experience of the Holocaust. Alterations in consciousness were evident in her description of dissociative states and avoidant PTSD symptoms. She described a sense of shame and survival guilt in relation to her dead family members. Isolation and withdrawal seemed to characterise her relationships with her present family. This was manifested in her description of disrupted relationships and persistent distrust. An alteration of meaning systems was identified in Lenna's account of her loss of faith and her ongoing sense of hopelessness and despair about the loss of her family during the Holocaust. Lenna had hidden her vulnerability and coped by being self-reliant. It is possible that her withdrawal from the interview process was a final act of self-reliance and avoidance, exposing her vulnerability with another.

4.5.5 Experience of Aging: Integrity Versus Despair

Lenna did not fully share her traumatic experiences, and the interview process was discontinued as she was too traumatised to speak further about this period of her life. Some of the information she shared was indicative of her state of mind. She said that she had intense survivor guilt and often asked herself why she had survived as opposed to her brother or members of her extended family. As a result, she said she struggled to enjoy her accomplishments as well as the luxurious standard of living that she had achieved. She was plagued by a sense of inadequacy about her lack of education, and she said that in her personal/family relationships she felt *trampled on*. She reported that she struggled to speak up for herself when she felt victimised. She also said she saw herself as *mad* and that her children understood that they had a *mad mother*. Although she coped outwardly, on the inside she felt severely damaged and carried this alone, experiencing enduring inner turmoil. This presentation is consistent with how Dasberg (2001) describes child survivors carrying their pain by creating a "split" between their inner emotional life and their everyday functioning in the outside world.

As previously mentioned, Lenna is likely to have experienced disrupted bonding and early grief as a result of her father's illness and death, before the Holocaust. It seemed she used a defence of self-sufficiency and self-reliance, as well as well as compartmentalisation, in order to cope. It appears that Lenna was perhaps in some respects repeating her trauma by engaging in relationships in which she continued *to feel trampled on* in struggling to assert herself. It was perhaps the case that her early experiences of compliance and self-negation were important to survival in the camps and continued to manifest as a way of being with significant others in her present life. She said that she struggled to enjoy her wealth and success and it was almost as if she did not fully identify with the person who had achieved in this way and was unable to own her sense of mastery.

It seemed Lenna had an inner sense of despair and turmoil as well as repressed anger and survivor guilt, the latter powerfully affecting her sense of legitimacy to a fulfilling life. Despite her outer success and resilience in coping, she clearly coped by compartmentalizing her Holocaust experiences. The possibility of discussing her experiences proved to be too much of a threat to her defences, and it seemed that she needed to keep her trauma largely unspoken. It is interesting that although Lenna would not share her experiences at Auschwitz, she did share her difficulties in coping with her present life. She mentioned that she had ambivalent

relationships with both her children, however she loved her grandchildren. She also proudly showed me around her exquisite townhouse and gave a detailed tour of her art collection. The art provided her with a sense of escape, and it was clearly also a hallmark of her great financial success and seemed to represent having achieved some refinement.

4.5.6 Process Observations

At the time of the interviews I felt great compassion for Lenna in her very evident ambivalence about sharing her traumatic experiences. It appeared that she was able to describe her early history but became overwhelmed when the time came to share her traumatic experiences in the camps. I realised that Lenna's experience of not being able to share her story was typical of many Holocaust survivors who view their traumas as 'unspeakable'. I felt traumatised upon hearing Lenna describe the *screaming and wailing* at Auschwitz. Since the interview, I have visited Auschwitz, and thought about the horror she endured.

Lenna was friendly and engaging and very apologetic that she was unable to continue the interview process. Although pleasant interpersonally Lenna did not appear to attach to me in the manner that many other participants did, and in some respects, it seemed that she re-enacted avoidance and distrust with me, defences that she had developed to manage prior trials in her life. However, Lenna retained intermittent contact by telephone and requested to be my friend on Facebook. She remains in touch from Israel, suggesting that she was invested in the research process and that some meaningful connection was made between us.

4.6 Case Summary: Isaac

Isaac was born in Germany and was eighty-one years old at the time of the research interview. He was an only child and his biological mother died of cancer when he was three years old. His father remarried when he was four years old and the couple had a son who was six years younger than him. He was fourteen years old when the Holocaust began and nineteen when it ended. He reported that in 1941 the Gestapo beat his father up and then his family was rounded up and sent by train to the Riga Ghetto, in Latvia. Isaac said: *They took the Latvian Jews and killed them to make room for us, it was as if their food was still warm on the table*.

Isaac lived in the Riga Ghetto with his family from 1941-1943. Soon after he and his family arrived in Riga, his father was sent to a work camp. He was told that his father was shot on route to the camp. He reported that while in the Riga Ghetto he was forced by the Nazis to hang other Jews. When Isaac was seventeen, he arrived home from work in the Riga Ghetto to find that the family home was empty. He was then told that his stepmother and younger half-brother had been sent to Auschwitz, where he later established they were killed. The Germans took him to Niewals to work at the harbour. He recalled that a Russian plane dropped a bomb near the bomb shelter where they had hidden and both Jews and Germans were killed. Thereafter, he was moved to a Hamburg jail where he worked on the railways. Isaac was then sent to Bergen-Belsen concentration camp where he stayed for three months until the British liberated the camp in 1945.

After the war Isaac worked for the Red Cross at Bergen-Belsen as well as at different displaced person (DP) camps. He was the only survivor of his nuclear and extended family in Europe. After the war he came to live with an uncle and aunt in South Africa. He trained and worked as an electrician, married, and had two sons. At the time of the interview Isaac was physically handicapped as a result of a knee problem and as a result he struggled to move and used a walking stick. His limited mobility caused him to be very frustrated. In addition, he reported that he had financial difficulties. I saw Isaac on four occasions at his home in Cape Town and recorded six hours of material.

4.6.1 Memories of Early Parenting

Isaac had no memory of his biological mother who died of pneumonia when he was three years old. After her death, he was cared for by his maternal grandmother who he described as *strict*.

Although Isaac had no memory of his mother the loss of a primary caretaker at such an early age would inevitably have been traumatic as he would not have had verbal skills to express grief related to the loss or the cognitive ability to grasp the reality of his mother's death. Isaac was cared for by his grandmother for a year and then lived with his father and stepmother. His relationship with his attachment figures as he described his history appears to have been inconsistent and fragmented. His attachment was further disrupted as he was placed with his grandmother for a year and then relocated to the care of his father and step-mother. It is important to note that Isaac reported that he experienced both his father and grandmother as

strict and that his father was physically violent. This suggests that he had aggressive role modelling from his father and that he may have internalised a punitive super-ego as a result of caretaker inputs. His fragmented bonding is likely to have disrupted the establishment of basic trust (Erikson, 1982). Thus, it is apparent that Isaac entered the period of the Holocaust possibly already at some disadvantage in terms of psychological and interpersonal strengths.

4.6.2 Traumatic Experiences and Recollections

Isaac said he felt helpless and angry about the murder of his father who was shot by the Germans and he felt the same way about his stepmother and brother being sent to Auschwitz. Isaac had no closure regarding these deaths and was unable to say goodbye. The family were uprooted and sent to the Riga Ghetto, where surviving Jews told them that the Latvian Jews had been shot at the edges of mass graves in the forests. Isaac also recalled seeing a German soldier shoot and kill a baby in its mother's arms, as the mother had come too close to the ghetto fence.

According to Isaac, he and other Jews were rounded up in the Riga Ghetto and forced to hang other Jews. The Jews that were hung stood accused of petty crimes, such as stealing a piece of bread. He was forced to carry out six or seven executions during this time. (This element of Holocaust experience will receive further elaboration later in this discussion). Isaac stated that had he not carried out or co-operated with the executions he would almost inevitably have been killed himself. He said that this experience of being forced to be complicit in the killings of fellow Jewish inmates had left him with hatred towards the Germans and he still wishes for revenge. Ever since the Holocaust he has been an angry person, noting that he often shouts at his wife and sons. According to him it was his past traumatic experiences that had left him very angry.

In Bergen-Belsen the conditions were terrible. There was a shortage of water and food. The crematorium was small and they could not cope with the number of dead bodies that needed to be burned, so the bodies were piled up. Isaac remembered the horror of the smell of the burning and rotting bodies. At night he shared a blanket with six other men and said that he was full of lice and a walking skeleton. He would help to move dead bodies to the crematorium and it would take four men to lift a body as they were so weak from starvation. In addition, Isaac worked for the Red Cross at Bergen-Belsen after it was liberated when he encountered thousands of scattered, rotting bodies as there was no place to bury or burn them. Isaac said that

he would never forget the repulsive smell of human decay. He also told me that I should include the observation that there were so many dead bodies lying around in different stages of decomposition that the English reported that they could smell the camp from several miles away. It is thus apparent that Isaac was exposed to terrible experiences of deprivation, death and degradation and was also compelled to become involved in aggressive acts himself. This left him with many intrusive memories, sensations and palpable anger.

4.6.3 Developmental Disruption

The death of Isaac's mother at age three was the first trauma in his life. The disruption of the mother-child attachment, at the rapprochement phase in this instance, is likely to lead to the child becoming anxious and fearful (Mahler, Pines & Bergman, 2000). Erikson (1982) says that trauma during this phase leads to shame and self-doubt, as the child often tends to blame him/herself for the trauma. Early loss predisposed Isaac to sadness and depression. His maternal grandmother was mourning for her own daughter at the time that she was taking care of Isaac, so it is likely that she was somewhat emotionally preoccupied. At age four he was separated from his grandmother and returned to live with his father and stepmother further interrupting his bonding. It is also possible that he felt displaced by his younger half-brother who was born when he was six years old.

Because of traumatic circumstances Isaac was forced to grow up before his time and had a sense of foreclosed identity. In Dasberg's (2001) terms he was deprived of a normal adolescence. At the start of the war he was an adolescent of fourteen which marked the beginning of the formation of his masculine and adult identity. Being unable to save his parents and younger half-brother from death left him feeling impotent and hopeless. Being forced to execute other Jews worsened his helplessness and contributed to a kind of impotent rage and a need for revenge. The experience of the rage and its correlate of underlying helplessness has left its mark on Isaac's personality, as he admitted that he is an irascible and argumentative husband and father. He has been married for fifty-one years and has two sons. Although he says he has enjoyed being a father, he admits that he is easily annoyed and shouts at his family. It is clear that Isaac feels unable to contain his aggressive outbursts.

As an aging person, his difficulty walking and poor health may have exacerbated his helplessness and rage. His mobility is severely restricted as a result of injuries sustained in two

post-Holocaust motor vehicle accidents. Although he can walk and drive, Isaac does this with extreme effort and difficulty. He has been in this compromised state for the past eight years, contributing to great frustration. His body has let him down - he says, *I get angry with myself.* This has perhaps re-ignited and exacerbated his earlier feelings of helplessness and rage, core feeling states experienced for most of his life. He reported that he fought with his neighbours and said that he felt that he was not treated with respect, in part because he struggled financially. He suggested that if he were wealthy he would have been taken more seriously. This left him feeling full of rage, bitter and disappointed in his fellow Jews. Isaac's rage and his sense of being let down and attacked by family members and neighbours create the sense that he may be stuck in primarily paranoid-schizoid position functioning (Klein, 1935).

4.6.4 Mental Health Impacts

Isaac said that a psychiatrist had diagnosed him with PTSD and depression, however he refused to take medication as he felt that he didn't need it. Isaac described persistent difficulties in affect regulation, including dysphoria and explosive anger. In addition, alteration in consciousness was described, including transient dissociative episodes and depersonalisation and some intrusive PTSD symptoms.

Isaac's helplessness was exacerbated by his lack of mobility. He expressed a sense of hopelessness. He had kept aspects of his Holocaust experiences secret for fear of being stigmatised and appeared to carry internalised guilt for his actions, even if these were defended. In many respects he was completely isolated from others. It emerged from his testimony that decades later he was still preoccupied with fantasises of revenge against the Nazi perpetrators. Owing to his persistent distrust of others his family relationships were disrupted, and he felt very alone. Isaac felt hopeless about his health and financial circumstances and expressed a sense of despair about what still lay ahead for him. He also clearly had unresolved distress regarding the horror he endured during the Holocaust, and the deaths of his father, stepmother and sister and brought this into the interviews.

4.6.5 Experience of Aging: Integrity versus Despair

Within the framework of Integrity versus Despair, Isaac's emotional experience was coloured by rage and helplessness as a result of his Holocaust experiences as well as by anger and

disappointment regarding his present circumstances. His failing health and financial difficulties have exacerbated the sense of impotent rage generated during his time in the Ghetto and camps. When one listens to his narrative it seems his inner world is filled with persecutory objects. He expressed that he has no empathy and generally perceived others as antagonists. He reported that he is *hard* when he hears about other people's difficulties and he has a *tough luck* approach. He also carries feelings of inadequacy and in response to this tends to project blame or responsibility onto others. It was apparent that Isaac was a deeply unhappy person with considerable self-doubt. His rage and lack of empathy highlight the way in which he appears to be stuck in Klein's paranoid-schizoid position. His survival of the Holocaust horror appears to have translated into functioning via the employment of the defences of 'splitting' and projection for much of his life.

Isaac also reported that he feels somewhat emotionally blunted, indicating that he perhaps uses dissociation as a defence against his vulnerability. The experience of wisdom and despair can be understated as a continuum and it appears that most people have experiences of both aspects of the continuum to a lesser or greater extent. Isaac's preponderance of negative emotion and cognition indicate that he predominantly experiences despair and is generally pulled towards this pole. It seems he uses his anger as a defence mechanism to avoid dealing with his vulnerability, helplessness, envy and shame. His physical disability caused him to be frustrated, and he reported feeling very stressed regarding current financial difficulties, suggesting that current life stressors also precluded cultivating a sense of reconciliation with his past.

Nevertheless, Isaac said that for a long time after the Holocaust life was good. He felt blessed that he had survived and is grateful that his mother's family took care of him when he came to South Africa after the Holocaust. He was able to earn a good living and look after his wife and children, for which he felt some pleasure. However later he felt that a range of difficulties hampered him. He regrets that he did not make more money and was also able to admit that at times he felt remorseful for his fairly constant irritability with his family, although he also appeared to want to justify this. He said that his relationship with his wife was highly problematic and he was suspicious of possible infidelity. He had resented her for years, which resulted in ongoing fights. He said that his sons were disrespectful and he fought with them. It was thus evident that Isaac's relationships did not feel supportive or generative to him.

Despite difficulties in many areas Isaac's relationship with God seemed to be intact as he mentioned that he frequently attended synagogue and he often referred to how God saved his life during the Holocaust

4.6.6 Process Observations

Despite his description of himself as irascible Isaac was very friendly and co-operative and spoke in a coherent and engaging manner during the interviews. He had never spoken about his Holocaust experiences except for having given a public address some two weeks before the research interviews began. However, it was only in his interviews for this research that for the first time he divulged his experience of being forced to execute other Jews. I was aware of feeling deeply sad and disturbed that he had had to keep such a heavy secret for so long alone and also had to process my own feelings in response to his 'confession'.

Isaac appeared to use primitive defences of splitting and projection in engaging with the world, and this was evident in the way he came to idealise me and the research process but remained devaluing of his family. At times I experienced his disclosures about his personal and familial difficulties as rather unboundaried and discomforting to hear. He was needy and dependent and initially became aggressive when I had to cancel an appointment due to being sick. However, thereafter Isaac was both respectful and needy of attention, appearing to treat me as somewhat of a rescuer. As a parting gift Isaac gave me original pictures taken by the British when they arrived in Bergen-Belsen. The pictures were horrifying and depicted piles of rotting emaciated bodies. He said that I could use the pictures in my research. It seemed that the sharing of the photographs represented a wish for me to grasp the full horror of his experiences and to bear witness beyond words.

Given my concerns about Isaac and what I perceived to be a level of depression, with his agreement I referred him to a social worker who subsequently visited him. However, Isaac continued to contact me and to ask for help and it was evident that he struggled to manage the termination of the research engagement. While I continued to be supportive for a period I urged him to entertain the possibility of engaging in a properly therapeutic relationship.

4.7 Case Summary: Anne

Anne was a child survivor from Lithuania and was seventy-four years old at the time of the interview. She was born in Subachus, a small town in Lithuania. The Russians took over Lithuania a year before the Germans invaded. She described that many of the bourgeoise were sent to Siberia. The Russians threatened to send her father to Siberia two weeks before the Germans invaded Lithuania. Anne was six years old at the beginning of the war, and twelve when it ended. She reported that when the Germans threatened to liquidate the ghetto where they lived there was chaos and panic. Anne's mother left her and her younger brother in the house and ran to her father's factory outside the ghetto to warn him about the liquation of the ghetto. As her mother returned home to fetch her children, she was shot dead. Ann recalled that a witness told her father that a German soldier cut the finger off her mother's dead body in order to take her wedding ring.

Anne indicated that Germans and Lithuanian police knew that her family had escaped the ghetto and Anne recognised that she and her brother were in danger. She reportedly took him and ran outside the barbed wire to her father's factory but found that he was not there. A woman they knew took them to hide in a barn where her father and older sister were hiding. Subsequently, Anne, her father, brother and older sister hid in a tunnel in a haystack where they could only sit or lie down. Anne said in the chaos, her other sister Miri who was 11 years old, went into hiding alone. The Germans discovered her hiding place and shot her. Anne had been very close to this sister. Anne described how her family survived living in a haystack for a year. The farmer used to bring them food and they had to whisper in order not to create suspicion. Eventually, owing to the lice, cold and hunger, her father decided to take them to a temporary labour camp in the hope of better living conditions. A Jewish guard allowed them to stay as long as the children remained hidden when the Germans came to fetch the Jews in the morning for work. Apparently, the Germans later threatened to kill the Jews in the labour camp and Anne and her family escaped.

Anne described how she went into hiding with a Russian family and how they converted her to Catholicism. She worked as a *herd girl* looking after cattle. The mother of this family did not know that she was Jewish and was told that the priest had asked the family to take the child in. Anne had no idea where her family was or if they were dead or alive. She reported that her father later unexpectedly arrived to fetch her having managed to get false papers to get them

out of Lithuania. They crossed the Alps and stayed in a displaced persons camp in Italy. Later Anne's oldest sister made the decision to move to Israel, while her father decided to move the family to South Africa to be with extended family.

When they arrived in South Africa Anne met her childless, married aunt who she became close to and moved in with in Durban. Anne said that after the war she was like a *lost sheep* who could not speak English or integrate socially. She did not want to return to school and eventually got a secretarial diploma. She moved to Johannesburg at the age of seventeen and lived with her father's relatives. She married in her early twenties and had three sons. She reported that her first husband was emotionally abusive and she divorced him after several years of marriage. She said that she had had problems in her relationships with her daughters and had struggled to cope with being a mother. She said that fortunately her second marriage was more peaceful. However, she was frequently troubled by her ongoing difficulties with her daughters who had a conflictual relationship with one another. I interviewed Anne at her home on four occasions and recorded eight hours of material.

4.7.1 Memories of Early Parenting

Anne came from a financially prosperous family. Her father had a wood factory. She was the third of four children, having two older sisters and a younger brother. She describes her father as a wonderful man who managed to save three of his children. Anne, her oldest sister and younger brother, survived the war together. Her mother and sister, Miri, were murdered soon after the war started. She described happy memories of playing in the street with her friends, doing well at school, and riding on her father's motorbike with him, prior to the war. She described her mother as a very good mother who *looked after her children and took interest*. She says that she was attached to both her parents and she remembered that they had a *very happy marital relationship*. The family went to the river in the forest during the summer time and for summer holidays in Russia. She said, *life before the war was very happy*. It appeared that Ann had a secure attachment to both her parents as well as to her siblings.

4.7.2 Traumatic Experiences and Recollections

Anne reported that at the beginning of the war German soldiers came to her house for supper. The one soldier took her mother to the bedroom in the middle of the meal. Her father remained

with his four children. After a period of time her mother and the soldier returned. Anne said that with hindsight she thought that the German soldier threatened her parents and raped her mother during this event. As a child, she remembers being confused as to why this man took her mother to the room and when she thinks about it now it fills her with *disgust*. She felt uncomfortable about an incident that she did not understand and sensed that something was discordant. However, she felt that neither she nor her father could protect her mother. She remembers feeling that something *bad* had happened.

When news broke that the ghetto was being liquidated Anne said there was chaos and panic. Anne was told by her mother *to stay home and wait*. She took her brother and ran to the next-door house. When she attempted to get back to her home a German officer kicked her and told her to *go inside*. She was afraid, yet she had the good sense to take her brother and run away to her father's factory. She said that the death of her mother was the worst traumatic experience of her life. As was explained above, her mother was shot returning to fetch her children. Anne says she heard a shot and is sure that it was the shot that killed her mother. The violation of her mother's dead body by the German soldier who cut her finger off deeply traumatised Anne. As a child Anne may have felt somewhat responsible for her mother's brutal death as she was returning in the interests of her children. Anne was also deeply affected by the callous murder of her sister that took place shortly after her mother's death. Anne was told that her eleven-year-old sister had begged for her life saying, *please don't kill me! I will work. I will do anything*!

Living in the haystack with her father and sister Anne reported that she was constantly afraid. The family knew that German soldiers were looking for them. The living conditions were terrible and they were hungry and cold. Anne's toes froze and her father was afraid that they might have to have them amputated. However, the farmer who was hiding them used goose fat to treat and heal her feet. *The terrible thing was the screaming and shouting we heard. The mobile killing units used to march them [the Jews] into the forest, get them to dig a grave and shoot them. We heard their screams and gunshots like an echo in the night when we were in hiding, and we were so scared*. Another terrifying incident reported was when she and her brother were hiding illegally in the labour camp. One morning, a German soldier and his Alsatian dog came to inspect the camp. Anne and her brother were hiding under the bed. The dog came up to the bed and smelled them, then moved away. According to Anne this was *a miracle from heaven*.

Anne attributes her intermittent depression throughout her life to never having recovered from her mother's and sister's deaths. At the time of the interview she was on anti-depressants but was non-compliant. She told me that although they were prescribed she was afraid to become *addicted*. She reported that she cried a lot, as does her sister who lives in Israel.

4.7.3 Developmental Disruption

Anne's trauma and loss seem to have caused her difficulties throughout her life. Although she was attached to her father and her aunt in South Africa, she reports that for years she cried alone over the death of her mother and sister. Her description of herself as a *lost sheep* in adolescence shows how difficult it was for her to bond with her peer group, probably because she was too preoccupied with her grief and trauma. The importance of a supportive environment has been emphasised as crucial in ameliorating some of the effects of trauma (Herman, 1992; Keilson, 1979). In Anne's case, it was clear that her post-Holocaust environment was not sufficiently supportive and she struggled to adjust in South Africa. She reported that her short marriage ended in a difficult and traumatic divorce and that her three sons were in boarding school. Her life settled in her later years when she married her second husband and she was able to look after her grandson. As an older person Anne's ongoing sense of helplessness due to her health problems and difficulty in walking seemed to have precipitated a deep depression. Her current frailty may have triggered memories of being helpless and trapped in the haystack and later in the camp, occasions in which she was afraid and endured prolonged suffering.

4.7.4 Mental Health Impacts

Anne suffered from severe depression over many decades but reported that she was unwilling to take her prescribed medication. She reported difficulty with affect regulation and this was evident in her persistent dysphoria and extremely inhibited anger. Her alterations in consciousness include reported intrusive PTSD symptoms such as flashbacks and intrusive thoughts. Anne also reported a sense of hopelessness and paralysis of initiative that appeared to be part of her depression. As a result, she felt isolated and rather impotent in her world. Her divorce and difficulty with her one son were evidence of her struggle within personal relationships. As indicated previously, Anne had unresolved grief surrounding the death of her mother and sister.

4.7.5 Experience of Aging: Integrity versus Despair

Anne experienced sadness and depression related to unresolved mourning and this was complicated by her poor health, contributing to hopelessness and despair. Anne was relatively in touch with her feelings of grief and despondency and able to express these in the interviews. She did not appear use compartmentalisation or dissociation in the same way that other participants evidenced and was unable to block out or escape the persistent mourning and despondency that she experienced in old age.

Anne said that although her first marriage was very abusive, her second marriage was successful. She said that she struggled with her conflictual relationship with her one daughter, however, she remained close to one grandson.

Anne said that as she looks back on her life there have been good things, like having children, and she stated at times that the Holocaust seems like a *bad dream*. She also noted that being a survivor had prepared her to deal with later hardships. She said she could not forget about the Holocaust and she has been most affected by her sadness regarding the loss of her mother and sister. At the end of the interview Anne asked to show me pictures of jewellery that she had made. The jewellery was constructed of handmade silver presented in a unique and beautiful style. It thus appeared that Anne had found an outlet for personal expression and creativity and had brought objects of beauty into the world. It was also apparent that in her jewellery making she had been able to persevere with tasks and to be productive. It would seem that in showing me her pictures Anne was demonstrating some level of mastery that she had been able to achieve despite her ongoing depression.

4.7.6 Process Observations

Anne was very kind, warm and co-operative in her interactions with me and she seemed keen to relate her story in a detailed and cohesive manner. I felt an incredible heaviness when I was with her and was often left feeling very depressed after the interviews. I wondered whether this may have been related to a powerful projective identification that occurred in the context of the research interviews, in which I became the unwitting container of aspects of her profound sadness and helplessness in addition to being a witness to her tragic story.

Towards the end of the interview process I expressed my admiration for her jewellery craft when she shared pictures of this with me. It was the first time during the process that I was able to see a sense of animation and pleasure in her and this seemed to contrast with the heaviness of her depression.

After the research interviews were completed, I was able to refer Anne to a social worker and she was able to terminate the relationship with me. Anne adjusted to her case worker and formed a warm relationship with her. The social worker was alerted to Anne's resistance in taking the anti-depressants and appears to have encouraged Anne to reconsider her rejection of the medication. When I followed up some months after the interviews had taken place Anne reported that she had begun to take her medication and was seeing her case-worker regularly.

4.8 Case Summary: Shmuel

Shmuel was a child survivor from Poland who was seventy-nine at the time of the research interviews. He was born in 1928 in Poland. Shmuel was eleven years old when the Holocaust began and seventeen years old when it ended. His family was very religious, and they spoke Yiddish at home. During the Holocaust, he was sent to a labour camp for six months; thereafter he was sent to Blechammer (Auschwitz 4 Labour camp). He reported that he was taken on a death march to Gross-Rosen concentration camp for ten days. Finally, he was marched to Buchenwald where he remained for a short period before liberation. After the war Shmuel went with a group of child survivors from Buchenwald to Israel, where he lived on a kibbutz. He became an officer in the Israeli army and joined the Haganah (informal Israeli army) as a fighter. At the time of the interview he lived in Johannesburg with his wife of fifty-three years. They have two sons and three grandchildren. Their older son had emigrated from South Africa and their younger son was a resident in Johannesburg. At the time of the interview Shmuel's health was good, and he was still working full-time in his own business. He was interviewed on three occasions and four hours of material was recorded.

4.8.1 Memories of Early Parenting

Shmuel spoke of his mother with love and admiration. He described her as a nurturer, to whom he felt very close. *She made wonderful 'Shabbos'* (Friday night) *meals. I remember her food, for example, she made 'challah'* (Jewish blessed bread) *as well as fish cutlets and 'cholent'* (stew). *She was a 'model mother' who was good to me. She cleaned and cooked and prayed and said 'Tehillim'* (Psalms). He described his father as a good man, to whom he was also attached. His father was religious and he owned a grocery shop. The family lived in a two-bedroom flat. *My father prayed every morning, and he had a 'Shtiebel'* (a small room used for communal Jewish prayer). *Most of the people in his Shtiebel were family because we had a big extended family - my mother had six siblings and my father had five*. Shmuel said that he was close to both his parents, particularly his mother, and was the youngest of five siblings. Shmuel described his relationships to his older brothers and sister as very warm and caring. He felt particularly close to his oldest brother who was his only sibling who survived the Holocaust. He said that his parents were happily married and there was order and structure in the family. For example, Shmuel would not leave the table until his father had finished eating. Shmuel's family were very close to his extended family and they would all gather together on a Friday night. He spoke nostalgically about his life before the Holocaust and said that he was very happy. There were sixty-thousand Jews in his town, all of whom spoke Yiddish. He reported that he went to '*Cheder*', a strict religious school, where he had '*payes*' (ringlets hanging from the side of the head, worn by very religious Jews). He said that he *studied the Torah* (Bible) at school from beginning to end.

4.8.2 Traumatic Experiences and Recollections

Shmuel explained that he was eleven when the war started and clearly remembered when the German troops marched through his home town. There was a curfew and they kept indoors with their doors locked after 6pm. He remembered how frightened he was. He knew that Jews were being hurt in Germany as there were rumours about this in Poland. The Germans publicly executed a baker and a butcher to frighten the community, however he was not present to witness this. He had heard his parents discussing the event and he realised that they were also frightened. According to Shmuel the Germans closed his religious school and he had to work in a factory. He remembered his mother crying when his two older brothers were taken away to concentration camps. He said that his separation from his mother was particularly traumatic.

Shmuel, his parents, and his sister were taken to a soccer field for selection with other Jews in 1942. The Germans kept them captive for three days and three nights without food. It rained continuously and there was no shelter. He said that the intention was to weaken them. There were three points of selection: he, his sister and father were allowed to pass through. However, his mother was stopped at the gate and sent to Auschwitz. He was told that she was going to a work camp and he recalled that they had *no time to say goodbye… no time to say anything*. He never saw her again because she was killed at Auschwitz.

Shmuel was fourteen years old when he received a letter from the Germans to report for further selection. Both his father and his sister came to say goodbye at the train station. They kissed him and cried. It was the last time he saw them as they too were sent to Auschwitz where they were killed. He said that he was sent to Erfurt near the German border. It was a labour camp of three to four thousand people. He said he was hungry and frightened and stayed there for seven months, where he again worked in a factory. Thereafter, he was sent to Blechammer where his arm was tattooed with the number 184738. According to Shmuel Blechammer was cleaner and there was more food there than at other camps because the Red Cross did inspections of the camp. However, many Jews were beaten to death and there were public hangings. He reported that every two to three weeks everyone was forced to stand and watch as Jews were hanged. These hangings were conducted in response to petty offenses such as stealing a piece of bread or having a wire shoe lace that could be used for *sabotage*. The offence was announced before the hanging took place.

Shmuel explained that he and his fellow inmates *never knew what tomorrow would bring*. There was always fear that they would be hanged next. He reported that during his two years at Blechammer a Jewish Kapo (Jewish prisoners who were given authority by the Germans to police the inmates in the camps) who was kind to him assigned him to assist a German engineer who taught him to weld iron. This man did not agree with Hitler's politics regarding Jews and did not persecute Shmuel. He taught him welding skills that he was able to use successfully at a later date. He remembered that the Kapos were sometimes good and sometimes cruel. *The Kapos worked for the Germans therefore to impress the Germans the cruel Kapos would hit the Jews for no reason* He reported that the Germans liquidated Blechammer as the Russians were approaching and he was taken on a three-month death march in the middle of winter, where they walked for 25 kilometres daily. He said, *you did not think about your parents or your family or being burnt alive, you only thought about food because it was freezing and you were*

starving, hungry! They arrived at Gross-Rosen concentration camp. He said that it was such a terrible camp that prisoners ran into the electric fences to commit suicide. He reported that he witnessed a stampede where people choked in the mud. He said he was lucky to survive this camp and he lived in fear of his life. He stayed at Gross-Rosen for two weeks. It was reported that the Americans were coming and so prisoners were taken to Buchenwald where he was held captive for a short time before liberation.

When speaking about the loss of his mother Shmuel explained that he continued to feel grief and sadness until the present time because he was so close to her. Shmuel felt that he had no closure as he had no time to prepare to separate or to say goodbye to her. During the interview he became very emotional whenever he mentioned his mother. His father, mother, sister and two older brothers were killed at Auschwitz. In addition, Shmuel's extended family, friends, and community were all killed in the Holocaust. He said that very few people from his hometown survived. His oldest brother survived and moved to the USA. He was told that a cruel Jewish Kapo in the camps beat his one older brother to death and he felt enraged by this. He said that when he dreams about his family, he wakes up happy and looks forward to being reunited with them after his death.

4.8.3 Developmental Disruptions

Shmuel explained that he was deeply attached to his mother and came from a very close family. He describes his mother as an archetypal *Yiddisher Mamma,* a loving nurturer who was focused on caring for her family. His description of her indicated that he had introjected a very positive image. His closeness to his family and nostalgic description of his happy life before the Holocaust sharply contrasted with his later catastrophic loss of parents, family, and community. In relation to Erikson's (1965) theory, Shmuel's Holocaust experience fell into two stages. Firstly, he was at the end stage of Industry vs. Inferiority (Erikson, 1965) when the Germans invaded his town. At the same time his religious school was closed and he was sent to work in a factory. Thus, it appears that the stage of Industry versus Inferiority (Erikson, 1965) was disrupted as Shmuel was forced to drop his academic studies and became aware of being vulnerable and discriminated against, in part through his parents' anxiety. As conditions worsened, he moved into early adolescence where he was traumatically separated from his mother at fourteen years old. He was then separated from his father and sister and sent off alone to a concentration camp. According to Erikson (1965), the time of identity formation takes place

when the adolescent moves away from his family towards his peer group. In Shmuel's case this separation was forcible and he had no known peer group to bond with as he was sent off with a group of strangers to the concentration camps. His identity was also compromised by the attack on many aspects of family and cultural identity he held dear – that which he cherished also became that which placed him at risk, adding complexity to his identity formation. It is also evident that he had to place survival above all other needs for an extended period in his adolescence.

Shmuel's resilience and fortitude were evident in the manner with which he accepted the German engineer as a mentor and was able to learn to weld steel despite his terrible trauma and physical suffering in the camps. In addition, he was able to use this knowledge creatively at a later stage, namely, building machine guns in the Israeli army and making a living out of welding. He said, *I had to grow up and do what I had to do*. It seems he built his identity around work and this was useful to him during and after the Holocaust. He lived in fear and witnessed death, cruelty and starvation, yet what seemed to be the hardest was his loss of his mother and immediate and extended family. Shmuel described a lack of closure regarding the loss of his beloved family and observed that he has lived with the sadness all of his subsequent life. At sixteen years old, he immigrated to Israel as an orphan and lived on a kibbutz. He described a sense of belonging on this kibbutz, and perhaps this was his first point of healing after the Holocaust. Significantly, Shmuel went from being a camp prisoner and orphan to an officer in the army. This indicated his capacity for some mastery over his trauma.

4.8.4 Mental Health Impacts

Shmuel described alterations in consciousness such as dissociation and derealisation. In addition, he described intrusive memories and reliving of events in the form of PTSD symptoms. He spoke of a sense of isolation and a persistent distrust of others. Although he spoke of being attached to his wife and children, he had never discussed the details of his Holocaust experience with them. Despite his success Shmuel carried a sense of despair regarding the loss of his parents and siblings and appeared to have aspects of complicated bereavement. As a consequence, he struggled with his sense of loss of faith in a God who had failed to save his family and to protect the Jews during the Holocaust.

4.8.5 Experience of Aging: Integrity versus Despair

According to Shmuel, his business had been very successful and he was financially affluent. He worked full-time and demonstrated that he was proud of his achievements. He was very active in his community and had built gates for the building in which he lived. He played golf and had a socially active lifestyle. His resilience was seen in his creativity and his ability to make a continued contribution to his community.

Despite Shmuel's deep sadness, he functioned very well and did not suffer from depression. He was able to establish a family and had been married for over fifty years. He was attached to his wife, who he said had taken away his sense of aloneness: *Otherwise, I would have been alone in the world; my wife took the feeling of being alone away from me. And my children, my own flesh, and blood*. He said that looking back his wife and sons had been a great solace to him.

Shmuel said: *I have clear memories of some things and have forgotten a lot, like how my parents looked - no pictures. I am still sad about losing them because I was so young and alone in the world from fifteen.* Despite his positive experiences within his current family Shmuel remains deeply disillusioned with God and religion. He follows cultural rituals related to Judaism such as going to synagogue and giving money to charity, but continues to feel disappointed that God did not help the Jews during the Holocaust. Shmuel explained that he thought more about his parents as he got older and hopes to meet them after he dies. He added that he frequently saw them in his dreams and he woke up feeling happy for this fantasy contact.

Shmuel said, *it would be better to get old and get younger so we could enjoy our lives better. As you get older it's harder to enjoy life, you get sick, and you don't know when you're going to die.* He said that he thinks more about the Holocaust now because he has fewer current worries, such as concerns about money. He said that as he gets older, he gets sadder as opposed to angrier.

Shmuel seemed to express a parallel experience of both integrity and despair. He was proud of his achievements, grateful for his wife and family, enjoyed his work and generally functioned well. However, he said that he gets very sad that he has no siblings with whom he can grow old. His disappointment and sadness regarding God have also intensified as he has aged and this has not been easy for him. Given these polarities Shmuel seems to have a good measure of

ego integrity but this is coupled with an experience of perhaps appropriate despair. Initially Shmuel appeared to be very aloof and as the interview process developed and a rapport was formed, he seemed less guarded and spoke of his grief related to the loss of his parents. Shmuel's presentation is perhaps in keeping with Dasberg's (2001) observation that many survivors embody a parallel existence where they may have outer success but still feel inner despair that was compartmentalised.

4.8.6 Process Observations

Shmuel initially interacted in a business-like manner and appeared to be somewhat of an intimidating and preoccupied businessman. As the interviews progressed and his defences dropped, he shared a narrative that was fraught with traumatic loss. During the interviewing process I was aware of my role as interviewer and worked at fielding my way through Shmuel's defences. I was somewhat surprised by the sadness and deep despair that emerged. At the completion of the interview process, Shmuel said that he wanted to show me the gates he had made outside his building. The gates were very artistic and solid. They were the main gates of his apartment block that was situated in a very affluent area. Shmuel's need to show me the gates seemed significant in that he demonstrated the level of mastery that he had achieved in acquiring a skill in Auschwitz that he had been able to use for the benefit of the Israeli army as well as in his business in South Africa. He was also able to contribute to his community where he lived. This was his concrete proof of his mastery over his trauma. In addition, Shmuel showed me pictures of himself as a young man in his soldier uniform. This picture hung on his wall and was a testimony to his trajectory from a child/teenager who lived in captivity to a soldier who rose in rank to an officer and fought as a free Jew in the Israeli army.

Upon reading the case history and transcripts, I felt a terrible sense of sadness for Shmuel's loss of his Yiddisher Mamma. I also felt a deep sense of mourning for his description of an idyllic shtetl lifestyle that was destroyed by the Holocaust. After the interview process had ended Shmuel phoned me and said: *Please will you write my story. I want you to write a book about me.* I said I was unable to do so as I was busy with the research and referred him to an author. He reported that he had an argument with the author and his book was never written.

Shmuel said he enjoyed speaking to me as part of the research process. *No one has ever asked me those kinds of questions because they don't want to hear the answers.* A week after the

interviews were completed, I checked in with Shmuel who reported he was well. He lived close to my home and we would often bump into each other at the shops and chat for a while on more neutral topics.

4.9 Case Summary: Rina

Rina was a child survivor born in Holland in 1936 and was seventy-one at the time of the interviews. She was three years old when the Holocaust began and nine years old when it ended. In 1942 the Germans invaded Holland. She was five and a half at that time and she lived with her parents and her older brother. After the German invasion she and her family were taken to Westerbork, a transit camp where Jews were kept captive before being transferred to Auschwitz or Sobibor death camps. The family remained there for sixteen months. Rina had no memories of her father at Westerbork and this loss of memory surrounding him has been distressing for her, leaving a disturbing absence in her mind. She reported that she knew that her father was taken to Buchenwald concentration camp where he died. He was badly beaten and as a result was weakened, which led to his death. Rina, her mother, and brother were sent to Ravensbruck Women's camp for sixteen months. Her older brother was moved to Ravensbruck men's camp when he turned fourteen. Since Rina's mother held an English national passport, they managed to leave Ravensbruck for Sweden as part of an international agreement. After spending six weeks in quarantine in Sweden they were allowed to join their extended family in England. Rina's older brother also survived the war and he managed to meet up with them in England. In 1946, Rina and her family moved to South Africa.

After finishing high school Rina studied and became a librarian. She had been married for fifty years and had four children at the time of the interview. Her daughter and one of her sons have both emigrated. She has two children remaining in Johannesburg. She was interviewed for a total of six hours at my practice office, over a three-week period, and she was interviewed twice a week. She requested that the interviews take place at my office to allow for privacy and to be free of disturbances.

4.9.1 Memory of Early Parenting

Rina reported that she had positive memories of both parents, who she says were loving and affectionate. She said she was more attached to her father in her early childhood. He used to read her stories, tuck her into bed and comfort her when she was afraid of the dark. When she became sick with measles at the age of five she remembered him saying, *if you wake up in the middle of the night, wake me, not your mother; she is tired*. She remembered her mother sewing and making dresses for her as well as clothing for her doll. Rina described her mother as affectionate, *very caring, but strict and reserved*. She remembered her father as more affectionate than her mother, however, she said that she felt loved by both parents.

4.9.2 Traumatic Experience and Recollection

Rina was five and a half years old when the Germans ordered the family to leave their home. She reported that as they were packing, she grabbed her favourite doll. *My father said, 'Rina you can't take that doll!' and I said 'Why?' and he said, 'I promise we will come back for it'… and we never did… I never forgot that (with tears in her eyes). I see his point of view now, we could carry so little, and they were banging down the doors, he wanted me to rather carry a warm jersey… Why do I mention it? Because I never remember seeing him after that, even though we were with him for sixteen months at Westerbork transit camp.* Rina spoke continually about her difficulty in remembering her father. Rina said she had no memory of the traumatised people at Westerbork transit camp and she has no memory of her brother's Bar mitzvah. She also does not remember saying goodbye to her father before he went to Buchenwald concentration camp where he died. Her only memory during that period was of singing Hebrew and Yiddish songs with the other young children.

Rina arrived at Ravensbruck concentration camp at the age of seven with her mother and her older brother. She said that she was scared and horrified on her arrival there when she saw the emaciated women prisoners whose hair had been shaved off. She said that thanks to her mother who cleaned her hair, she did not have lice and never had to have her hair removed. Rina reported that her mother was very protective and always covered her eyes with her hands to shield her from traumatic incidents and did not answer her questions about what she was seeing around her. She mentioned many times that she felt her mother was overprotective by constantly covering her eyes and refusing to discuss or explain what Rina was seeing or hearing.

Rina reported that she felt empathy for her mother's sense of shame and humiliation when her mother was forced to parade naked in front of the German guards. She remembered the smell of unwashed bodies and the dirty barracks at Ravensbruck. She described life in the camp in the following way: *You never saw a flower, you never saw a tree, you saw nothing but stone walls and the electric fence. You didn't see kindness or niceness, people screamed and cursed, it was dirty. You were always hungry and cold, it was horrible, but you had to adapt.*

Although she was hungry, Rina remembered the bad taste and disgusting smell of the food. *They gave us a piece of bread in the morning, it wasn't proper bread, it was mixed with sawdust, but it was something to eat. Nobody got lunch, and at night there was this ghastly soup.* Rina reported that she was so malnourished that she did not grow in three years. She was considered very small for her age after the war. *It must have been terrible for my mother to see her children hungry and worrying about us all the time…We were forced to go on parade and stand for hours in the cold at 28 degrees below zero, and they counted us, nobody had a jacket. We were always cold and always hungry*. During the day, Rina's mother went to work and she spent time in the barracks with other children. She always worried that her mother would not return and she suffered terrible fears of abandonment throughout the Holocaust: *Worse than the screams or anything was not knowing if my mom would come back or not.*

With tears in her eyes, Rina said that as a child in the camp, *I wished that I could grow wings and fly over the walls of the camp to escape from the horror and misery.* She said that once a day the prisoners had to stand in line for roll-call and the German soldiers would bring their dogs who would often attack the emaciated inmates. Despite her mother covering her eyes, she has ongoing recollections of the screams that she heard taking in information in an auditory way. The sound of the screams made her fearful. As an adult, she read about Ravensbruck and realised that the screams she remembered hearing were from victims undergoing medical experiments or being tortured. Rina's worst traumatic memory was of a Gentile Polish woman prisoner who burnt her on the neck with a hot iron, at Ravensbruck. She was seven years old at the time and was left with a big scar that was surgically removed after the Holocaust.

After sometime Ravensbruck staff built a gas chamber and crematorium. *There was black smoke belching out, and the smell and the screams were terrible. The smell was of burning flesh. I could never forget the smell! I would say to my mom 'what's that?' and she would cover*

my eyes and say, 'don't look, I don't ever want you to look!' and she never told me what it was. It would have been better if she had not covered my eyes because I had many empty patches in my memory and I had nightmares for thirty-five years! Rina mentioned that a German guard saved the family, who were on a list of inmates to be sent to Auschwitz. This woman called her and her mother and showed them their names on the list. She crossed out their names and added three other names instead: *Who she picked we don't know, but the poor souls went and never came back. This woman gave me a green ribbon for my birthday and saved us, yet afterwards, we heard she was a war criminal and beat a few Jewish women to death*. It was evident that Rina had recollections of several contradictory experiences with adults in the camp that left her confused and not knowing who to trust. It was also apparent that she had done mental work (perhaps in her therapy) to attempt to retrospectively comprehend aspects of her experience and what transpired during the Holocaust.

Rina said that her father had died in Buchenwald. Owing to her deep attachment as a young girl his death was heart-breaking for her. She engaged in a search to find out what had killed him and she found her answer from her uncle who was at Buchenwald with him. To her horror and devastation, she found out that he died a Musselman. He had been beaten so badly that he was unable to work and he ate very little. He became like the *walking dead*. According to her uncle, her father *died in the mud, he collapsed, and that was that!* When she described this incident, she cried both for the loss of her father and because of the degrading death he suffered. During the research interviews Rina would cry whenever she spoke about the loss of her father and her lack of closure regarding his death. As described by Durst (1995), Rina experienced her father as impotent and unable to protect her or himself, a particularly poignant image when one appreciates her prior sense of him as a comforting, protective and capable person.

In addition to her practical search for information regarding her father's death, Rina had tried to see if she could remember relating to her father in Westerbork, however she has no memory of saying goodbye to him. To attempt to recall memories of her father, she searched her memory for decades, including undergoing hypnosis twice under a psychiatrist and returning to the camps as an adult. These attempts did not help, and the lack of memory remains a source of great regret and discomfort. The gaps in memory appear to be suggestive of a degree of dissociation and lack of full engagement with the external environment as a self-protective measure, as has been observed in other child survivors (Herman, 1992). Rina reported that she

was still in her old age looking for closure regarding her father's death and that parting from those she loves remains a difficult, painful and somewhat dreaded experience.

4.9.3 Developmental Disruption

Rina reported that she was securely attached to both her parents as a young child. However, she remembered her father as the more nurturing caretaker. It is clear from her description of her early childhood experience that she felt she was the focus of her parent's attention. From age five and a half to eight and a half years, Rina was in the camps. These would have been her school years, and consequently the negotiation of the stage of Industry vs. Inferiority was disrupted. She did not receive a formal education although her mother taught Rina to read and write. At school in England after the war she reacted badly to anti-Semitic remarks from another child. She reported that she beat this child so badly that she was asked to leave the school. It is apparent that in this context Rina felt able to express some aggression derived from her frightening and complicated experiences in the camps.

The extent of the efforts Rina has made to retrieve further tangible memories of her past including having hypnosis and returning to the camps, illustrates her desperation to hold onto something of her father as a positive introject. Her traumatic separation from him seems to have precipitated a preoccupation with his death. Her crying and lack of closure regarding this loss demonstrate that she still feels this pain, many decades after the Holocaust. Her relationship with her mother was ambivalent, being both appreciative and critical. On the one hand, she was grateful for her mother's caring while on the other hand she resented her mother's *overprotection*. For example, her mother's refusal to explain the screaming Rina could hear around her but could not see reportedly left her with gaps in her memory and led to the experience of nightmares for over thirty-five years. It seems that her mother was so deeply traumatised that she was unable to mediate the trauma for Rina and attempted to protect her by encouraging a defence of denial – what one does not see cannot be real and should not affect one. Although Rina's mother's motives were to reduce the harm her daughter was exposed to and this left her feeling anxious and unable to process what she knew to be true in the camp. Consequently, she was left with violent fantasies which manifested in her nightmares. In addition, she reported that after the Holocaust she would run out of the room and cry if her brother discussed the Holocaust. She was unable to read books or to see films about the Holocaust.

When Rina met Holocaust survivors shortly after the war in Israel, she did not disclose that she too was a survivor. She enjoyed the fact that people thought she was not Jewish, owing to her blonde hair and blue eyes. This suggests that Rina was unable to absorb and process her Holocaust experience at this time and avoided thoughts and feelings about the experience, as originally encouraged by her mother. It seems that her traumatic nightmares drove her to seek psychotherapy and the therapeutic experience helped her to deal with some aspects of her trauma.

During her childhood she was aware of her mother's humiliation and powerlessness in the camps and remained deeply anxious that her mother would not return from work. She was terrified that she would be abandoned, helpless and unable to survive alone. The vicious burn attack she experienced at seven years old may have exacerbated her fear for her survival without the protection of her mother. She was overwhelmed by fear, owing to the cruelty she witnessed and experienced. The German guard who saved their lives presented her with an anomaly as this was a person capable of both kindness and cruelty. Her aggressive outburst at a child, soon after the war, as well as her sense of glee about the destruction of Berlin, indicate that she was extremely angry regarding the cruelty, degradation and loss that she had endured. Rina's raging outburst is also a good example of the way trauma shatters the child's ability to self-regulate, as described by Cook et al. (2017).

Rina reported that she did not suffer from any depression or anxiety in adulthood, however, she indicated that after the Holocaust she suffered from unremitting nightmares for which she sought treatment. As an adult, Rina had surgery on her eyes to correct her vision. During the local anaesthetic the smell of her burning flesh triggered an olfactory flashback of the smell of burning flesh from the crematorium at Ravensbruck. She reported that her therapy experience helped her to integrate and accept her Holocaust experiences and after thirty-five years, the nightmares finally abated. Rina's willingness to seek and utilize therapy suggested a capacity to trust others to assist her.

Rina's resilience can perhaps be largely attributed to her secure attachment to her parents in early years and the development of a deep sense of trust, autonomy and initiative. In addition, Rina survived the Holocaust because her mother loved and protected her at all times. This was a major factor in building her resilience. Although she was an angry child who lacked

confidence, she completed her education and worked as a librarian. She reported that she was not afraid of close attachment and was very demonstrative with her children and grandchildren.

4.9.4 Mental Health Impacts

Rina described alterations in consciousness such as her amnesia for traumatic events. This was evidenced by her difficulty in remembering her father. In addition, her trauma was triggered by flashbacks, intrusive thoughts and nightmares that could be understood as PTSD symptoms. Rina reported feeling a sense of stigma regarding being a Holocaust survivor and a sense of survival guilt. In addition, her meaning system was disrupted by her ongoing sense of despair regarding the loss of her father and her unresolved grief. After suffering from nightmares in her thirties, she consulted a psychiatrist. In addition to psychiatric treatment she also received psychotherapy twice a week for six months. This experience was very helpful in allowing her to work through her Holocaust trauma and she reported that the nightmares abated.

4.9.5 Experience of Aging: Integrity versus Despair

Rina was able to have an intimate relationship with her husband and she reported that they grew closer over time. She thrived in generativity, largely from the experience of being a mother. She said that having her four children was the *best thing I ever did*. This was a source of mastery and self-healing where she was able to give her children the childhood she missed. She realised that she had made mistakes as a mother and acknowledged that she was over-protective of her own children but they enjoyed loving attached relationships. Her relationship with her only daughter was difficult, however, and she reported that this often distressed and upset her.

Rina survived cancer twice as an adult. A few years prior to the interviews she had a partial mastectomy and radiation treatment. She reported that she had also survived two vehicle hijackings. Despite these later traumatic experiences Rina appeared to be functional and well adjusted. She described her coping skills as follows: *I don't dwell on the past, I move forward.* This appeared typical of Rina's coping style. When asked how she had experienced the interview process Rina said: *You asked if me going through the Holocaust had made me stronger, I have had eighteen operations, I've been hijacked twice had cancer twice, yes it has made me stronger, but I have never verbalised it.*
Researcher: *How has this "strength" helped you?*

Rina*: I don't panic in a crisis and also as a child I remember that you never make eye contact with an attacker*.

These comments demonstrated that Rina has a level of mastery and resilience that was part of her repertoire of coping skills. She observed that surviving the Holocaust had strengthened her capacity to adapt and to recover from trauma.

As I get older, the memories of the Holocaust do not get clearer, and I am not depressed. Since I have had cancer, I am grateful for every day, every day is a gift, the skies are blue, the grass is green, and I have my family and thank God we are healthy. It is clear that Rina has a good sense of ego integrity regarding her aging process. Rina had been for twice weekly in-depth psychotherapy for six months and it seemed to have helped her to deconstruct her defences and work through her Holocaust trauma. *At my age, I have survived so many things including cancer and hijacks. It's no good saying 'woe is me or why did this happen?* She acknowledged that she had made mistakes in perhaps being overprotective as a mother and had clashed with her daughter over certain issues. However, she remained committed to her children and she was very involved in caring for her grandchildren. This was deeply rewarding, she said. Rina had a deep sense of gratitude for and acceptance of her life, both good and bad, and a stable sense of ego integrity.

4.9.6 Process Observations

Rina was very cooperative and engaging. Although she frequently became emotional, she demonstrated insight into her experiences. It was extremely useful for the purpose of the research that Rina was able to convey what it meant for her to experience a concentration camp through the lens of her childhood memory. I felt deeply moved by her story and was grateful that she was able to portray her experiences as a child with such clarity. She arrived at the final interview with a gift saying: *I want you to have this perfume, it's special, and I want to thank you, I just feel good when I leave here, it's like having a comfort blanket it's nice*. Rina thus appeared to experience the interview process as not only respectful but also nurturing and gratifying. It is possible that her positive experience of the psychotherapy and her early secure attachment was transferred to me in the engaged listening process of the data collection.

I phoned a week after the final interview to ask how Rina was. She reported that she was well and asked to meet at a public place for lunch where she engaged socially and did not mention the Holocaust. Significantly, Rina did not appear to form a dependent transference and unlike several other participants did not appear to prolong contact. She is still in touch infrequently and continues to attend group functions for Holocaust survivors.

4.10 Case Summary: Menachem

Menachem was eighty-one years old at the time of the interview. He was born in a town in Poland, near Krakow. He was 13 years old when the Holocaust began and 18 when it ended. In 1943 the Germans took over his town and he started working for the Judenrad (the Jewish council who supervised the deportation of Jews, to the concentration camps). As such, he received temporary protection from deportation. Eventually Menachem was himself captured and interned at a labour camp, Pustkow, for six months. At a later stage he was sent to Blechemmer, a labour sub-camp of Auschwitz, where he remained for two years until the end of the war. Menachem's mother died of typhus in 1941 when he was 13, so just before the advent of the Holocaust. He lost his whole family during the Holocaust. In 1948 he met his wife and her family. They took him in and he married at the age of twenty-one. Initially he and his wife moved to Israel where they lived for three years. Due to scarce work opportunities they decided to immigrate to Rhodesia and then to South Africa during the 1980's.

Menachem said his memories of the war years were sound, however, it must be noted that he suffered a mild stroke some twenty years ago. Since then he has held a full-time position of employment as a manager in a large retail chain. According to his wife he had made a good recovery from his stroke. At the time of the interviews Menachem was retired from his job and did sewing alterations to earn extra money as he and his wife struggled financially. He had been married for sixty-one years and has two sons. One son lives in Canada and the other in South Africa. He has four grandchildren and five great-grandchildren. I saw him weekly over a three-week period and three hours of material was recorded.

4.10.1 Memories of Early Parenting

Menachem was the second born of four children. He had an older sister and a younger brother and sister. His father was a kosher butcher and his mother worked as a seamstress. He

remembered helping his mother thread her needles and fixing her sewing machine. The family were religious and kosher and Menachem wore a 'kippa' (skullcap). He described his mother as *not having time for us as she was either busy working, cooking or cleaning.* In addition, she was described as *strict*. Menachem reported that he was very attached to his father, who was a loving parent. He spent time helping him in his butchery. He described his father as a warm and charitable man who would give food to the poor and he had happy memories of spending time with him. He was closely bonded to both sets of grandparents and he had joyful memories of playing with his friends in the woods before the Holocaust.

4.10.2 Traumatic Experiences and Recollections

When the Germans first took over Menachem's town there was a strict curfew. *We were only allowed out from eight in the morning until five in the evening, you could not walk from place to place after five, and we were forced to wear yellow armbands. Jews who walked in the street after five pm were shot.* The Polish police shot Menachem in the leg while he ran away in the Ghetto on one occasion. Fortunately for him, it was a flesh wound. He said that he often had nightmares relating to this incident where he was running and was shot at. As a result, he often woke up startled and afraid during the night.

In 1943 the ghetto was liquidated. He remembered how the Germans surrounded the town so that nobody could leave. They ordered them to each pack a suitcase and wait in the street until nine am the next morning. He was fifteen years old when he got a job working for the Judenrad. His job was to go to houses to warn Jews that if they did not obey orders they would be shot. This meant that he had some authority and protection from being persecuted and relocated to a concentration camp. He reported that many Jews were taken to the cemetery, forced to dig a hole and undress. Once their valuables were confiscated, they were shot. He said he was forced to work together with a Polish policeman. This man would shoot Jews in front of him and Menachem was then forced to remove their wallets and hand over their money to him. He said that after the Holocaust he bought a gun with the intention of killing this policeman, however he was never able to trace him. Menachem's two sisters were sent away to Majdanek concentration camp. As they left, they gave him a piece of bread. Both his sisters died at Majdanek.

When his Ghetto was liquidated Menachem described how the Germans would search the houses. He said that he witnessed babies and children being thrown out of the windows of three-story buildings. *Sometimes they were seven days old, or between two and three years, it was unbelievable. Mothers who had given birth that day and were not able to move were shot by the Germans and had their babies thrown from the windows.* Since he was working for the Judenrad one of his responsibilities was picking up dead bodies from the floor and taking them to the cemetery. Having witnessed the inhumanity just described left him deeply troubled with spiritual issues. *In the beginning, I could not believe it. Never in my life have I seen such a thing! Babies being thrown from the third floor of a building, so how could I believe in God at all?* Menachem reported that at present when he lies in bed at night, he has flashbacks of these experiences, even though it has been over sixty years since the Holocaust.

Menachem said that eventually he became accustomed to seeing dead bodies: *Eventually, you get used to it; I have seen hundreds of dead bodies.* In addition; he lived with fear each day and expected to be killed. His younger brother, aged seven, was in hiding on a farm in Poland and Polish people from a nearby village informed the Gestapo that he was Jewish. The Gestapo tied him up and shot him. This incident continued to be a source of rage for Menachem. He reported that the Polish police shot his cousins and extended family. His father was shot in the woods while building bunkers to hide Jews. He said that he was deeply saddened that his father died at the young age of thirty-eight. Menachem was taken to Blechemmer labour camp for nearly two years. He remembered seeing Jews kicked and beaten by Germans. *Every minute you were waiting to get killed, if you got sick, they shot you, it was very cold, and the guards always had Alsatian dogs*.

After the camp liberated Menachem returned to his hometown. He found out that his whole family had died during the Holocaust and that the entire town was burned down. He felt completely alone and robbed of any anchoring points in his life. There were 15 survivors out of 500 Jews from his town.

4.10.3 Developmental Disruption

Menachem described his mother as somewhat absent, unavailable and preoccupied with household chores. He described his attachment to his father as warm, loving and close and he saw his father as an enlivening and generous man. He was in his early adolescent years when

the Holocaust began and it was apparent that he was unable to fully negotiate the phase of Identity vs. Confusion. The Holocaust related experiences disrupted his personal social and educational development. In addition to witnessing ongoing violence the catastrophic loss of every family member focused his attention on survival. The trauma and loss he experienced had a shattering effect, compromising the negotiation of a coherent and positive identity. Up until the present time Menachem continues to feel guilt, helplessness and rage about the loss of his father and siblings. His spiritual conflict regarding God presented him with a dilemma as he had been raised in a religious home. This further contributed to problems in achieving a sense of self that felt wholesome or whole. His early marriage was linked to his focus on survival as his wife's family *took him in* and he was perhaps plunged into adult responsibilities before he had a chance to properly recover from the trauma and loss associated with the Holocaust. In addition, he was forced to be complicit in the harming and destruction of other people at a critical time during the formation of his masculine identity. This experience seemed to have left him with a sense of helpless rage and a need for vengeance indicating a developmental rupture.

4.10.4 Mental Health Impacts

Menachem reported that he had been diagnosed with depression and PTSD and has been on psychiatric medication for the last decade. He described alterations in affect regulation such as persistent dysphoria. In addition, he described dissociative episodes and intrusive symptoms of PTSD such as ruminative preoccupation, nightmares and flashbacks, continuing many decades after the Holocaust ended. These persisted until the present time and Menachem reports of his intrusive symptoms suggested that he has remained fixated on the trauma he experienced. Alterations in self-perceptions were described as well as a sense of paralysis of initiative, which formed part of Menachem's depressive picture. He expressed a sense of shame about his financial struggle during his life and felt very alone. He had been and still was to some extent preoccupied with a need to take revenge against the Nazis. He was withdrawn and distrusted others. He expressed a lack of faith in God and a sense of continued grief regarding the loss of his parents and siblings. Menachem reported that he frequently felt tearful and felt negative regarding the meaning of life.

4.10.5 Experience of Aging: Integrity versus Despair

Menachem married at the age of twenty-one and has been in a stable marriage for sixty-one years. When asked what it was like to get married so young, he answered, *we just worked on survival matters, there were no emotions involved*. Despite his struggles, he was able to parent his children and recognised that he was attached to both his sons.

In his old age Menachem suffered from lung problems as a long-term health consequence of having had tuberculosis in the concentration camps. He said that aging was difficult as he had lost his independence and had debilitating health issues. *It's not so nice getting older, as a young person I was so independent., I recently broke my knee.*

He said that the Holocaust interrupted his education and prevented him from obtaining qualifications that might have prepared him to engage in a lucrative profession. He regretted that he was unable to make a consistent living and described himself as a *Jack of all trades, but never completed anything*, indicating an apparently low self-evaluation. According to Menachem the pain of the impact of the Holocaust has intensified as he has aged. Not having his siblings around him was a constant source of sadness: *I lost everybody.* As he got older Menachem reported being less busy allowing more mental space for his Holocaust related memories to return and re-traumatise him. He said he would never have closure because of the gravity of his losses and retained frustration in relation to not having been able to personally avenge the harm individuals had committed against his family and community. He seemed deeply depressed and despondent about his life. Menachem appeared to be the most compromised of all the participants in terms of his current functioning and it was evident that he leaned strongly towards the polarity of 'despair'.

4.10.6 Process Observations

I struggled to establish rapport with Menachem as his English was poor and his concentration fluctuated. This could be owing to his posttraumatic stress, his health difficulties and the stroke he had suffered. In spite of this limitation he was able to convey his traumatic experiences and I was profoundly affected by hearing about his experiences. The detailed account of the harming of infants was particularly troubling for me. In addition, I was distressed by Menachem's conviction that he had been abandoned by God. I phoned Menachem after the interview to see

how he was and he reported that he had already been seen by a social services representative, an intervention that I had recommended. I gave feedback to the social worker that he appeared to be deeply depressed and needed ongoing care and management. I understand that he remains in the care of Jewish Social Services.

4.11 Summary

Given the detail and extent of narrative material that emerged from the interviews this chapter presentation has attempted to capture core aspects of the life trajectory of each participant in a case study orientated manner. Observations about developmental disruptions, mental health impacts and the negotiation of the aging life conflicts associated with Integrity versus Despair have been extrapolated. It will be evident that in each instance prior life experiences and extra-Holocaust events played a significant role in their lives and contributed to their adjustment as children in internment camps. It is also evident that all of the participants were exposed to traumatic events of great severity both as direct victims and as witnesses to the suffering of others. Such exposure appeared to have had chronic effects of various kinds almost without exception. Nevertheless, all of the participants had married and the majority had established productive careers and had borne children of their own. As elderly people they were coming to terms with the impact of the Holocaust on their lives in varied ways as they reflected upon in the course of the interviews. It is impossible to do justice to the entire body of material that was shared with me but it is intended that the more longitudinal and individually focused analyses will serve to underpin and inform the across case analysis presented in the following chapter. Within this subsequent chapter many of the issues highlighted in relation to individual cases will be elaborated and engaged in greater depth. It is intended that the across case analysis will deepen appreciation of the complexity of integrating experiences of this kind of magnitude into one's life trajectory from childhood onwards.

5 ACROSS CASE ANALYSIS - THE IMPACT OF HOLOCAUST TRAUMA ON CHILD SURVIVORS

5.1 Introduction

In the first part of this discussion each case was described in detail. In this section themes that emerged across the participants relating specifically to the negotiation of aging and the life crisis of integrity versus despair will be emphasized as this was the main focus of the study. Since it is accepted that this final life stage is predicated upon earlier life experiences and negotiation of core conflicts the discussion includes elaboration of a range of areas that emerged as salient across the interviews. Examples from the cases and verbatim testimony will be used to elaborate the developmental disruption, traumatic experiences and the apparent mental health and psychological impacts of living through the Holocaust as a child or adolescent. Coping capacity and defensive style will be described and examples of different defence mechanisms will be explored in relation to the different cases. The description and exploration of defence mechanisms are relevant as described in the literature review. The last section of this chapter will examine aspects of integrity versus despair in more depth.

5.2 Developmental Disruption and Child Survivor Syndrome

In the cases discussed previously it is evident that each participant was denied a normal childhood or adolescence as a result of the traumatic impact of the Holocaust. Child survivors in the present study suffered the physical loss of parents and close family members as well as the losses associated with being interned in concentration camps. The present research tends to substantiate the prevalence of what Dasberg (2001) described as “child survivor syndrome” in child Holocaust survivors, where the combination of trauma, fear and loss in child survivors resulted in the loss of a childhood. In accordance with Dasberg’s description of “child survivor syndrome” all of the participants in this study were subjected to hunger, conditions of inadequate hygiene, vulnerability to infectious diseases, cold and the lack of a stable home environment. This was particularly relevant for those who were subjected to these extreme conditions in the concentration camps and in hiding. All of the participants in this study were exposed to severe traumatic stress, both in Ghettos and in concentration camps, where they felt terrorised and helpless. This had a long-term impact on the development of PTSD symptoms, their capacity to self-regulate, alterations in their relationships, and contributed to alterations in

self-perception and the development and consolidation of meaning systems that needed to take account of what they had experienced and witnessed.

The child survivors in this study were all victims of traumatic loss – both in respect of the *circumstances of the loss* and in respect of the magnitude of the losses they suffered. They lost their families and communities and many found themselves very alone after the Holocaust, needing to build relationships with those who were available but unfamiliar to them. Dasberg (2001) emphasises unresolved grief and mourning as part of "child survivor syndrome", which was seen clearly in all the survivors mentioned above.

5.2.1 Age Related Developmental Disruption

In the present study, the child survivors were clustered in different age groups in terms of the period of their lives during which they endured the war. Helene and Rina were both around five when the Holocaust began, and Lenna and Anne were in the latency stage. These children were particularly young when they lost their parents. Their education was disrupted and they were uprooted from their familiar environments. Miriam, Shmuel, Dave, Isaac and Menachem were all in early adolescence during the Holocaust. From Erikson's (1982) perspective, their capacity to form a stable identity was disrupted. Miriam spoke of sexual humiliations in the camp as an adolescent girl and all the males struggled with a sense of helplessness that was damaging to their developing masculine identities.

There may be different emphases in the impact of trauma at different developmental stages based on developmental capacities to absorb and manage what the environment is demanding. It seemed that younger children experienced the horror and perhaps processed the trauma in more sensory ways but did not necessarily fully comprehend some of the meaning related aspects of what they endured, whereas older children could better grasp some of the enormity of the threat and perversion exemplified in certain incidents. For younger children there was also greater reliance on adults to mediate trauma impacts whereas older children were often removed from care as they came of a certain age and were compelled to become prematurely resilient and self-sufficient. This was evident in some of the differences in coping styles adopted by participants. Early exposure to trauma altered their sense of identity and self formation as described in the literature review (Cook et al., 2017; Herman, 1992; Laub & Auerhahn, 1993; Van der Kolk, 2007).

5.2.2 Mediators of Trauma

The purpose of this discussion is to compare and contrast aspects of the case material discussed in the previous chapter, in this instance with specific reference to trauma exposure and developmental disruption. Klein (2012) made the point that each survivor is different based on early developmental history, form of Holocaust trauma, and life circumstances post-liberation. This was true for the survivors described in the present research, where early attachment experiences, traumatic experiences, and life post-liberation was very different.

Klein (2012) spoke of the importance of early attachment in building resilience in Holocaust survivors, and this has been substantiated by previous research (Isserman, 2013; Lee, 1998; Paris, 2000). The participants in this study displayed the capacity for secure attachments, with some variation. Shmuel and Helene described the strongest maternal attachments. All the others reported "good enough" attachments to their parents. Isaac lost his mother before the Holocaust, and Menachem reported that he was not attached to his mother. It was also apparent that parental mediation was more significant at a younger age. For example, Rina was very young and depended on her mother as was Anne, who relied on her father. In both instances the presence of these parents proved directly protective and also appeared to serve some function in allowing them to retain an image of a caring adult who was to some extent able to minimize threat and to act strategically in the environment, reducing the sense of utter helplessness in the face of annihilating forces.

Before an attempt is made to compare survivors, it is important to outline their differences. For instance, Helene had secure early attachments to her parents and spent a few months with them in the concentration camp before being sent away. In contrast, Isaac lost his mother before the Holocaust and was exposed to extreme cruelty in the Ghetto. This cruelty included being forced to hang fellow Jews as an older adolescent. Anne was in a concentration camp for three days, and then she was in hiding with her father and brother in the fields of Lithuania, while both Miriam and Rina were with their mothers in concentration camps for years. As Keilson (1979) mentions, it is relevant to notice the life trajectories before, during and after the Holocaust. For example, some of the participants describe the anxiety that was experienced prior to actual internments such as Anne's sense of her mother probably having being raped, Dave's sense of running away from the fire in Rotterdam and Helene's memory of Kristallnacht. This indicates that many of the child survivors in this study experienced terror in the lead up to deportation

and imprisonment. In accordance with Keilson (1979) the trauma was present in an ongoing way leading up to the Holocaust and disrupted the developmental trajectory of child and adolescent survivors over an extended period of time.

Keilson (1979) emphasised that a supportive environment after liberation was an ameliorating factor. This was reinforced by both Herman (1992) and Klein (2012). In the present study, child survivors experienced a great variance in their post-liberation environments. For example, Lenna and Shmuel were the sole survivors of their families and were taken to kibbutzim in Israel. Both of them described the sense of comfort and solidarity they felt on the kibbutzim, and they remained connected to these environments, visiting their former kibbutzim decades after leaving. As outlined in the literature review, Klein (2012) demonstrated in his research that Holocaust survivors experienced kibbutz life in Israel as offering a supportive environment, giving survivors a sense of belonging and a sense of home which was needed after their traumatic loss. It was also an ameliorating factor, post-liberation. Both Lenna and Shmuel demonstrated strong levels of resilience in their coping styles, and it is possible that their supportive experiences on the kibbutzim were a factor in building their resilient coping.

Helene, who was sent to live with relatives in South Africa after the Holocaust, described her uncle and aunt as very supportive. However, she never discussed the Holocaust with them and it was years before she was told of her parents' death. Both Helene and Rina described needing to fit in with others, and this to some extent compromised their personal individuation, in keeping with observations offered by Kellermann (2001). Dave described his post-liberation environment in South Africa as critical and unsupportive. He felt marginalised in relation to social groups and the betrayal of being beaten up by fellow Jews in Israel immediately post liberation was devastating for him. From a similar perspective, Anne experienced her post-liberation environment as alienating, as she did not fit in socially. She felt like a *lost sheep*. It is possible that the alienation experienced by Anne and Dave isolated them socially during the period of middle adolescence, a time during which peer input is particularly significant. Social isolation is the opposite of what is developmentally required at this stage. Erikson (1982) states that the task of adolescence is to find an emergent identity within a peer group. Menachem struggled to integrate socially living in tents in Israel together with other immigrants. He said he felt traumatised by this experience and after some time left to settle in Rhodesia. The various testimonies demonstrate that although some of the survivors had environments that were supportive to varying degrees, they carried their memories and were unable to process their

traumatic experiences, the most common consequence being an inability to integrate and feel accepted by their peer group. This further lead to an inhibition of feeling and reluctance to speak of these experiences. In addition, they were responsive to signals from others that their Holocaust experiences were not to be revisited in conversation.

Other participants such as Miriam, Helene, and Rina experienced their post-liberation environments as supportive and were able to make friends and integrate socially. It would seem that both previous theory and research, as well as the present study, support Keilson's (1979) findings that a supportive environment after liberation was an important protective factor for child survivors in the amelioration of their traumatic loss and trauma. Conversely, negative post-liberation experiences further exacerbated the trauma and sense of loss of all significant connections amongst child survivors. All of the participants in this study who coped well and displayed resilience reported a supportive post-liberation environment. On the other hand, all of the participants who struggled to adjust to hostile, unsupportive environments, describe a continual struggle with PTSD, depression and a sense of social isolation. As such, Keilson's (1979) theory regarding the importance of a supportive post-liberation environment in ameliorating trauma is substantiated by the present findings.

The presence of a parent during the concentration camp experience was a mitigating or protective factor in the face of trauma (Klein, 2012) however, it presented complicated dynamics. This was explained by both Rina and Miriam, who survived with their mothers. Both participants said that they were constantly afraid of being separated from their mothers, as this was a threat to their survival. A difference did become apparent between the two cases. Miriam, an older child, idealised her mother and expressed ongoing gratitude towards her. Rina, a younger child, was critical of the way in which her mother covered her eyes and later refused to explain or discuss what they had experienced, decades after the Holocaust ended. This left Rina feeling resentful of her mother's perceived overzealous protection of her. Eventually, Rina saw a therapist to help with her ongoing trauma which allowed her to process some of what had been hidden. Dave stayed with his mother for a period. He stated that he often thought about her pain, having to witness two cold and starving children who she was unable to nurture and protect, indicating an important capacity to identify with her and to reflect on her experience. He said she fed him emotionally by teaching him about poetry and he appreciated her supreme effort to keep her children alive and as safe as possible. All the child survivors in this study were traumatised by the impotence of their parents in not being able to protect them (Durst,

1995). Rina felt angry, but Miriam who idealized her mother, was perhaps unconsciously protecting herself against any negative feelings towards her. Some survivors arguably felt unconsciously angry towards their parents for failing to protect them (Hass, 1995), in addition to feeling guilt either about their deaths or about any critical feelings they had (Kellermann, 2001). This was possibly evident in Miriam's idealization of her mother and her inability to even consider any negative thoughts towards her mother.

Another protective factor, as described by Klein (2012) and Herman (1992), was the significant relationships formed in the concentration camps. Dave mentioned having a younger friend to protect and look after. Anne, Shmuel, Helene, Lenna, and Isaac all described the pure desolation and aloneness they experienced. The world lacked empathy (Laub & Auerhahn, 1998) and they felt abandoned by all good objects (Eagle, 2013; Garland, 1998; Gerson, 2009). However, several of the child survivors in the study also made some reference to the kindness of righteous gentiles who helped to save their lives. Miriam spoke at length of her nanny who was both a maternal object and a rescuer, who at one stage hid Miriam and risked her life to save her. Dave spoke with great gratitude about an SS woman who saved his life by feeding him extra food when he was sick and weak. Rina mentioned a non-Jewish woman who saved her and her mother. Helene spoke about the nuns in the convent who secretly taught her catechisms at night so that she could successfully hide her Jewish identity. Shmuel spoke of the German engineer at Auschwitz who was kind to him and taught him welding, a skill that enabled him to be very successful after the Holocaust. These experiences of humanity were crucial in saving their lives and also symbolised some hope in the goodness of humanity. As described by Klein (2012), hope was a crucial aspect of the internal worlds of survivors and these redeeming experiences in the face of so much brutality and inhumanity were significant and well recollected.

Klein (2012) links the importance of hope to parental attachment, acquiring a sense of agency, surviving trauma, and rebuilding a life after the Holocaust. His observation concerning this was supported by the testimony collected in this study, where the attachment to parental objects appeared to have facilitated creative resilience. This was seen in Shmuel, Rina, Lenna, Dave, Helene, and Miriam, who all reported secure parental attachments and were able to find and access helpful relationships during the Holocaust. Also, they were able to make good object choices and build positive relational connections in their lives post liberation.

5.2.3 Developmental Disruption as a result of Witnessing Murder and Violence in the Concentration Camps

All nine survivors were interned in concentration camps for various periods of time. Most of the survivors spent extended periods of months and years in the camps. This included Dave, Miriam, Lenna, Isaac, Rina, Menachem, Shmuel and Helene. In addition, many of the child survivors were in two or three camps and also went on death marches. All the child survivors with the exception of Anne reported seeing piles of dead bodies and witnessing the horror of murder in the camps. Anne spent only a few days in a camp and was in hiding with her father and brother where she heard the mass killings at night. Being exposed to death and murder on a large scale and living in the context of danger in the concentration camps meant that normal developmental tasks of childhood and adolescence were disrupted.

The chaos of death and horror was described by Dave, Miriam, Rina, Helene, Menachem, Shmuel, Isaac and Lenna, who all witnessed it. The developmental disruption of this severe trauma meant that their sense of being protected children was over. They lived in fear of their lives and were in a constant fight for survival as they were part of a group that were marked for death and confronted by humankind's capacity for evil. This witnessing of murder and cruelty in the concentration camps, as described in all the case histories, engendered a primitive fear of death as well as a fear for their own safety which extended for years beyond their captivity. The ongoing terror created a developmental disruption that changed their lives forever. They were no longer worried about normal developmental tasks of childhood or adolescence – survival became the only task that was of any relevance. As described by Eagle (2013), it forever shattered their trust in people. This was also described by Garland (1998) and Gerson (2009) who concur that the trauma survivor has a sense that the world has no empathy and is impervious to suffering. In addition, they needed to re-establish some of the 'illusion of safety and invulnerability' as these had been shattered by their traumatic experiences during the Holocaust. This level of repair seemed to be difficult in cases of such severe trauma (Shmukler, personal communication, February 7, 2019).

5.2.3.1 Child Survivors Witnessing and Experiencing Cruelty

Children and adolescents were not protected in any way in the concentration camps. Rather they were targeted for death and cruelty to the same degree as adults. The following description indicates the level of cruelty that child holocaust survivors were subjected to. At the age of seven, Rina was attacked by a non-Jewish Polish prisoner in the concentration camp. The woman was responsible for washing the SS uniforms, and she offered to clean Rina in the dirty water. She washed and dried Rina and while Rina was getting dressed, she burnt Rina on the neck with an iron: *I screamed and said to her, 'What are you doing?'. The woman replied, 'I am doing it because you are a Jew! And I hate Jews!'. She burnt me, and I had a big scar. Of course, my mother never allowed me near her again. The scar remained, and I had plastic surgery to remove it after the Holocaust*.

The account demonstrates that child Holocaust survivors were not only witness to trauma and genocide but were also direct victims of cruelty and torture. To experience pain and cruelty at this level was to experience the world with no empathy (Eagle, 2013; Garland, 1998). In this example Rina was deliberately tortured by an adult who treated her like an object of hate. This form of treatment shattered her sense of trust in other adults and in the benevolence of the world in general (Gerson, 2009). Rina's mother was unable to protect her from general cruelty and stigmatization and in this instance her physical integrity was violated (Pynoos et al., 2007). What is also evident is that it was the betrayal of trust in a situation in which she was ostensibly to be cared for that shocked and alienated her. It is evident that something of this experience of potentially being discriminated against and misled remained with Rina as a kind of psychological scar.

Children and adolescents who witnessed murder were sullied with a sense of horror. For example, Menachem's responsibilities included picking up dead bodies, including infants who were thrown out of windows and their mothers who had recently delivered them were shot. When Menachem spoke about the infant killing described previously it was evident that the level of inhumanity felt beyond comprehension to him. His preoccupation with this part of his Holocaust experience communicated that some fundamental sense of trust in a meaningful and ethical world had been broken and remained difficult to rebuild. Having witnessed this deliberate level of cruelty in which not even the life of a recently born baby was sacrosanct he found it impossible not to forget that human nature could take this form. He said that he stopped

believing in God after seeing these atrocities being perpetrated, and that his spiritual beliefs were consequently shattered (Greif, 2005; Herman, 1992; Janoff -Bulman, 1985).

Shmuel's experience of horror was experienced at Blechemmer labour camp where every week he was forced to watch hangings: *There was a permanent scaffold, three or four people were hung at a time, they stood on a chair then the chair was kicked away… The Germans were cruel to those who could not walk. They were immediately shot, or petrol was thrown onto them, and they were burned alive. They were made to walk in rows of five. If one of the group fell or was missing, the remaining four were shot.* He further recounted similarly sadistic and brutal treatment of inmates at Gros Rosen concentration camp: *We were put in a building with no roof, and it rained all night, and there was no place to sit. The next day the Germans came with dogs and chased us out. There were holes in the ground, people fell into the holes, on top of each other and they could not stand, so they drowned and suffocated and choked in the mud and the stampede, it was terrible.* Shmuel recalled these traumatic experiences vividly during the interview and it was clear that like Menachem he was unable to make sense of this cruelty and inhumanity and said that he did not understand how God had allowed this to happen. He too carried these memories throughout his life. As described by Eagle (2013) in relation to extreme forms of interpersonally inflicted trauma and violation, the experience forever shattered his trust in people.

Menachem and Shmuel were not the only participants to describe sadistic and inhumane acts. Participants such as Miriam, Leah, Rina and Helene saw deformed and dead bodies in the camps. They spoke with a level of disbelief that such things could have occurred and yet they were direct witnesses to such atrocities and therefore forced to comprehend that such grotesque acts did indeed take place. The child Holocaust survivors were exposed to a world of horror at an early life stage. The knowledge that existence could become degraded and threatening to the extent that they had experienced stayed with them in some form for the rest of their lives. This kind of damage to meaning systems and assumptive worlds presented by the Holocaust has been well documented by others (Chalmers, 2015; Grief, 2005; Jannof-Bulman, 1985). As described by Garland (1998), Gerson (2009) and Eagle (2013), in these kinds of conditions the trauma survivor is left with a sense that the world has no empathy and is impervious to suffering. Worse still, the child survivors reported that they were confronted by humankind's capacity for sadism and cruelty on a daily basis.

As time passed and they grew older, they were able to reflect on what they witnessed. The long-term impact of this cruelty and horror lead to symptoms of PTSD and C-PTSD. In some participants the witnessing of extreme horror caused them to question not only interpersonal relationships but also their subsequent spiritual beliefs. Their belief in a benign God was questioned and this led to a profound sense of spiritual isolation. In some instances, this led to decades of feeling spiritually abandoned and bereft of this form of solace, as will be further elaborated in subsequent discussion.

This discussion will now move to discussing long term symptoms and mental health related conditions experienced by child survivors.

5.3 Mental Health Symptoms and Long-Term Impacts

A ubiquitous finding of this study was that all the participants suffered from symptoms of traumatic stress, including aspects of PTSD and C-PTSD. The purpose of this section is to elaborate the particular nature of the trauma that was endured and the mental health sequelae of this exposure so that the long-term implications for the aging process can be better appreciated. In the present study all survivors, whether or not they were part of a clinical subgroup suffering from diagnosed or diagnosable depression, reported that they suffered for decades with symptoms or conditions that clinically would be associated with traumatic stress, even though they did not all meet criteria for the disorder of PTSD.

Almost half of the participants in this study, Dave, Anne, Menachem and Isaac, suffered from severe depression and PTSD. These participants comprised a clinical subgroup in the larger group of participants. Shmuel, Lenna, Miriam, Rina and Helene employed various defences to block the overwhelming trauma they had been exposed to, some of which compromised their functioning. These survivors formed part of an apparently resilient subgroup in this study. Rina had suffered from debilitating nightmares and had attended psychotherapy, however, she seemed to be somewhat anxious rather than depressed and her coping skills were generally good. Rina and Dave had both attended in-depth psychotherapy to deal with their Holocaust traumas.

5.3.1 Intrusive Symptoms

Examples of intrusive symptoms will be discussed including reports of nightmares, flashbacks and intrusive thoughts and memories. It is interesting to note that each survivor had a unique profile of intrusive symptoms

Lenna describes an experience with intrusive symptoms related to her dream life: *The nightmares have been with me since after the war. They have been less the last few years. The dread of talking about my experiences to you has brought them back. I am sorry I cannot discuss my Holocaust experiences*. The interview process reportedly triggered more nightmares for Lenna, who was not able to give testimony as it proved to be too traumatic for her and it was evident that decades after her time in the camps her nightmares were still so vivid as to cause her marked distress.

Miriam's account of her ongoing nightmares indicate that she was persecuted by her intrusive symptoms for decades across her life trajectory: *For many years after the Holocaust I would wake my husband up as I had been screaming in my sleep from nightmares. I would wake up so stiff from anxiety that I couldn't move. I always dreamt that the Germans were attacking my children, even though at the time of the Holocaust I was a child… my children were born twenty years later. My repetitive nightmares continued for many years.* One has a sense that suffering with this ongoing symptom further isolated her from others and, as with Lenna, kept her concentration camp experience vivid in her consciousness. In addition, it is possible that Miriam's nervous system remained in a hyper-aroused state when she awoke from the repetitive nightmares as evidenced in her comment, *I would wake up so stiff from anxiety that I couldn't move*. It is also interesting that her experiences became transformed in her dreams into persecution of her children. It is not uncommon in PTSD for nightmares to be associated with the traumatic event but to represent this in a more symbolic manner. It seems that Miriam identified with both mother and child parts of herself in her dreams. Miriam's description of her debilitating nightmares demonstrates themes of fear and terror as well as a sense of being worn down by their repetitive quality. She reported that they caused significant distress for years. Several of the other participants also described intrusive nightmares.

It is clear that for a child survivor like Lenna unprocessed memories continued to distress her throughout her life despite her best effort of avoidance. Rina also described nightmares that

endured for decades: *I had nightmares for thirty-five years I don't know if I was screaming or making a noise but I would wake my husband, and he would shake me and say 'Rina are you okay? Wake up!' I would run to my children's bedrooms to check they were ok, make a cup of coffee and go back to sleep… and when I went back to sleep I would carry on the dream where I left off. I am not joking*

Researcher*: It sounds as if the dreams persecuted you.*

Rina*: It persecuted me for years, but it was horrendous! I dreamed I am six or seven years old. I dream in Dutch. It's night, and I am on my own, and the Germans are behind me, and I hear their feet marching, and they are shouting and I know I have to get away because if I don't they will take me back to the camp, and as I am running my feet get heavy like iron and I can't walk and they are getting closer and closer and in my dream they never catch me because I wake up crying… and when I get back to sleep it would start all over again from where it left off, and they would get closer, and I would wake up in the morning exhausted and in a cold sweat. When I had children, I dreamed they were alone with me. And the Germans are wanting to take me back to the camps, and I am thinking 'I can't go through this again, how will I protect my children?' And that dream was ten times worse than being chased myself.*

A possible explanation for the persistence of the nightmares is that adrenaline is triggered when there is such a visceral fear response and it is likely that these nightmares triggered a physical "fight or flight" response which may have kept her Holocaust experience alive at a neurophysiological level as well as at the level of imagery and affect. Clearly it was impossible for Rina to effectively block out her Holocaust experiences as they returned to disturb her at night.

It is important to note how the traumatic experiences of the Holocaust evolved into fearful dreams involving the survivor's own offspring. Their fear of not being able to protect themselves transferred into a fear of not being able to protect their children as mothers in the present. Their trauma had continued in time and through a generation. It is possible that they as adults identified with their mothers' helplessness and empathised with their mothers' struggle. It is significant that both Miriam and Rina, survivors who were in camps with their mothers, have nightmares about protecting their own children. These participants demonstrate that even on an unconscious level, trauma ruptured their sense of trust and safety in the world and had become an internalised aspect of their identity. (Eagle, 2013; Garland, 1998; Gerson, 2009; Herman, 1992). As highlighted in the case analyses in the previous chapters it was evident

that in many instances children were not unexpectedly very attuned to their parents' anxieties and fears and this was reflected in their traumatic representations of danger in their nightmares.

The intrusive symptom of trauma-related nightmares appeared to persist after the Holocaust for Lenna, Rina and Miriam, all of whom reported suffering from chronic nightmares in spite of their generally effective functioning. This indicates that post-traumatic symptoms may well endure for decades after the Holocaust as described by previous researchers. (Barak, 2013; Barak et al. 2005; Barel et al., 2010; Cohen et al., 2003: Joffe et al., 2003; Kellermann, 2001; Wardi, 1992). Even though survivors found ways to continue engaging productively in life, it is painful to think of aging survivors having had to endure the ongoing levels of anxiety and stress which emerged in their dream life. It is also apparent that this anxiety was communicated to others such as husbands and children.

Menachem who was diagnosed with PTSD and depression also described being affected by nightmares. Menachem said that he had symptoms of post-traumatic stress, including flashbacks and nightmares regarding the babies who he witnessed were thrown out of windows. He reported that his nightmares were so intense that he would often wake up in the middle of the night in a state of anxiety. He said he would also have a repetitive dream where police were chasing him and he was shot in the leg. Although he received a flesh wound from which he recovered in the actual shooting that took place in later life, the trauma continued to torment him in his dreams. His psychiatrist who diagnosed him with PTSD told him that his nightmares were from a lack of closure concerning the loss of his family. It is interesting to note the severe anxiety reflected in his nightmares, and how they continued, unremitting for decades. Both the horror of the infant killings and the physical injury and life threat related to the shooting (probably mapped onto prior Holocaust trauma) continued to haunt him in the present. It was evident from the reports of nightmares by four of the participants that the Holocaust continued to play out in their unconscious life but in such a way that their replayed imagery and physiological sensations often broke through into consciousness. All four survivors spoke of this symptomatic feature of their lives as deeply troubling and debilitating although they had come to live with the prospect of facing frequent nightmares.

In addition to nightmares, other kinds of intrusive symptoms were also volunteered by participants. Rina described a particular experience when an olfactory flashback from the Holocaust was triggered in her sixties. She had a kerectomy procedure to correct her vision:

They burn off the top layer of your retina to correct your vision. As soon as the doctor lasered my eye, I got the smell of burning flesh, and I thought Oh my God! It was terrible! I couldn't move. I couldn't do anything! I was supposed to go for my astigmatism, but I couldn't go back. As Rina elaborated, the eye procedure had triggered the olfactory memory of burning flesh from the crematorium at Ravensbruk concentration camp. The above example demonstrates that as a 'high functioning resilient survivor' Rina experienced flashbacks five decades after the Holocaust. Van der Kolk (2007) and Pynoos et al. (2007) discussed the long-term deep and indelible mark that trauma leaves on the psyche of a child, and this is demonstrated in the case material here – the olfactory memory having been unconsciously retained and resurfacing unexpectedly.

Lenna, although one of the more resilient survivors, could not find the words to describe her experiences. She continued to be tormented by her intrusive traumatic memories:
Lenna: Visiting Auschwitz is a quiet experience for me now. You don't hear screaming anymore; you don't hear wailing.
Researcher: Did people used to wail?
Lenna: Yes, they knew they were being taken to their deaths, and they used to cry out and beg to be saved.
She made it clear that the intrusive memories of Auschwitz lived in her mind like a permanent dark cloud that could easily overwhelm her consciousness. Intrusive memories continued to traumatise her and she said that her recollections of Auschwitz and her family's deaths live with her constantly and have continued to interfere with her capacity to enjoy her present life. She reported that her PTSD symptoms were a constant reminder of her past from which she was unable to escape.

Dave described persistent traumatic recollections after the trauma he endured. He remained preoccupied and obsessed with the Holocaust and it seemed he lived a parallel existence where his memories were so intrusive that he struggled to engage with his present life. He spoke of the way in which he was violently beaten by gypsies in the concentration camp and as a result he was constantly vigilant and fearful of being humiliated and attacked in his present life. Dave described an intrusive memory that continued to trouble him from when he was thirteen at Ravensbrook concentration camp: *I was sent to feed a group of 'Musselmanne', these were people who were on the brink of death. I was traumatised for the rest of my life after seeing the following image: All these skeletons got up and shuffled towards me, open mouths, staring*

hollow eyes, their hands stretched out, they never grabbed. I gave them the biscuits as quickly as I could and ran away. It was such a horrifying experience that I was traumatised for the rest of my life! They went on the next transport to Auschwitz. As an older man, he described his terror as a child upon seeing such a horrifying spectacle. Terror filled his voice and it was clear that he continued to be affected with a sense of horror, decades later. The sense of awfulness of this engagement was palpable in the interview room and brought this image chillingly to life.

Miriam described an intrusive memory that haunted her for decades: *When the Ghetto was liquidated there was blood all over the walls. I was horrified. There were pools of blood and dead bodies and broken bottles, most of the ghetto had been burned, and out of thirty-thousand, three-hundred survived. It happened in 1942 on the day of my thirteenth birthday. I have never been able to celebrate my birthday since; the memories are too horrific.* Miriam said that this memory tormented her until the present time leaving her unable to experience the joy of her birthday and leaving a cloud over this celebration ever since. Miriam reported a terrifying memory. She described her experiences at Stuthoff concentration camp. *Although we were there for only two months, it was the most terrifying time of my life. When we arrived the sight of it was a chilling indication of what was in store for us: on both sides of the entrance were mounds of shoes, spectacles, some artificial limbs and suitcases bearing silent testimony of what had gone before.* Thus, Miriam described the horror of knowing that Jews were being killed at the camp and the imagery of clothes, crematoria and skeletal corpses filled her with fear that possibly she and her mother would also be killed. Living with this threat of death over a long-term period may have been overwhelming and perhaps have contributed to Miriam's use of dissociation and compartmentalisation as a way of coping as will be discussed later. However, what is evident here is the detail of the recollection and how it is an association continues to impact on the present.

At fourteen, Dave's work in the concentration camp was to collect dead bodies, load them into a wheelbarrow, and drop them off in a room. He described a time when *soldiers took me by my hands and feet and began to swing me over the dead corpses as if they would throw me in, as they did this they laughed. I was terrified that they would drop me on the corpses, and this scene tormented me for years after the Holocaust. My psychiatrist said that that experience was one of my worst traumas*. It would seem that the trauma of this experience was associated not only with being exposed to the dead bodies but primarily with being sadistically taunted by the soldiers. As a fourteen-year-old boy, Dave's horror was not only that he would join the dead

but he was taunted and rendered helpless by two adult men. This incident highlights how cruelty etches itself on the psyche in the form of intrusive PTSD symptoms that torment the survivor. For Dave, it symbolised a persecuting world and the loss of a connection with an empathic other (Eagle, 2013; Garland, 1998; Gerson, 2009; Laub & Auerhahn, 1993; Van der Kolk, 2007). Cruelty leaves a permanent scar on both the psyche and the nervous system (Herman, 1992) and the experience remains an emotionally laden intrusive memory.

From the examples presented it is evident that intrusive symptoms continued to disturb survivors across their life trajectories and that these included intrusive images and memories, somatic associations, nightmares and physiological arousal. The level of detail in the accounts speaks to the retention of material in traumatic form. Most of the testimony from the participants had an "unprocessed trauma" feel as the imagery was vivid and the recollections were accompanied by strong affect in many instances. They also had a 'present tense' quality. This conveyed something of the way in which these participants carried unbearable trauma that remained unprocessed and became present in unexpected ways.

Having discussed some of the intrusive features associated with PTSD that were evident in the accounts of the survivors, the following sub-section looks at some of the more avoidance related features.

5.3.2 Avoidant Symptoms

Avoidant symptoms of PTSD enable the survivor to avoid confronting the painful affects associated with the trauma (Herman, 1992). Emotional numbing and dissociation have been described as the severing of the link between thought and feeling as a response to severe trauma and is related to the fact that this is sometimes the only mechanism to deal with the ongoing, paralysing fear associated with traumatization in captivity (Herman, 1992). Wardi (1992) employs the term, "robotization" to refer to a similar aspect of impact. All respondents reported in great detail the horror and revulsion they felt upon witnessing degradation, harm and murder in the camps – however they explained that after a period of time they became impervious to the horror they witnessed and endured. Dave, Miriam, Isaac, Rina, Shmuel and Lenna all described how they became emotionally blunted after being repeatedly exposed to horror and trauma. For example, Dave said after being horrified by dead bodies he came to view them as *potatoes*. Miriam said that after a period she became numbed to the experience of being forced

to parade naked before German Soldiers – *we didn't care*. Isaac said that he got used to seeing and smelling the piles of rotten bodies in Bergen Belsen. In addition, most of the survivors in this study came across as emotionally blunted. Both Dave and Isaac were aware that they were emotionally "numb" and spoke about it in their testimony and Miriam appeared particularly emotionless when discussing her internment. Of all the participants in this study, Lenna had the most extreme avoidant symptom as she was unable to speak about her experiences in the Holocaust at all.

As will be discussed in greater detail in relation to defensive strategies, the most extreme form of avoidance across cases was represented in the compartmentalisation of Holocaust related recollections and associations. For the greater part of their lives the survivors appeared to have almost packed away this period of their life history and had avoided talking about their experiences to anyone. Whether this avoidance was a feature of PTSD and their own anxiety about what approaching such material might evoke, or whether it was in response to non-receptiveness from others (or both), is hard to determine. Nevertheless, there did appear to be some cognitive or mental effort expended in ensuring that difficult Holocaust related contents of their minds was generally kept at bay or locked away.

In conclusion, in relation to PTSD and traumatic stress symptoms the testimony outlined in this sub-section demonstrates that these child Holocaust survivors have aspects of posttraumatic stress that have persisted for decades - as has been documented in previous research (Barak, 2013; Barak et al., 2005; Barel et al., 2010; Brom, 2001; Cohen et al., 2001; Joffe, et al., 2003; Kellermann, 2001, 2009; Wardi, 1992). Both the clinical subgroup and the non-clinical 'resilient' subgroup experienced intense symptoms of post-traumatic stress, in keeping with what has been documented by Cohen et al. (2001). This indicates that both high functioning resilient survivors and as those diagnosed with PTSD may well suffer from traumatic stress symptoms decades after the Holocaust. Child survivors in this study, not unsurprisingly given the events they were exposed to, reported that they were traumatised by Holocaust events into their old age.

The constellation of traumatic stress symptoms of participants in this study had both differences and similarities. Whilst all of the participants had PTSD symptoms, the clinical subgroup (Dave, Isaac, Anne, Menachem) had a joint diagnosis of PTSD and depression. In addition, they had more intrusive PTSD symptoms such as flashbacks and ruminative symptoms. It is possible

that with the exception of Shmuel the males in this group had worse PTSD as they were exposed to particular kinds of traumatisation where they were involved in directly handling dead bodies. While almost all of the participants appeared to have some intrusion related symptoms, it was also evident that many had experienced shattering of core assumptions and continued to struggle to comprehend the kind of world in which these events could have taken place. In addition, those who had either been forced to be complicit in some way or had enjoyed partially helpful relationships with particular perpetrators struggled with feelings of guilt and ambivalence of a kind that might be associated with more complicated forms of traumatic stress.

For the purpose of this study, Herman's (1992) concept of complex traumatic stress is helpful as it describes the long-term characterological changes that take place as a result of trauma in captivity, associated with difficulties in affect regulation, dissociative presentations and alteration in systems of meaning, amongst other features. When trying to make sense of the impact of years of ongoing trauma it is possible to formulate that for child survivors there was a significant rupture of the self (Benyakar et al., 1989; Dasberg, 2001; Gerson, 2009; Herman, 1992, Kellermann, 2001; Laub & Auerhahn, 1998), in addition to a rupture in relationships to others and the world. As a result of severe ongoing trauma and loss, survivors' developmental process was disrupted and often perverted in ways that presented both consciously and unconsciously. In spite of this, most of them were able to cohere in some way and then generally were able to live productive and functional lives. The function of defences in coping with the trauma as well as the impact on the developmental stage of aging will be discussed later in this chapter.

5.3.3 Pervasive Anxiety and Fears of Abandonment

For those who had access to caretakers, the participants' fear of being abandoned by their parent in a ghetto or concentration camp was life threatening as they depended on their parent for survival. The atmosphere of death and violence and fear of losing their parent lead to a pervasive sense of anxiety and fear of abandonment that is clearly described by Rina:

I was seven and a half at the time. I was hungry and cold and frightened all the time. I heard screaming and screaming. I was old enough to understand that people were screaming from pain… I saw a lot of people being beaten, and I saw people being attacked by dogs, bloodhounds and Alsatians. Thank God, my mother was never beaten. Every day she went out to work, and

I remained with the children in the barracks. My biggest fear was that she would not come back and who would look after me, and what would happen to me?

In this quote, Rina described her fear that her mother would disappear and that she would be left at the mercy of the camp guards to face the continual horror that she witnessed, as well as the continual threat of death.

Miriam described her panic when her mother disappeared and then returned so badly beaten that Miriam did not recognise her. Her mother reported that she had been tortured by the Nazi's and this left Miriam with a pervasive fear that she would lose her. Both she and Miriam were constantly afraid of losing their mothers. They feared the loss of their mothers as primary attachment figures, and they also knew that their chances of survival without their mothers were unlikely in the terrifying atmosphere of the concentration camp. Their sense of safety and security was lost and this disrupted their negotiation of separation and individuation as might be anticipated in normal childhood development. Van der Kolk (2007) described the vulnerability of a child on a biological level and argued the likelihood that enduring anxiety at this time of life might contribute to later problems with intimacy and productivity of various kinds.

5.3.4 Loss and Mourning

The literature review discussed the centrality of loss for child Holocaust survivors and the case material described the tragic loss and unresolved grief of each child survivor. Within the data of this research, loss emerged as a major theme and unresolved loss and traumatic bereavement was experienced by all participants even six decades after the Holocaust. It is evident from the testimony that child survivors sustained losses on multiple levels. The extent of the grief and mourning is hard to imagine as all the participants in this study lost at least one parent as well as siblings and extended family. The following were orphaned: Isaac, Lenna, Menachem, Helene and Shmuel, having lost both primary attachment figures. Dave, Rina and Miriam survived with their mothers, however, their mothers were traumatised themselves and compromised in their capacity to perform normal maternal functions. Often the mothers were themselves changed after the Holocaust and unable to process their own loss and trauma Their compounded losses interfered with their capacity to assist in the healing of their children.

Anne was deeply traumatised by the loss of her mother, however, she survived with her father who she reported never discussed the Holocaust with her. She was deeply traumatised by the loss of her sibling, as were Lenna, Menachem and Shmuel. The multiple losses of parents, siblings, extended families and communities were so overwhelming that survivors were unable to mourn in a manner that led to some resolution of grief. The difficulty in mourning may be attributed to the extent and intensity of the loss and in addition there was no support or opportunity for them to express their grief as they had to focus on survival.

Helene, who as previously described, cried for hours during her interviews, also described how the grieving for her parents had remained permanently open or unresolved, in part because she had not allowed herself to fully appreciate what had happened to them. *I think I felt the trauma I was hiding, but I never got over the loss, there was no closure.* Helene also referred to a sense of loss with regard to growing up without her parents. *I just think of the way I loved them and the way they loved me. I am crying, and I can't stop because for the first time I am allowing myself to think about how I missed out and I am left with emptiness and incompleteness.*

Helene's comments echo the lack of closure regarding unresolved loss and mourning in relation to Holocaust survivors as described in the literature review (Dasberg, 2001; Durst, 1995; Krell, 1985; Witztum & Malkinson, 2009). Frequently grief was delayed as there was a more immediate focus on survival and there was little post Holocaust containment and support to express grief. The unexpressed grief that lay dormant and was repressed for decades found its expression in the outpouring of grief that continued for hours in the research interview.

Lack of closure regarding loss was observed in the present research and substantiates the findings of previous researchers (Durst, 2003; Gampel, 1988; Kellermann, 2001, 2009; Kestenberg & Brenner, 1986; Klein, 1974, 1983, 2012; Krell, 1995; Wardi, 1992; Wiesel, 1974; Witztum & Malikson, 2009). Traumatic loss will be discussed under several sub-headings to further clarify the nuanced experiences described by participants in this study and to deconstruct the core issues that contribute to the intensity of traumatic bereavement.

5.3.4.1 The Lack of Opportunity to Anticipate Loss and 'Say Goodbye'

Traumatic bereavement in essence entails a sudden loss where there is no preparation or leave taking. The sudden severing of primary attachment relationships caused a major distress, trauma

and developmental disruption. Many of the child survivors described how they 'lost their childhoods' as they were forced to fend for themselves after losing their parents.

Most of the children in this study described the initial shock of being separated from their parents during the Holocaust. Miriam described her father's arrest and removal from the family. Isaac described how he arrived home to find that his family had been sent to a concentration camp, where they were murdered. Anne described hearing the gunshot that killed her mother and was also devastated by the murder of her older sister, having had no opportunity to say goodbye to either. Menachem and Lenna also spoke of their ongoing grief for their younger brothers who were killed without warning. This sudden and traumatic loss, with no sense of closure, continued to torment child survivors even in their old age. It is possible that the suddenness of the deaths contributed to the ongoing enduring sense of catastrophic grief.

It seems that the moment of loss is frequently engraved on the psyche of child survivors.
Rina described the loss of her father and her intense pain at not having anticipated that she would not ever see him again. Rina said, *I don't remember saying goodbye to my father at Westeborg transit camp, I was very close to him, and it has worried me all my life, I went to two psychiatrists for hypnosis, and I got nowhere. My father died in Buchenwald concentration camp, and I never got to say goodbye. (crying) Until today, I cannot say goodbye I find it very hard because the people you were close to you couldn't say goodbye to them.*

Shmuel became very emotional when he described his final separation from his mother and his brothers, who were all taken to Auschwitz. When he was fourteen years old, he was held captive with his parents and siblings for three days without food and shelter. They were hungry and afraid and this preceded the traumatic separation, meaning that to some extent they were each preoccupied with survival. According to Shmuel he and his father and sister were allowed through the gates during selection. *As we went out from the gate, they stopped my mother and sent her on a train to Auschwitz. That was 1942, we never saw her again (his voice cracked). It happened so quickly there was no time to say goodbye.* Later he was called up for selection by the Germans. His father and sister took him to the train station, they kissed him goodbye, and they all cried. His sister and father were both sent to Auschwitz, where they later died. There is something about the arbitrary nature of the decisions that took his family that leaves Shmuel still tied to these memories of partings. In the case of his father and sister it is evident that they may have had some sense of this being a final leave taking but that the notion of this was too

overwhelming to fully entertain and so their sadness was expressed but there was a limited capacity to acknowledge the significance of this moment. He continued to say in a deeply sad tone of voice: *I hate a cemetery. Because my parents are not there and I don't know where their bodies are! I get upset, even though I am nearly eighty it still upsets me*. This statement demonstrates that there is no mourning site to visit and no closure for an unending grief that continues into old age. Shmuel was profoundly sad as he talked of these immediate family losses and being robbed of the opportunity to say goodbye. Because he was unable to physically locate his loved ones somewhere this left his grief in a kind of limbo. He felt torn from his family without warning and he was deprived of the opportunity to mourn and achieve closure.

When asked if he gets depressed, Shmuel said he has never suffered from depression, however, he has *gotten used to being sad*. He said he was always sad that he did not have access to his family, with whom he was so close. He said that worse than the cruelty and torment of the Holocaust was the loss of his family, for whom he continues to grieve. The lack of closure and inability to engage in ritualised mourning practices leaves a gap where memory is the only memorial left for loved ones. Although Shmuel is very resilient and successful, his description of his mourning suggests the presence of an open wound, as described by Amir and Lev-Wiesel (2003). It is clear that traumatic losses left Rina, Shmuel and Helene with a sense of unresolved bereavement that continued into old age similar to other participants in this study.

5.3.4.2 Scale of Loss of Family and Caretakers and the Loss of Childhood

The loss for children of parents or caretakers threatens their survival and in the case of the participants made them feel utterly alone and vulnerable in the dangerous world of the Holocaust. Although Lenna would not speak about her trauma, she expressed her experience of being alone as the sole survivor of her immediate family. As a child survivor of the Holocaust she reported: *I lost everyone – they died in Auschwitz, my whole family, my brother, my mother, my grandparents from both sides. Aunties and uncles. Cousins from both sides.* This quote highlights the impact of loss for Lenna when she found herself completely alone in the world at the age of thirteen. As a result, she was forced to fend for herself as were many of the participants who lost both parents, experiencing extreme developmental disruptions as they were prematurely catapulted into adulthood. The overwhelming loss is difficult to conceptualise. By listing her losses, Lenna emphasised the scale of her loss and her sense of isolation from her family.

Dave illustrated the way in which compounded loss disrupted his childhood in the following way: *I lost my father and my childhood during the Holocaust including sixteen members of my family who were murdered at Auschwitz.* Dave also listed his losses as a way of emphasizing his sadness and suffering. He claimed that this was the root cause of his depression as he was unable to come to terms with the magnitude of loss of his family members. The extent of this loss, coupled with the trauma he endured, lead to the depression and PTSD he suffered over the decades of his life.

The experience of being left utterly alone is also expressed in the following testimony from Menachem. *When I went back to Poland, I did not find any of my family alive. My father's side were a big family, and they were all gone, no sign of them*. He said that his whole family was killed and he was the sole survivor. He was particularly grieved about the loss of his father to whom he was very attached. It upset him deeply that his father was shot in the woods by the Germans and lost his life at the young age of forty-eight. Not having his siblings around him was a constant source of sadness. *I lost everybody***.** Menachem expressed that the loss of his whole family left him alone and vulnerable in a dangerous world.

Miriam spoke at length about the loss of her father at the beginning of the Holocaust. However, she said she was *devastated about losing my nanny, who was like a mother to me*. Although she said she was never depressed or sad, she described this devastation in a very solemn voice. It was clear that her nanny was a central parental introject that she lost as a result of her Holocaust experience. Her deep sense of mourning regarding the loss of her nanny demonstrates that although she survived with her mother, the loss of her nanny who had cared for her in her early years, embodying a major maternal figure, was experienced as significant across her life trajectory. It was evident from her constant mentioning of her nanny that Miriam was deeply impacted by the loss of this important mother figure who she missed for decades.

It is evident that not only was the scale of loss devastating in terms of leaving child survivors dislocated from those who would have assisted them to negotiate both every day and extraordinary life demands, but that the loss of anchoring relationships also left them struggling to retain continuity of identity. The kind of mirroring of self that children receive from caretakers and extended family was no longer available to them. These child survivors were uprooted from their communities and geographically dislocated so continuity of identity was

difficult to sustain and they were forced to adjust to cultural changes related to living in a new country and learning new languages. It is difficult to maintain a coherent sense of self after such trauma, loss and relocation. Dasberg (2001) and Kellermann (2001, 2009) describe how child survivors placated their new caretakers as a means of survival. Helene and Rina emphasised how they did their best to fit in and look *normal*. However, the cost to the development of a secure and coherent identity meant they were plagued by insecurity. Dave and Anne spoke of their struggle to adjust to their new communities. Dave became detached, and Anne said she felt like a *lost sheep*. As such, both were aware of the developmental disruption that was caused by their loss and trauma as well as the impact it had on their lives. Many references have been made to Dasberg's (2001) child survivor syndrome. He was specific about the fact that child survivors were deprived of a childhood because of the loss and trauma that they endured.

The testimony above points to how intense the traumatic loss of parent and family was and the way in which these losses had a significant impact on participants' childhood trajectory where they were forced to fend for themselves and also lost the sense of going-on –being tied to familiar people and environments.

5.3.4.3 Grief Exacerbated by Empathy for the Circumstances of their Parents Deaths

Owing to the empathic attachment between children and their parents it is possible that children felt a deep sense of empathy for the suffering that their parents endured during the Holocaust and this was certainly evident in much of the interview data. It is possible that this was a retrospective process whereby greater empathy occurred with age and adult perspective.

Helene said that she had avoided thinking of how her parents suffered and died in Auschwitz and described how she repressed her associations to the likely circumstances of their deaths until the time of the interviews. *I have never cried the way I'm crying now. To think that my mother had to live in such horrible conditions, and my father who was a businessman was reduced to that. They were stripped of their dignity. That is unbearable…*

Rina's testimony also shows how decades later, her parents' suffering and the circumstances of death hold unbearable pain: *My uncle told me that my father was beaten so badly at Buchenwald camp, that he could not work, he stopped eating and got weaker and weaker, and then he died in the mud!* In this instance, Rina was crying for the loss of her father and the loss of his dignity,

as well as her own internal loss of a protective, parental introject. She carried terrible pain knowing that her protector had died in such a defeated way. As a result, she described her lack of closure and unresolved grief for her father who was remembered as a damaged object. With adult perspective came a renewed identification and understanding of her father's suffering.

In both the above cases, Helen and Rina wept about the loss of their parents who died brutally. Anne also described the way her mother's dead body was defiled a Lithuanian policeman cut the finger off her body as he wanted her ring. In each instance parents were internalized as damaged objects which may have intensified their trauma and grief. It may be possible that internalizing dead parents in this way was so devastating that it caused a shattering of the self that led to either severe PTSD and depression as in Anne and Dave, or the use of defences such as compartmentalisation and repression as observed in the more resilient survivors - Helene and Rina.

5.3.4.4 Loss, Melancholia and Problems with Subsequent Attachment

The impact of the deaths previously described appeared in some cases to have led to melancholia as opposed to mourning as described by Freud (1935). For example, Anne described the way her mother was shot dead as she returned to attempt to protect her children from harm. She said, *it was terrible. Too terrible! Before I couldn't talk about it, I would just cry!* She spoke in a shrill tone, and it was evident that she continued to be horrified by the image of her dead and defiled mother. In this instance, her sense of horror (as discussed above) and catastrophic grief were indelibly entwined.

The concept of melancholia is used to describe Anne's deep despair and ongoing grief about the traumatic loss of her mother – in this case a literal and symbolic loss as her mother's goodness, protectiveness and capacity to protect her children was also denied Anne through her death and made very evident in Anne's subsequent experiences of danger and deprivation. Although she lost her mother in reality, it was evident that also on a parallel psychic level, her good attachment figure was rendered impotent. Her internal container was shattered. (Garland, 1998). Her sense of the loss of a good internal object was palpable in her sadness. She spoke about the traumatic loss of her mother as if it was a recent event and described the subsequent shootings in the forest with fear in her voice. It seemed that she had internalised a 'damaged and violated' good object, an object robbed of agency and the capacity to protect. She expressed

that she still carried guilt as it was her mother's tenacity and commitment to her children that placed her in danger and cost her life. It was evident that Anne had internalised an identification with a damaged mother and that she in some way felt complicit in having produced this damage as it was her mother's attachment to her children that led her to be in a position of risk.

Menachem was also deeply depressed about the loss of his family decades later. He was particularly upset by the deaths of his brother and father who were murdered by the Nazis. Dave was preoccupied with the death of his father and the sixteen family members who perished at Auschwitz and spoke incessantly about the Holocaust. Given the way that Anne, Menachem, Isaac and Dave were engulfed by grief and depression it was as if a part of them had died too, as they seemed to struggle to re–engage with life and they remained cathected to the dead objects that they had lost as described in cases of melancholia. This also led to difficulties in the capacity to attach libido to new relationships in the aftermath of the Holocaust.

After suffering from such extensive loss, it is easy to understand why forming new attachments was associated with the fear of further loss. Helene said: *It took me years to get over the feeling that my children didn't belong to me, because I carried the feeling that nothing belonged to me, too many things had been taken from me. I felt sad very often…* She added that the fear of loss held her back as she was afraid to attach and lose again. This dynamic affected her relationship with her first child who in her own words *bore the brunt* of her Holocaust experience. In addition, she struggled to believe that her husband loved her.

Helene described her lack of closure in the following way*: To be an orphan - no one can replace the love of a mother and a father. I hoped for years after the Holocaust that my parents would return*. This comment demonstrates how child survivors held onto the hope of their parents return, thus complicating the grieving process as fantasies that loved ones were still alive persisted. Helene said that looking back she feels that she is not compassionate and that as a consequence of losing so much she did not attach as strongly as she should have in her adult life. She thinks this perhaps limited her capacity for empathy. This may be linked to her capacity to risk mutual dependency and demonstrates the enduring impact of catastrophic loss on the capacity to form new attachments.

Rina said that she was aware that her traumatic loss of her father had made her over protective of her children and she mentioned that she particularly struggled to bond with her female child.

Although Dave did not have children, he reported that he struggled to attach to others after the Holocaust and preferred to be alone and only felt safe to cry with his dog. Isaac also struggled to form new attachments and complained that he fought continuously with his family and Lenna complained that she struggled to express herself within her family relationships. This suggests that possibly the impact of traumatic loss may have led to difficulties in forming satisfying attachments after the Holocaust. It is possible that child survivors suffered from melancholia as there was no closure for the sense of loss and there was a difficulty in transferring libido from lost objects to new attachments. Their capacity for intimacy was cauterized in some way.

Most of the survivors said that they did not share the details of their trauma and loss with their spouses as they preferred to compartmentalise their painful emotion, further limiting their capacity for intimacy in interpersonal relationships. In addition, Rina, Lenna, Helene Anne and Isaac spoke about difficulties with their children indicating that their traumatic experiences may have compromised their capacity to parent effectively. Although the present research did not cover this topic in detail a body of literature has been written on second generation Holocaust survivors and the difficulties that survivors faced in parenting their children born after the Holocaust (Klein, 2012; Wardi, 1992).

5.3.4.5 Depression as a Consequence of Catastrophic Loss

The literature demonstrated that depression was a common long-term effect of Holocaust trauma. Within this research, Dave, Anne, Menachem and Isaac suffered from depression. This was clearly a long-term mental health impact that included a sense of "deadness" and bleakness in their internal worlds – a sense of hopelessness that was a long-term outcome of their extensive loss and trauma. All these participants had been diagnosed with depression by a psychiatrist and were prescribed anti-depressant medication.

Anne said that she continues to mourn her mother and sister who died when she was five years old:

Researcher*: Do you think it had something to do with your depression now?*

Anne*: I am sure!*

Researcher*: In what way?*

Anne*: Because of the way my mother died. She was coming to fetch us (pause), and that was the main reason. I loved my mother very much and growing up I did not have a childhood. I grew up with a cloud over my head.*

In this quote, it can be seen that Anne's depression and loss were related to the circumstances of her mother's death, as well as survivor guilt. She said that her depression started soon after she arrived in South Africa at fourteen years old. It seemed that her depression resulting from of traumatic bereavement which persisted across her life span and remained as a continuing vulnerability in her old age. Her description and use of the metaphor of a cloud to describe her depression gives the sense that her dark feelings and bleak outlook permeated her life.

It is significant how Isaac spoke about the loss of his father, stepmother, and half-brother. After the war, he was the sole survivor of his family. He was the only participant who did not express extreme sadness and mourning. Rather he expressed a great sense of rage at his father's death and at not being able to say goodbye to his family. Indeed, his rage may have been a defence against his pain. He was clearly deeply depressed and his depression was expressed in an angry and agitated form. Garland (1998) describes this kind of response as a function of being so traumatised that a person may be stuck in the paranoid-schizoid position. Isaac used his anger as a defence against his vulnerability and it is possible that the traumatic bereavement he endured contributed to his depression in old age.

It seemed that the traumatic grief experienced by child survivors left its mark by causing long term problems with depression in some survivors. Dave had a bleak outlook as a result of the trauma he had suffered and his depressive symptoms took the form of emotional blunting and a bleak perspective and he was fixated on the Holocaust and spoke about it constantly. This may be understood as a symptom of both depression and PTSD. For Menachem life had a sense of meaninglessness – he was so overwhelmed by his losses and traumatic memories that he was chronically depressed and unable to focus on the present.

5.3.4.6 Catastrophic Grief and Traumatic Loss

Each participant mentioned the impact of the traumatic loss of parents and siblings in addition to the losses of extended family and community. Kellermann (2001, 2009) noted the significance of this loss on multiple levels and underscored the fact that there was no closure

for mourning. This was substantiated in the present research, where the scale and depth of loss was catastrophic. Typically, the term, 'traumatic bereavement/grief' is used to describe the loss of Holocaust survivors (Witztum & Malkinson, 2009). In the trauma literature, traumatic bereavement is considered to be an applicable term when there is a single loss that occurs traumatically for example, the violent and sudden death of a parent (Pynoos et al., 2007). Witztum and Malkinson (2009) suggested that a lens of 'traumatic grief'' be utilised in understanding Holocaust survivors as trauma and loss coexist. However, it is proposed that the term 'catastrophic grief' may be even more apt when describing the nature of the grief expressed by aged child Holocaust survivors. This is because child survivors endured multiple traumatic bereavements, over an extended period of time, in the context of severe ongoing trauma. Their continuing grief stemmed from these facts: who was lost; how many were lost; the circumstances of their dying; the degree of personal life threat associated with their passing; the helpless and dangerous circumstances within which they found themselves while trying to process loss; and the limited psychological tools they had available to make sense of experiences at the early developmental stages of their lives. In addition, there appeared to have been limited opportunities, if at all, to process loss even when in post-Holocaust environments. Their developmental trajectory was disrupted by catastrophic loss that occurred on multiple levels and remained present for decades after the Holocaust. There was an intensity to this dimension of participants' testimony that attested to the primacy of this early exposure to the death of significant others in shaping all subsequent development. Although other researchers have emphasized loss as a core dimension of Holocaust impact, it is argued that the elaboration of loss amongst the child survivors interviewed for this study represents an expansion of prior understandings. The burden of catastrophic grief was a defining theme in the life trajectories of participants contributing to their sense of despair in this late developmental stage.

The description of "catastrophic grief" also links to the well-recognised catastrophic nature of the Holocaust and the word catastrophe is the root of the Hebrew word Shoah which means catastrophe. Indeed, the term catastrophic grief captures the extreme loss and trauma of child genocide survivors given that the losses they experienced were catastrophic in both their volume and intensity.

A critique of Herman's (1992) construct of complex traumatic stress, is that despite applying the construct to Holocaust survivors she does not include any mention of the grief of those who have been subject to prolonged traumatization. Within the literature terrible grief has been

described as a core element of their distress by almost all Holocaust survivors (Dasberg, 2001; Durst, 2003; Malkinson & Tur, 2005; Witztum & Malkinson, 2009), as well as genocide survivors in general (Gerson, 2009). Within her diagnostic model it would be helpful to specify that unresolved grief and mourning may be a key or added dimension of C-PTSD stemming from genocidal type traumas. Herman (1992) does not cover the complexity of bereavement and loss in relation to genocide survivors. The formulation of C-PTSD is helpful in understanding survival related strategies of victims/survivors in enduring months or years of cruelty, in captivity. However, as a mental health formulation C-PTSD does not do justice to capturing the loss and grief dimension of Holocaust trauma. The present research is suggesting that Complex Traumatic Stress as applied to child genocide survivors should incorporate some formulation of alterations in the self-structure and symptom expression that occur as a result of the developmental disruption caused by unresolved bereavement.

It is a significant finding of this study that while the participants had differing degrees of depression and PTSD symptoms, they all carried intense catastrophic grief regarding the loss of parents, siblings, families, friends and communities as a result of the Holocaust. This combined with their C-PTSD contributed to their experience of despair in old age as will receive more attention later. At present this discussion will move to an important affective impact of the Holocaust, namely anger in child survivors.

5.3.5 Anger and Rage

Herman (1992) discusses the experience of rage as a response to the devastation of trauma and anger has also been reported in Holocaust survivors in their life subsequent to the Holocaust (Gampel, 1998; Kestenberg, 1984.). Within the present study rage and anger emerged as a major theme in many of the testimonies taken from participants.

5.3.5.1 Anger as a Response to Catastrophic Grief

Many of the participants in this study described their anger towards the Germans because of the loss of their families. Helen, Rina, Lenna, Anne and Menachem mentioned specifically the rage they felt towards the Germans who had killed their parents and their siblings. It is possible that anger is a defense against catastrophic grief that enables the trauma survivor to feel less helpless

and despairing. As children they felt angry about having lost a parent under such traumatic circumstances and it seems that this sense of outrage persisted in the long term

Lenna expressed her unforgiving rage against the Germans who killed her whole family as follows: *I never buy anything German. People say, 'forgive and forget'. To forgive, never. I don't care what the Germans do. I don't care how they try to make up for it. I don't care how many generations come after. A German is always a German, forever.* It is clear that for Lenna, the loss of her family was so catastrophic that decades later it is beyond forgiveness and reparation. Her rage is unremitting. Her furious tone conveyed that she refused to be talked out of her position, however unreasonable she knows it to be – it is possible that her position expresses her way of remaining faithful to those she has lost. Both Menachem and Anne were deeply traumatised by the death of their young siblings who were hunted down and murdered. Anne said, *The Lithuanians were all murderers, they took the Jews from their homes and took all their possessions. My mother and my sister were killed! Of course, I carry a grudge. I don't like the Germans and am still angry.* This sentiment was echoed by Shmuel, who lost his parents and sister: *I don't trust the Germans I hate them; all Jews hate them. I hate them for what they did to my family.* From these quotes it can be seen that these survivors were unable to let go of their anger because to do so would diminish the injustice of their loved one's treatment and deaths and they held on to their anger as a way of remaining loyal to them. In addition, the enduring anger expresses something of the enduring loss and suffering that they carry in their lives because of the irreplaceable loss of family members.

According to Menachem, he was particularly enraged that his nine-year-old brother was hunted by the Germans and reportedly tied up and shot. This was after a Polish man tipped them off about his whereabouts. He said that he remained enraged about this throughout his life: *I hate the Polish more than the Germans because when the Ghetto was liquidated, they stood in the street clapping their hands.*

Miriam's response was different. She said she was not angry towards the Germans and wanted to forgive them, but not forget. She said, *feeling hatred is destructive, and it spoils one's life.* This was an interesting response because she frequently mentioned her anger at religious Jews and Rabbis for not adequately commemorating the Holocaust and the loss of Jews and she refused to buy German products, thereby displaying her anger towards Germans. Shmuel, Dave and Menachem said that they were not really angry with the Germans but rather they were

disappointed and angry with the God who had allowed the Holocaust to happen. It is interesting that some participants were angry with the perpetrators while others held God accountable. Perhaps it is easier to hold the Germans responsible and protect God from ultimate responsibility (Juni, 2005). Those who were angry with God, such as Dave, Shmuel and Menachem, also seemed to have deeper levels of despair. It is possible that the ultimate disappointment and anger in God is a hopeless despairing position to hold.

Most of the survivors expressed their rage at the Germans, who they held responsible for the murder of their parents, siblings, and extended families. From this perspective, anger is primarily linked to loss and grief, and what is notable is that as with the sense of loss, the anger has remained for decades. Although males had more revenge fantasies women raged too, although they were less graphic in describing revenge fantasies.

5.3.5.2 Anger and a wish for Revenge

Anger and a wish for vengeance was expressed by Rina - she was able to explain her anger as a child and her wish for revenge. Rina was eight and a half years old when the Holocaust ended. She remembered driving through Berlin with her mother at the end of the war: *Berlin was devastated, there was hardly anything standing. This was the most beautiful sight I had ever seen, and I said to my mother 'Good! Now they are suffering!' I was happy they were suffering… after what we went through because we were Jews! I mean what crime had we committed?* This comment illustrates a young child's anger and wishes for revenge against the Germans. After the war she went to school in England at the age of nine years old. At this school a fellow learner called her a 'bloody Jew'. She said, *I went mad. I pushed her although she was bigger than me; I pushed her head to the ground and banged her head on the stones. I would still be banging if they had not stopped me! I was expelled from the school*.
Researcher*: I can hear that as a little girl you were angry.*
Rina*: Sure, I was angry, you can't forgive what happened, if you forget it, they can do it again.*
This is a good example of how traumatised children lash out and struggle to self- regulate, as described by Cook et al. (2017) and Van der Kolk (2007). Her testimony adds a childhood perspective on primitive anger and revenge.

The participants' rage and wish for vengeance occurred in the context of genocide, and Laub (1998) makes the point that genocide is resonant of the death instinct. The ongoing cycle of

rage and homicidal revenge is understood within a cycle of violence where the death instinct prevails. It would seem from the present research that the themes of rage, retribution and killing in genocide, to some extent support Freud's (1920) idea of the death instinct, and Klein's (1935) concept of the paranoid-schizoid position. It was clear that the wish for vengeance persisted across the life span and the rage persisted into old age. While some participants blamed the Germans and others blamed God, anger itself emerged as a predominant theme in the testimony of aging survivors. The presence of anger in the testimony of so many participants suggests that rage is a permanent long-term effect of Holocaust traumatisation in many child survivors, pointing to the presence of perhaps another dimension of C-PTSD.

5.3.5.3 Forced Complicity and Rage

Herman (1992) states that when trauma survivors are put in a moral dilemma, or forced to do something that is morally questionable, the damage to the self is intensive. For those participants who had been compelled to become complicit in some way with their persecutors (in this study exclusively male survivors) this tended to represent a profound aspect of their traumatization and subsequent life torment. This is illustrated in the following excerpt from the testimony given by Isaac about his experiences at 14 years. Although he appeared dispassionate in the telling he subsequently told the me that he had never divulged this information to anyone. It seemed that he carried a level of guilt and shame and feared that he would be persecuted for what he had done and so therefore chose to keep it a secret, in a sense from both himself and others.

Isaac*: (describing life in the Riga Ghetto) If a person was caught stealing, they would be hung.*
Researcher*: Did you see the hanging?*
Isaac*: We did the hanging.*
Researcher*: What do you mean?*
Isaac*: You could put eight or ten people to be hung at the same time, and you put a rope around their neck, and they stood on a plank. They take us and give a signal, and we would pull the rope, and you pull the plank away, and these people hung. The aim was to break the neck. If the rope broke, the S.S. would come over and shoot the person in the neck.*
Researcher: *How did you experience this?*
Isaac*: It was just another part of life. I mean it wasn't the right thing to do, and you had to do it, or the German's would kill you.*
Researcher*: How did this affect you?*

Isaac*: The only way to deal with it is to hate the Germans.*
Researcher*: How many group executions where you forced to do?*
Isaac*: I must have done five, six or seven.*
Researcher: *If you would have refused would the Germans have shot you?*
Isaac*: Probably yes, but nobody would have thought to resist them, if that were the case people would have resisted before they took us to the camps.*

It was striking that Isaac conveyed this significant aspect of his trauma in an apparently matter of fact way. He described the way he was forced to murder other Jews in a very dissociated, unemotional manner, with no obvious sense of regret. He appeared to have translated any distress he felt into feelings of intense anger. He explained that this trauma left him with a sense of impotent rage, a rage, that he later explained, affected every area of his life. In Kleinian terms, it could be argued that he felt paranoid and angry as a result of an attack by a bad internal object that would not forgive him for his own aggression exercised in the service of survival and that he needed to expel his feelings of guilt, even if these were largely unconscious. Possibly his feelings of internal badness and shame compelled him to attack others. A clear rupture in his sense of self seemed to be evident in the way he devalued others and he was unable to self-regulate his rage (Herman, 1992). His pervasive feelings of paranoia manifest as an inability to trust in the goodwill of his loved ones. In addition, his sense of guilt, while not admitted, seems likely as he had never told anyone about his actions, fearing their judgement. This increased his sense of isolation and paranoid-schizoid approach to his world.

Although Menachem was not forced to kill other Jews, he worked for the Judenrad and he was also forced to work for a policeman who would kill Jews and steal their belongings. He said that this work left him feeling enraged that he was forced to be complicit in the killing of Jews. He, like Isaac, did not express guilt – just rage. It is possible that the shame of taking part in aggressive acts is so overwhelming that it is unbearable and perhaps the rage is a defence against the shame. Both men expressed themes suggesting ongoing helplessness in relation to their lives. It is possible that their extreme helplessness at being forced to be complicit in killings had long term consequences as it challenged their sense of agency and mastery across the trajectory of their lives. Both men remain deeply depressed and angry and both have ongoing symptoms of severe PTSD, indicating that perhaps the forced complicity has severe long-term impacts. This is in line with what Greif (2005) found when he interviewed members of the Sonderkommando who were forced to prepare Jews for the gas chambers and were responsible

for removing their belongings and disposing of dead bodies. Like the participants of the present research, those who were forced to be complicit in the Nazi death machine showed the severe impact of long-term PTSD and ongoing rage about their forced complicity.

5.3.5.4 Preoccupation with Revenge as a Result of Forced Complicity and/or Violent Attacks

Although all the participants who expressed anger spoke of some feelings of revenge, this section will focus on the participants who were preoccupied with revenge as a result of their forced complicity or involvement in collecting dead bodies. For example, Isaac describes his impotent rage after disclosing that he was forced to hang Jews in the Ghetto. He described his anger towards the Germans: *I could put them all in a hall and burn them, and I wouldn't care! I could go out for lunch with you afterwards!* Isaac articulated his murderous fantasy that he wanted to be a perpetrator of mass murder and has no sense of conscience or guilt. The fragmentation of his sense of self resulted in a rage that he unleashed against his wife, sons, and people around him. He admitted to me that he shouted and screamed a lot and was unable to trust his wife. He was constantly involved in conflicts with others. His functioning was at the paranoid-schizoid level where he constantly felt persecuted by others and was very aggressive in response to perceived attacks. When asked about his anger he said*: These experiences left their mark of anger and hatred that I will carry with me to the grave*. Menachem said that for decades he had harboured revenge fantasies about the Germans who had murdered his younger brother and the Poles who had informed the Germans. In addition, he said that for decades he had wanted to kill the policeman who had forced him to help to collect the valuables.

The death instinct, introduced by Freud (1910), and underscored by Laub (1998) as important in the case of Genocide, seems relevant here. Isaac was forced to murder other Jews and Menachem was forced to be complicit in helping a policeman to kill Jews and steal their valuables – both carried shame and a homicidal rage against the Germans, for several decades after the Holocaust. Neither expressed guilt as they explained that they were forced to do this. However, both carried a sense of shame and said that they did not disclose these experiences to others. Hass (1995) makes a point that often survivors cope with their sense of personal responsibility by focusing their rage on the Nazis. In the case of both Isaac and Menachem this

may be true, as they were trapped in their rage and shame which led to an embittered world view as described by Lifton (1967) and Auerhahn & Laub (1984).

Similarly, Dave expressed a wish for revenge. He appeared to be so psychologically damaged from anger and humiliation at being beaten up by the gypsies in the concentration camp and expressed homicidal rage:

Researcher: Do you think that as a result of all the humiliations you experienced left you angry after the war?

Dave: Ya.

Researcher: How did this anger present itself?

Dave: If I am attacked, I am prepared to kill rather than relive the humiliation.

Both these quotes express the homicidal face of rage that is a consequence of violence and humiliation. It is worth mentioning that the above three participants illustrate how victims of a genocide or Holocaust experience homicidal rage, that is borne from utter impotence. They may have experienced their trauma as teenage boys, as an assault on their developing masculinity, and have harboured this rage for decades after the Holocaust. Impotent rage had led to homicidal rage in all three instances.

The testimony from Isaac, Dave, and Menachem showed a homicidal anger and a wish for vengeance. On a developmental level, they were young adolescents who felt impotent in protecting their family from death. All three of these participants were involved at the coal face of death, Dave and Menachem in collecting dead bodies, and Isaac in the hangings of Jews. Their involvement in the Nazi killing machine made them prone to anger and also at risk for PTSD – a diagnosis they all shared. It is possible that their anger and wish for revenge in old age was some evidence of Complex Traumatic Stress.

Although fantasies about avenging the wrong perpetrated were only evident in three participants, the feelings were sufficiently strong to comment upon as part of the trauma impact. Menachem and Isaac in particular were preoccupied with a need for revenge on the Nazi perpetrators – Dave was randomly looking for an opportunity to vent his rage. It is perhaps not unexpected that it was the three male participants who presented with this kind of ideation given gender socialization and expectations of men to counter aggression with aggression. Their revenge fantasies seemed to be associated with regaining potency through retribution, both on

behalf of themselves and on behalf of other victims, including family members. It is possible that if there had been more men in the participant group the theme would have emerged more strongly although it should be noted that many of the women participants also carried anger and rage even if this did not translate into revenge fantasies.

Menachem said that he still he wished he could take revenge on the Germans who hunted down and killed his younger brother. Isaac wished he could seek revenge on the Nazi's by killing them. Dave wanted an opportunity to fight a nameless perpetrator. While all recognised that the original perpetrators might not be available for punishment, they nevertheless continued to entertain fantasies of exercising aggression in relation to them. It was noteworthy that these three participants had more intrusive PTSD symptoms, such as flashbacks and ruminative symptoms, than many of the others. It is possible that the males in this group had aggravated PTSD as they were involved in the collection of the dead and other tasks that involved contact with violated human bodies. Significantly – Shmuel the only other male in the present study was not involved in the collection of dead bodies – had less PTSD symptoms and was not preoccupied with revenge. It is possible Isaac, Menachem and Dave had worse PTSD because they worked with dead bodies. They had a mature cognitive awareness of death and in the face of loss and trauma with no parental support they developed full blown PTSD and depression. The need for revenge may be linked to impotent rage. Their preoccupation with revenge may also have been linked to their shame about forced participation in the Nazi killing machine as discussed earlier. It is significant that their feelings of vengeance persisted for decades and were still present in their aging years. This says something about the sense of rage and indignation that they endured, and the sense of outrage that has not appeared to diminish with time and persists across the life trajectory.

It is important to think about what it might mean for an adolescent boy, poised to experience his independence and potency as a young man, to be subjugated and terrorised and how the need to escape this kind of emasculation may have endured for many male child Holocaust survivors. In addition, having witnessed the abusive use of aggression in the camps may also have left them with complicated feelings about their own aggression propensity, as discussed to some extent in the individual case analysis chapter. It is possible that part of male adolescent identity development includes the cultivation of physical strength, competence and the capacity to protect, fight and win. Their traumatic experiences undermined male development of physical capability. Instead their adolescent experience was that of weakness, failure and

impotence. This is potentially what sowed the seeds of revenge as feelings of humiliation, impotence and shame were experienced in a developmental phase of male adolescent development. Having discussed anger and the preoccupation with revenge this discussion will now move on to address the issue of guilt and survivor guilt.

5.3.6 Guilt and Survivor Guilt

Primo Levi (in Hass, 1995) described the burden of survivor guilt and how survivors had a sense of shame and existential pain that they had survived in place of another. Hass (1995) indicated that survivor guilt usually waned with time. This finding was not supported in the present study where guilt and survivor guilt were strongly represented in several testimonies. Some distinction is made between guilt and survivor guilt.

5.3.6.1 Guilt about Surviving while Others Suffered or Perished

Throughout Helene's testimony, it was clear that she considered herself fortunate and felt guilty that her parents had suffered terribly while she was protected and rescued.

Helene: When I think of my parents dying in Auschwitz I cannot come to terms with their suffering or their pain. What happened to them is much more unbearable than what happened to me. I had people who rescued me and loved me, but they had no one…they had to die and go through this terrible thing!

Researcher: So, you feel fortunate when compared with your parents?

Helene: Yes, look how they had to die, no one rescued them, and this is why I feel so bad for them, I still cannot bear to think of them in the showers being gassed, nor could I see them as walking emaciated skeletons (sobbing).

It would seem that Helene tried to cope by repressing both her sense of the circumstances of her parents' deaths and her guilt for having been spared from their terrible fate. Klein (2012) states that survivor guilt is linked to loss and when a person experiences guilt it signals a beginning of mourning. In Helene's case, both were unbearable affects. In her early life she seems to have felt abandoned by her parents as she was sent away with no explanation. It is evident that feeling angry with her parents and then hearing how badly they suffered would have exacerbated her sense of guilt. From this vantage point, it is understandable that she would use a defence mechanism such as repression to avoid dealing with these unbearable feelings.

Survival in the camps was a complicated process, as everybody was fighting for his or her life. Dave tells the story of how guilt had a lasting impact on him:
The death march was the worst experience. It took two weeks, and you passed dead bodies or stepped over dead people who were shot, and had people executed in front of me! There was a comatose man next to me, he could not move so they warned him, but he didn't move, so they shot him! I looked at him straight in his face as he was shot, no muscle moved, no fear in his eyes was present. I wanted to scream 'don't shoot him! don't kill him!'. But I was afraid I would get shot. Dave's description of this event implies his guilt surrounding not standing up to protect a fellow Jew and reflects his sense of shame regarding his lack of bravery. Herman (1992) describes the shame of putting one's survival ahead of one's fellow man. Dave's story is reminiscent of how Primo Levi (in Hass, 1995) described the shame of survivor guilt, where he felt that he was cowardly in not standing up for a fellow human being as he feared for his own life.

The guilt of surviving while other family members died can become an ongoing, perseverating thought that is disturbing, as explained by Menachem who felt guilty about accepting a piece of bread from his sisters as they left for Majdanek concentration camp, where they died. He said he could not forgive himself for taking it: *They needed it more than I did.* He explained that he was tormented by this thought for decades, and he was left with a sense of guilt and shame. His sense of guilt and shame left him feeling bad that he had allowed his needs to take precedence over theirs and they may have suffered intense starvation before meeting their deaths. This ongoing kind of self-recriminatory rumination may cause a rupture in the self (Herman, 1992) where the survivor has a sense of himself as bad and shameful, which in Menachem and Dave's cases intensified their depression. Their guilt endured for decades.

Survivor guilt is differentiated from normal guilt as there is the sense that survivor guilt is more about the sense of surviving at the expense of the other or that it could equally have been you that died had circumstances been different. Survivor guilt has a specific trauma related context and meaning.

The following example from Lenna demonstrates how extreme survivor guilt can cast a dark shadow on the potential to have a good life:

Lenna*: I feel sadness and guilt. I had cousins my age, and they are gone, and you ask yourself 'Why me?*

Researcher*: Is that guilt you are speaking about the feeling of 'why me'?*

Lenna*: Yah, there were ten months' difference between me and my younger brother, why did he go and not me? There are no answers for this; it's like hitting a brick wall. You think about the people you lost, who were close to you and vibrant who had the same right to life as you, they are gone…* Lenna's words suggest that there was an arbitrariness to her survival that makes the existential question as to why some lived and some died unanswerable. The phrase 'like hitting a brick wall' is a strong and brutal image and suggests the impenetrability of any meaning around this. Her feeling was that her younger brother had the same right to life as she did. His death may have left her feeling that she was not entitled to the life she did end up having, which may have translated into a sense that she was not entitled to pleasure and enjoyment. Somehow to take one's longevity for granted would represent a denial of the circumstances that made this possible.

Survivor guilt is in a sense an ongoing reparative exercise towards those that might have survived instead of you should circumstances have been different. This dynamic is similar for Anne who explained that her mother had been murdered and lost a finger while coming to fetch her. Here we see a child's sense of responsibility and guilt that her mother died violently and this intense survivor guilt contributed to her depression. In some participants such as Lenna and Anne their sense of obligation to the dead 'tainted' or 'haunted' their whole subsequent life experience.

5.3.7 Humiliation, Shame and Degradation

Herman (1992) and Wardi (1992) describe the way in which survivors were dehumanised in concentration camps. This was poignantly true for child survivors who were exposed to extreme deprivation, including cold, starvation, lice, dirt and inhumane treatment in the ghettos and concentration camps (Dasberg, 2001; Wardi, 1992). In the present study all child survivors described dehumanising conditions and humiliating experiences that they endured in the camps and ghettos. In addition, there was a compounded trauma for the children who witnessed their parents suffering humiliation.

5.3.7.1 Personal Degradation and Humiliation

Personal degradation and humiliation included the deprivations of concentration camp life. This was reported by all the child survivors in this study – including Anne who lived in hiding in a barn and only spent a short amount of time in a camp. Miriam, Rina, Shmuel, Helene Dave, Menachem and Isaac who were all in the concentration camps spoke about the continual hunger, cold, lice infestation and meaningless roll call. They all said that the extent of the hunger and cold was difficult to accurately explain as it was severe and hard for others to comprehend.

Dave reported that he experienced severe deprivation and illness while he was in both Ravensbruk men's camp and Sachsenhausen camp. He reported that due to the starvation he had suffered from stomach problems; specifically, chronic diarrhoea - this symptom persists until the present day.

Dave described his experience of being dehumanised in the following way: *When I saw a guard beat up a nine-year-old boy, I realised that myself and the other Jews were regarded as subhuman, irrespective of our age. When you come across a snake or a rat you kill it; you don't stop to ask how old it is. We were surrounded by sadists; the guards, the gypsies, the barrack leaders, and the Kapos. They were bent on inflicting pain and humiliation.* Herman (1992) explains how the survivor experiences a sense of shame from being powerless and at the mercy of another person. Here Dave describes what it feels like to be subhuman. As previously discussed by Herman (1992), the methods of dehumanising people were part of the assault on the identity and dignity of the survivor where their humanity was denied.

Dave reported that the roll-calls were an opportunity for the Germans to count and see if anyone was missing. They were forced to stand outside in freezing temperatures below zero for hours from three am in the morning. They were poorly clothed and starved: *We were fed two potatoes a day, and we were emaciated. To keep warm, we held the person in front of us as we slept. Often you woke up in the morning and you were holding a corpse. Sometimes in the men's camp, the guard would throw the boiled potatoes on the floor and watch the starving boys and men grabbing food from the filthy floor. The man would watch with a smirk on his face.* Dave said that towards the end of the Holocaust he suffered from bad eye infections: *You woke up, and your eyes were glued shut from the puss, you couldn't see, and the puss dripped all over*

your face. It is evident how this form of suffering and exposure to disgusting body material became commonplace.

Dave spoke at length about the way in which the Nazis controlled the bowel movements of camp inmates, and the humiliation associated with this. *Of course, diarrhoea was a big problem, and you would get beaten for losing control of bowel movements by the guards, as well as the other prisoners*. He went on to elaborate how the physical deprivation contributed to the felt dehumanisation and allowed the guards to see and treat prisoners as sub-human, something that was difficult to resist internalising given the circumstances. *In the camps, you were starving, cold, dirty and crawling with lice. You were a demoralised dehumanised person, they killed your spirit and then your body. Those who gave in to despair committed suicide or became walking zombies.* It emerged from the interview process that Dave was so disturbed by the humiliation he suffered, that it affected his behaviour on a long-term basis indicating that he had both PTSD and Complex Traumatic stress. Dave spoke constantly about the Holocaust and lived a parallel existence as if he was still 'there'. He said that he was a vegetarian and was unable to think of eating an animal that had been killed. His disgust at the degradation that he and others were forced to experience and confront was palpable in his descriptions and this seemed to have been one of the worst aspects of the Holocaust experience for him.

Miriam recalled that she was emaciated: *We were so cold and did not have proper clothes. I remember my hands were frozen; my skin itched from lice and eczema. We were starving and given a piece of bread a day. It's difficult to understand unless you were there. Until today I cannot throw away a piece of bread.* Miriam described the humiliation and dehumanisation and how fear of starvation impacts on her present consciousness. She focuses primarily on the deprivation she suffered and the manner in which it rendered her and others vulnerable to disease. The torment of ongoing hunger was present in her consciousness across her life trajectory and her obsession with not wasting food continued into her old age.

Shmuel showed the researcher the number tattooed on his wrist, from Blechammer (subcamp of Auschwitz). The number was written clearly as 184738, several decades later. He said the number was like his name. When they called his number, he had to say 'yes', demonstrating that he accepted his dehumanised role as it was in line with survival. In many respects survivors got used to being treated as things rather than people and having all individuality stripped away

from them. As mentioned previously, it was difficult not to internalise aspects of this dehumanisation and 'thing' status.

Concentration camp life in Bergen-Belsen was described by Isaac in the following way: *They put six of us in one bunk with one blanket, in winter. The blanket was full of lice. It was terrible, there was no fresh water, just a dam, and we used to drink the water. When the English came, they emptied the dam and found dead bodies. Probably the people who went to fetch the water were so weak they fell in it and drowned.* Isaac said that he and the other inmates were used to the smell of rotting bodies as it was part of their everyday life. Isaac explained further that when the English found the dead bodies in the dam that they were drinking from, it became clear that even the water was infected, which is part of what had exacerbated the disease and illness in the camp. It was a cruel reality. Isaac indicates that something that was vital to survival was contaminated but that their level of desperation to stay alive meant that they drank from the only source available, one which they subsequently discovered to be terribly polluted and tainted. He said that there were no gas chambers at Bergen Belsen, however, the poor sanitation and surplus of dead bodies causes a level of contamination and illness that killed thousands of people.

Rina described being publicly shamed and humiliated. The child survivors of the camps were exposed to both physical and psychological cruelty. All these experiences were absorbed and internalised to contribute to the child survivor's sense of a ruptured self. Rina described her humiliation when a Nazi officer, who thought she looked German, singled her out. This was because she had blonde hair and blue eyes and did not look typically Jewish. After examining her in front of thousands of people, he exclaimed, *she has Jewish ears!* She said that she felt publicly humiliated and ugly and it left a mark on her confidence. She said that as a young child she remembered posters in Holland *of Jews with big hooked noses and thick lips, grasping bags of money.* Rina said that this experience left her feeling humiliated as she was singled out in a potentially positive way and then she was ridiculed in a prejudicial way. This experience of being publicly denigrated made her feel very unattractive and self-conscious. She said that until the present time she always covered her ears and was very self-conscious about them. She explained that she would never forget how the German officer shamed her in public. This testimony demonstrates how the child survivors internalised the cruelty that they experienced at the hands of the Nazis, and this had an impact on their developmentally fragile sense of self. They were made to feel worthless and inferior.

The experiences of humiliation described in the interviews is linked to what Herman (1992) described as severe dehumanisation in captivity. The effect of such cruel and dehumanising treatment on children and adolescents contributed to developmental disruptions such as the internalization of a fragile or denigrated sense of self (Herman, 1992; Laub & Auerhahn, 1998; Wardi, 1992). The long-term effects of such traumatisation can be seen by the way these experiences impacted on personality formation as evidenced in compromised positive identity formation and lack of trust in others (Benyakar et al.,1989). The experience of shame as a result of being dehumanized was traumatic for child survivors. This could possibly support the contribution of humiliation in captivity to the development of Complex Traumatic Stress where the personality structures of participants were altered as a result of the cruelty they experienced and witnessed. Their C-PTSD included mood instability, depression, anger loss of meaning and a sense of despair – this was linked to the multiple abuses and cruelty they were compelled to suffer in the context of captivity.

As Klein (2012) said, children in the camps were betrayed by an adult world that aimed to humiliate, dehumanise, and finally destroy them. Being the object of hatred and persecution must have had an impact on their developing sense of self that was devastating, not only in some instances affecting their physiological development but also compelling them to take in negative images of their own and other bodies and bodily functions. In many instances this seemed to have resulted in splitting defences to cope with the overwhelming shame, rage and helplessness. Most of the survivors in the study were extremely well groomed and appeared to pay particular attention to their appearance. This is perhaps an attempt at compensating for the broken and shamed sense of themselves in the camps where they were dirty and humiliated.
H. Gordon (personal communication, February 1989) expressed this compensation in her description of Holocaust survivors wearing ‘silk bandages’ – this was a symbolic attempt to restore the dignity to a damaged and humiliated sense of self.

5.3.7.2 Sexual Shaming of Child Survivors and their Mothers

Chalmers (2015) describes how women were sexually humiliated during the Holocaust. This was described by Miriam, who was a young adolescent at the time. Miriam said that in the Ghetto the German’s took a group of ten women and divided them into two groups. They made them run in rows dropping soil.

Miriam: *This was a meaningless task. We were starved and cold, and we had to run up and down. This was torture. The cruelty was in the way they frequently gathered us and counted us for hours, no matter how cold it was. Once a month we were taken for a bath. The Germans would then use sticks to check for lice in our pubic hair. They wanted to make fun of us.*
Researcher*: Humiliation?*
Miriam*: Yes, humiliation. I was thirteen, after a while I didn't care anymore. We were so relieved that they didn't kill us…I saw a play written by Primo Levi I knew exactly what he was talking about. I was there I knew every expression, every cold, every hunger!*

As a young adolescent heightened by a sense of self-consciousness, Miriam would feel humiliated by having her pubic hair prodded by the Germans. However, she described a sense of detachment. It seems that dissociation and detachment was helpful in the service of survival, as described in the literature (Herman, 1992; Laub & Auerhahn, 1998; Wardi,1992).

Durst (1995) described how it was particularly traumatic for child survivors to view their parents as shamed in front of their families. Indeed, there is a compounded trauma when children witness their parents being humiliated. This is described by Rina in the following testimony. Rina said that at Ravensbruck camp, her mother and the women were stripped naked and forced to parade in front of the German officers:
Rina: My mother was very upset and embarrassed I could see. She was a reserved person.
Researcher: It was terrible for you to see your mother humiliated?
Rina: Not only my mother but all the naked women and their heads were shaved, and they were emaciated. You don't expect to see your mother naked They took her wedding ring and looked all the women up and down to see if they were fit to work.

Chalmers (2015), notes that this stripping and parading of women was a version of sexual abuse and shaming, that was inflicted on women in the concentration camps. This was mentioned by both Miriam who was an adolescent child, and Rina who was a young latency age child. Both carried their mothers' sense of shame and helplessness. This brings home what extreme levels of control captors had over their lives – including over their bodies – and that survivors had no rights to privacy of any kind.

5.3.8 Summary

From the above discussion, it is clear that the symptomatic and affective impacts of trauma continued to disturb and torment child survivors for decades. It seems that in the case of the traumatised child survivors interviewed in this study, catastrophic grief, anger and survivor guilt could be viewed as a 'Trauma Trilogy'. These affects seem intimately entwined for child survivors and appear central to the experience of the catastrophic loss experienced during the Holocaust. In some cases, survivors became trapped in their anger or survivor guilt as part of an avoidance of processing the pain of catastrophic grief. For example, it is possible that survivors like Isaac and Menachem were stuck in their anger and Lenna and Anne were stuck in their survivor guilt – as they struggled to process their underlying grief.

The participants in this study articulated the way in which their Holocaust experiences traumatised them and altered their lives forever. Their lives have been marked by unresolved grief and guilt. The experience of cruelty, degradation and humiliation and extreme dependence on others for survival, together with a compromised sense of agency, emerged in some presentations that were resonant of CTSD. All these experiences and affects have contributed towards the development of PTSD symptoms and ongoing Complex Traumatic Stress in several survivors, as well as a propensity towards clinical depression in many. Even for those survivors who appeared relatively resilient in relation to mental health impacts it was still evident that they suffered profound emotional impacts of a range of forms, as elaborated in this first broad set of themes.

5.4 Coping Capacity and Defensive Style

5.4.1 Introduction

Kellermann (2001) notes that the debate around the issue of child survivors regarding resilience versus vulnerability is ongoing. To not mention suffering is to betray the survivor, and to ignore any mastery they manifested would be to dismiss their bravery and resilience. Aging requires a retrospective perception of past experiences (Aarts & Op den Velde, 2007). This posed a challenge to child survivors who have used a series of coping mechanisms, ranging from repression to splitting, as a means of coping with and blocking overwhelming trauma and loss.

As explained by Laub and Auerhahn (1993) in their article, *Knowing and not Knowing*, psychological defences protect the survivor from the experiences of overwhelming trauma.

The following discussion will elaborate on defence mechanisms used by survivors as evident in this study. As previously argued, the severe trauma caused ruptures in the self that mobilised psychological defences to repress, split, or block memories associated with overwhelming loss and trauma (Dasberg, 2001; Herman, 1992; Wardi, 1992). This had consequences for the successful integration in the aging process. As argued by Dasberg, (2001) Holocaust survivors are at a disadvantage as their defences block them from integrating all their experiences, depriving them of the capacity to view their lives in a retrospective integrative way. However, without defences, they are likely to be overwhelmed with despair. This discussion will firstly look at defences in more depth before elaborating on their impact on the survivors' capacity to integrate their life trajectories. It is evident that defensive styles carried both adaptive and maladaptive features and that they were strongly linked to the life history experiences of the participants.

5.4.2 Suppression

It was evident that many of the survivors had supressed aspects of their experiences for extended periods. Klein (2012) and Dasberg (2001) speak about the suppression of grief and mourning. The grief of child survivors was overwhelming and in order to focus on survival their grief was suppressed. This was demonstrated by Helene:

Helene*: I used to block out all pictures in my head of my parents in Auschwitz. I only started mourning them when my husband died. Even now I won't allow pictures of my parents as walking skeletons; I don't want to see them dead. I don't want to see them as people who had to suffer, it makes me angry, and it's unbearable to think about (holding back the tears). I have always had a wall around me, and I feel if it's penetrated, I am going to suffer. I think as I am getting older, I am allowing emotions to come to the surface. I think I only started grieving for my parents yesterday when we spoke (she starts crying). I only started grieving for my parents yesterday.*

Researcher*: Do you think that it's because it was so difficult to think of them suffering that you didn't mourn them?*

Helene*: I think so, for now, it's difficult; it's the most difficult thing I have been through in all my life (crying). I am not a sad person I am always smiling, but my smile covers a lot; it's a mask I want to be seen as normal.*

This testimony demonstrates how Helene used suppression to block her grief out of consciousness for decades. She describes how the images associated with her parents suffering was unbearable and therefore blocking her visceral memories enabled her to cope with her life. Interestingly she said that as she was getting older it was becoming more bearable to engage with the painful memories – the interview process enabled her to begin to grapple with the grief she had repressed for decades. In addition, she described a normative mask that enabled her to 'fit in' and hide her grief.

In the case of Rina, her mother covered her eyes during the camp years to protect her. In addition, she refused to give her information about their experiences in the camps in the years following the Holocaust. She was resolute in keeping Rina protected from the full implications of what had taken place in the camps. This encouraged Rina to try and supress her Holocaust experiences: *My mother always taught me to look on the bright side, and not look back and be positive. She discouraged me from talking about the Holocaust, and when I asked a question she would say 'you are lucky, that you don't remember, leave it like that'. And would not even discuss my father's death with me! Meanwhile, not that it was her fault; I had nightmares for thirty-five years! I wanted to look like everyone else and talk like everyone else I never wanted anyone to know that I was a survivor*. With hindsight Rina was frustrated by her mother's unyielding protection of her as it gave her no closure and infantilised her on some level. Rina's mother's attempt to protect her daughter, even as an adult, by not talking about their experiences, also communicated to Rina that speaking about the Holocaust was shameful in itself.

Rina said, as *a teenager and young adult I didn't want anyone to think that I was different, and I avoided discussing the Holocaust. In 1955, I went to Israel, and when I saw so many survivors with numbers on their arms, I nearly died! And I never said a word, and never admitted that I was one of them*. Rina said that she enjoyed the fact that she had blonde hair and blue eyes and did not look Jewish. However, her unconscious mind did not cooperate with her attempt to repress her Holocaust experience, and despite her attempts at repression she was tormented with severe nightmares for decades. To some a large extent suppression was used and to some extent

repression was employed to avoid her overwhelming affect. Eventually, she was able to work through her experience in psychotherapy. Both Rina and Helene described how they supressed their traumatic memories and presented a 'happy' face to the world that enabled them to fit into their post Holocaust environments.

5.4.3 Compulsion to Repeat the Trauma

Freud (1920) and Van der Kolk (2007) explain the concept of compulsion to repeat the trauma, which is highlighted in the following testimony. They argue that repetition may reflect attempts to establish retrospective mastery over events in which the traumatized individual previously lacked control.

At the time of the interview, Dave reported that he would walk around his residential area, after dark, with a gun to protect himself. In addition, he would walk around areas that he perceived to be crime ridden during the day. It was clear that Dave was setting up the possibility of an attack so that he would have the opportunity to fight back. He said that he would choose to die or kill rather than face humiliation again. Dave said that the night that he and his family were told to leave their home made him decide that he would never be victimised again. He said that after the Holocaust he took up shooting as a hobby and competed on an international level: *If it hadn't been for the war, I don't think I would have developed this need for shooting. I had been a victim and did not want to be a victim anymore.*
Researcher*: I am thinking that during the war years you were developing an identity as a young man. During this time, you were attacked and humiliated, and after the war, you chose to become a fighter, do you think that gave you a sense of mastery?*
Dave*: Yes, I am not afraid anymore. I used to be afraid. I am not a sadist I just wanted to protect myself.*

Dave's compulsion to repeat the trauma was so powerful that he ignored both his logic and his wife's pleas. He was desperate to reclaim his dignity and his potency, no matter what the consequence. In his attempt to deal with his fear of humiliation, Dave was risking his life in the behaviour described above. He continued in this behaviour over a period of many years - illustrating how powerful this compensatory drive was. The repetition compulsion is evident in the fact that even when he has apparently gained mastery in getting a gun and learning to shoot this does not feel enough - he has to seek out and master conditions of threat again and again.

Further more subtle examples of compulsion to repeat the trauma are evident perhaps in the accounts of Anne and Lenna who both complained about their experiences of being abused in their interpersonal relationships – Lenna said she felt she was trampled on and Anne experienced difficulties in her first marriage where she felt abused. While such experiences clearly did not replicate those of the camps in severity it is possible that both women unconsciously engaged in relationships that replicated elements of dominance and submission (as observed is characteristic in C-PTSD) with the hope of achieving different kinds of outcomes. The fact that Anne was no longer married to her first husband may have been indicative of her capacity to extract herself from this problematic kind of relational dynamic.

5.4.4 Compartmentalisation

Dasberg (2001), describes one of the common ways in which survivors manage their unbearable feelings. He called it 'splitting' which seems to refer to a vertical split. This seems more like splitting off of feelings and memories or perhaps what others might refer to as compartmentalisation, rather than the traditional Kleinian idea of splitting, which refers to attempts to keep good and bad aspects of self and other separated out (although there may be overlaps between Klein and Dasberg's usages of the term "splitting"). Compartmentalisation is defined as a subconscious defence mechanism that underpins attempts to cope with conflicting feelings or cognitive dissonance (Leary & Tangney, 2005). Within this thesis the term is understood to refer to a form of separating out of life experiences in such a way that Holocaust experiences co-exist alongside a more functional present oriented self but remain largely locked out of awareness. However, these facets of history can readily be reintroduced into consciousness under specific circumstances, such as in this instance in response to the invitation to describe and talk about Holocaust related experiences. Lenna described highly successful functioning and resilient behaviour. However, she used compartmentalisation to block off her Holocaust experience, as focusing on it left her feeling traumatised and miserable:

Lenna: *I avoid talking about the Holocaust because it brings up feelings I would rather not think about. I try to push it back. I don't know if I can talk about the camps. I try blocking it. There are things that come to my mind very often, and I push them away or try to do something or go* somewhere *to distract me, and sometimes I succeed, and sometimes I don't.*

Researcher: When you don't succeed, what happens?

Lenna: It goes around and round inside me, and I get more and more hurt.

Lenna functions well externally but at times battles to block her Holocaust experiences and feels consistently upset when she thinks about them. Nevertheless, she has managed to largely successfully lock these associations away for much of her life. This is consistent with what Dasberg (2001) described as an inside/outside split where survivors look resilient on the outside, but experience suffering in their internal world. As Lenna mentioned, she struggled with survivor guilt and experienced anhedonia. In this way, she lived a parallel existence where she functioned well externally, however, she had symptoms of post-traumatic stress and survivor guilt. This is consistent with what Cohen et al. (1998) described, where although many survivors functioned very well, at the same time they lived with a traumatised internal world that could be relatively quickly accessed within certain circumstances. As she ages Lenna finds that her survivor guilt remains intense and contributes to her sense of despair.

Lenna added that she avoided conflict in her close family relationships and never discussed her feelings with anyone, consequently her communication skills within relationships were very limited. Lenna blocked and avoided all feelings and reported that she was unable to communicate feeling in her interpersonal relationships. However, she functioned at a high level and was a successful business woman. Here a split was observed, where she compartmentalised her trauma and kept it separate from her present life. Externally, in terms of occupational success she coped well, however internally she experienced a level of suffering that was too difficult to articulate (Dasberg 2001).

Shmuel described compartmentalisation in a similar way that highlighted a parallel process of outward apparently adaptive functioning together with inward suffering, as described by Dasberg (2001). Shmuel was resilient and very successful in his external world. When he was interviewed, he spoke about his ongoing sense of catastrophic grief about his parents, and his deep disappointment in God. It was clear that he was secretive about the suffering in his internal world. It emerged that he had never discussed the details of this with his wife and family, despite claiming that he was very close and attached to them. He carried his despair silently and almost secretly. With compartmentalisation it is evident that inhibition of memories and states associated with personal Holocaust history is employed as much in the service of the individual as it is to protect those around them from the magnitude of their experiences. The damaged Holocaust-infused part of the self exists alongside the socially functional part of the self, but is as far as possible kept boxed up or compartmentalised away in some manner.

Miriam, Dave and Rina survived with their mothers. Clearly, their mothers were deeply traumatised and, in some sense, must have been emotionally unavailable. They were preoccupied with their own sense of loss and grief, as well as having traumatic symptoms. Miriam said; *When we came to South Africa nobody asked about our experiences, nobody wanted to know. I put it aside. My mother also didn't talk about it*. Dave also said that his mother never asked him what he went through after they were separated and he was sent to the men's concentration camp at Ravensbruk. He and his mother did not discuss the Holocaust. Rina said her mother never discussed the Holocaust with her at all. These mothers did what they could to protect their children during the Holocaust and were so badly traumatised that they were unable to discuss or help their children to process their traumatic experiences. The mothers' silence may have reinforced their children's need to split off the trauma and focus on functioning. In Danieli's (1985) terms, their parents were role models to the conspiracy of silence.

Where compartmentalisation differs from repression or suppression is in the fact that Holocaust-related associations and recollections can rapidly be brought into the foreground of conscious awareness, suggesting that they remain psychically active. At the invitation to share such experiences the participants were able to revisit or access these dimensions of personal history in vivid and affectively loaded form in the present. This form of presentation seems to resonate with that described by Dasberg (2001) when he employs the term splitting.

5.4.5 Emotional Detachment/ Dissociation

Emotional detachment is described as an avoidant symptom of PTSD and Herman (1992) explains how emotional detachment and dissociation enables the trauma survivor to survive unbearable pain. Dissociation, as described in the literature is the splitting of thought from the feeling self (Herman, 1992; Wardi, 1992), causing a rupture in the self that leads to a deadening of feeling.

Isaac said he was very detached from compassion and did not feel sorry for people. When he read something terrible in the paper, he would think *Ag, tough luck.* Also, he said that he did not get upset about discussing the Holocaust. This suggested that his capacity for empathy had become muted. The ease with which he discussed his trauma, pointed to his use of dissociation,

where he distanced himself from experiencing emotion. Dave said that he was aware looking back of the way in which he cut off his feelings in order to cope. Dave said that he saw grown men cry from cold and torture and was surrounded by people dying of hunger and disease.

Dave*: In order to cope you hardened yourself…In the morning, I collected the corpses.*
Researcher*: How did that feel?*
Dave*: I felt nothing it didn't mean a thing to me, you know corpses leak, it's not a pretty sight, never worried me. It was like picking up a sack of potatoes*.

Here Dave described the way in which he split off any feelings of revulsion or empathy. He relied on being self-sufficient and emotionless, a narcissistic defence (Kohut, 1976) that helped him to survive and cope with the horror he was forced to endure. He did, however, acknowledge that he suffered from PTSD and depression. He explained that the nature of his depression was of being emotionally blunted as described in the literature (Herman, 1992; Kellermann, 2001; Wardi, 1992).

It is noted that, Miriam suffered terrible losses and ongoing terror in the camps, despite being with her mother. In the following quote, she shows how she split off her vulnerability in the service of coping. Like Dave, she used this defence in the service of survival:
Miriam*: After you have been through the Holocaust, nothing else is significant. I am not sensitive and don't cry easily.*
Researcher*: Are you saying that after you have been through that level of pain, whatever else happens in your life you take with a pinch of salt?*
Miriam*: Exactly I am very stable and can tolerate a lot of things without making a drama. Depression is not my scene!*

The last comment was said in a very derisory tone as if Miriam considered depression a sign of weakness or attention seeking behaviour. The manner in which Miriam split off her pain and vulnerability were extreme, and she acknowledged no emotional vulnerability at all. She seemed to see her stoicism and lack of sensitivity as positive qualities and it seemed that she idealised the coping capacities of both herself and her mother. This omnipotent grandiose defence may have been a manic defence against her helplessness and terror, as suggested by Melanie Klein (1935).

The deadening of the self or one's emotional responses to life is also understood as part of a basic rupture in the self (Herman, 1992; Laub, 1998). As Greif (2005) described in his interviews with the Sonderkommando, those who were forced to work with dead bodies in the camps appear to have shut down emotionally. This was described by participants in this study as well as just illustrated in the material from the interview with Dave. Dave elaborated on his responses towards dead bodies, saying he felt: *nothing, it was as if a dead body was a sack of potatoes… that's not true; I was starving! I would have shown more interest in a sack of potatoes!*

Menachem was responsible for collecting dead bodies, including dead babies in his town and delivering them to the cemetery as he worked for the Jewish Council. He said: *You get used to it, I have seen hundreds of dead bodies.* It is possible that Dave and Menachem used dissociation, like those used by the Sonnderkommando (Greif, 2005). Being forced to handle dead bodies was a risk factor for developing PTSD in both these men. However, both demonstrated emotional detachment as a way of coping.

The permanent damage of prolonged employment of dissociation was observed in the participants testimony. Their narratives described how they shut down emotionally to cope with the horror of enduring ongoing trauma during the Holocaust. This trauma was experienced in childhood or adolescence and seemed to lay down the pattern of dissociation in their developing adolescent identities. Their defences endured over several decades and were apparent in the aging survivors who participated in the present study. The defences enabled them to cope, however it seemed that shutting down emotionally may have had consequences for their capacity to experience a full range of both positive and negative emotions. In addition, the limited range of emotion may have had consequences for their capacity to attach deeply and share their inner worlds. As noted, most reported that they did not share their Holocaust experiences with their spouses or children. These examples illustrate the way in which defence mechanisms served to block traumatic memories and horrific experiences from the ghettos and concentration camps as discussed by Laub & Auerhahn (1989), who were both child Holocaust survivors.

The splitting of thought and feeling, as in dissociation, was described by Menachem, Dave, Miriam, Shmuel, Lenna, Rina, and Isaac. Their testimony indicated that dissociation was used

as a means of coping with the horror of the concentration camps. This was clearly demonstrated by the way they discussed horrific narratives in an emotionally disconnected manner.

It would seem that dissociation is a paradoxical defence mechanism. It blocks the pain of trauma and kills the capacity to feel, protecting the individual from overwhelming pain. The paradox is that dissociation enables functioning, however, the price is the death of the feeling self.

5.4.6 Summary

There were both differences and similarities in styles of coping and forms of processing trauma. In comparing and contrasting the defensive styles used by the participants, it was clear that, for example, while Helene supressed her bereavement, Anne was overwhelmed by grief during the interview process. However, it was evident that all the survivors had in some way blocked their catastrophic grief as a way of coping as there was no time and space for grief during the Holocaust because survival was the priority. Adjustment and building a new life in the post–Holocaust period became the focus. The defence mechanisms were instrumental in helping survivors to cope both during and after the Holocaust, (Herman, 1992; Laub & Auerhahn, 1998; Wardi, 1992), but came at some cost to psychological functioning. This will receive further attention in clarifying the impact of trauma on the developmental stage of integrity versus despair in old age.

5.5 Integrity Versus Despair in Child Holocaust Survivors

5.5.1 Introduction

The discussion will now look at Erikson's (1982) stage of Integrity versus Despair and focus on the long-term impact of the Holocaust trauma on the aging survivor. Firstly, indicators of despair will be discussed such as catastrophic grief, depression, anger, and survivor guilt. Then the discussion will look at the indicators of integrity such as mastery, resilience, hope and meaning. This research will then present a view of child survivors as engaging on a continuum of integrity and despair.

5.5.2 Indicators of Despair

The long-term impact of complex traumatic stress and catastrophic grief led to elements of despair in aging survivors. There is indeed an overlap of mental health impacts and the existentially mediated aspect of despair in old age. When looking at the child Holocaust survivors who are entering their final stage of aging, a developmental lens aims to connect the impact of the developmental disruption and link it to their functioning as aging survivors. Dasberg (2001), cautioned that now that child survivors were entering the stage of Integrity versus Despair, there would be complicated consequences. He cautioned that their use of defences such as repression and splitting, to cope with their loss and trauma, would compromise their capacity for ego-integration. This study proposes that not only is depression an indicator of despair (as argued by Erikson, 1982), but that in addition in the case of child survivor's catastrophic grief and its nuances of anger and survivor guilt - appeared to be further indicators of despair in old age. This discussion will now elaborate on the links between catastrophic grief and despair in aging child survivors.

5.5.3 Catastrophic Grief as an Indicator of Despair in Aging Survivors

A ubiquitous finding in the present research was that all the participants experienced catastrophic bereavement. Examples were given of how survivors carry a sense of continuous, catastrophic grief, several decades after the Holocaust. Although this phenomenon in Holocaust survivor experience was described in the literature review (Barak, 2013; Dasberg, 2001; Durst, 1995; Malkinson & Tur, 2005; Witztum & Malkinson, 2009) the depth and breadth of traumatic bereavement in the present study was striking. Both the resilient and vulnerable survivors reported the experience of catastrophic bereavement. It was evident that the intensive interview process that underpinned the research enabled a deeper and more elaborated exploration of the gravity of catastrophic grief in the participants. While many of the survivors in this study were resilient and functioned well and would in all probability have had a low score on a depression scale, their grief and enduring mourning experiences were still a significant feature in their lives. The nature of a qualitative research interview seemed to allow ostensibly resilient survivors to let down their guard and express their unremitting sense of loss that has followed them for decades and left them with a sense of a lack of closure despite the passing of time and other compensatory life experiences. They were also revisiting their losses at the life stage of

Integrity versus Despair (Erikson, 1982), as is anticipated to be part of one's life task at this time of life.

In attempting to understand the place of catastrophic grief in relation to integrity and despair the experiences of the 'clinical group' were instructive. Anne, Menachem, Isaac, and Dave were able to express how catastrophic bereavement interacted with their depression and PTSD symptoms. All these survivors highlighted the way in which catastrophic loss was implicated in and underpinned their depression and ultimately their sense of despair. It is possible that catastrophic bereavement is a critical feature in all child Holocaust survivors. This is because they faced multiple traumatic losses, including parents, siblings and their childhoods (Dasberg, 1987, 2001; Durst, 1995, 2003). This is a central issue in genocide survivors, because of the scale of losses sustained and the fact that the task of processing loss cannot be managed or prioritized when survival is of paramount importance (Gerson, 2009). It is also evident that with a few exceptions there was an absence of caretaking or containing persons to assist in processing the loss. Even when present, those caretaking persons could not function fully as emotional containers due to their own trauma. Researchers and writers have highlighted PTSD and depression and argued about the 'resilience versus vulnerability' of child survivors, however it would seem from the present research that all child survivors share the emotional wound that never heals, that of catastrophic grief (Barak, 2013; Dasberg, 2001; Durst, 2002) that contributes to despair in old age.

Researchers in the Holocaust field have argued that a central task of aging is a retrospective view of one's life, one's achievements and one's losses. (Aarts & Op den Velde, 2007). As Holocaust survivors enter the stage of integrity versus despair their catastrophic grief and PTSD impacts on their capacity to integrate their identities and leaves them vulnerable to despair. This was perhaps why Dasberg (2001) cautioned that this life stage could potentially be a struggle for child survivors. In old age, the extent of catastrophic grief may plunge survivors into deep levels of despair, although this may be mediated to some extent by the use of defence mechanisms to repress or compartmentalise ongoing grief. Nevertheless, it appeared that there was something about interviewing people at this particular life stage that brought to the fore just how raw, present and palpable their sense of loss and associated grief was. At this life stage child survivors were more physically vulnerable and some were frail – there was an awareness of the imminence of an approaching death. There was an awareness that their grief and loss would never leave them. Some may have hoped that they would be reunited with lost family or

at the very least gain some closure by finding some relevant facts about their loved ones. At this stage they were having to come to terms with the permanence of the loss and give up any fantasies of recovery of the dead or even of information about the circumstances of their deaths in some instances. In addition, their defences were somewhat compromised because of the losses and frailties associated with this life stage. Indeed, some survivors may have hoped that they would feel better or find some meaning and as old age advances, they know they will never find closure.

It is proposed that the 'Trauma Trilogy' of child survivors linked catastrophic grief to anger and survivor guilt. In this section it is suggested that both anger and survival guilt are additional markers of despair in old age. This is argued because the experience of catastrophic grief and its impact on despair was expressed in a complex manner across participants in this study. The different expressions of loss, anger and survival guilt were pervasive and affected the present life of the aging survivor and as a result their lives in old age were marred by different nuances of despair.

In the depressed group Anne and Menachem were overwhelmed with sadness whereas Dave was obsessed with Auschwitz and the morbid deaths of his family there. Amongst these three their conscious daily life was marred by the experiences they carried, leading to an overwhelming experience of depression and despair in old age. Helene and Rina, although largely highly functional, both expressed an overwhelming grief that they had compartmentalised for decades. They reported that it was only at this late stage that they were able to face some of the grief about the devastating losses they endured. Their sense of despair for the catastrophic grief they endured was expressed in the interview which they appeared to relate to as something of a life review process.

Many of the participants made special mention of the unrelenting grief they experienced for their siblings that died in the Holocaust. For example, Shmuel Lenna, Menachem and Anne expressed the continual pain of this loss as well as that relating to their parents. At this stage of their lives they were again deprived of the camaraderie of their siblings who did not have the opportunity to reach old age. In addition, this overwhelming sense of loss and mourning left child survivors feeling terribly alone and isolated, further contributing to their sense of despair.

5.5.4 Depression as an Indicator of Despair in Aging Survivors

The incidence of depression in survivors is widely mentioned in the literature (Barak, 2013; Barak et al., 2005; Dasberg, 1987, 2001; Durst, 1995; Joffe, 2003; Krell, 1985). Kellermann, (2001, 2009) describes the prevalence of both PTSD and chronic depression in Holocaust survivors. Within the present study, five participants voluntarily disclosed that they were depressed and four were apparently not depressed. The following vignettes describe the way in which depression was experienced by participants in this study:

Dave said that part of the *emotional damage* of the Holocaust was that he struggled to relate to people and often felt angry and depressed. He described his depression as an *emotional flatness*. *I often feel nothing. I read about the Holocaust all the time* He said that his psychiatrist diagnosed him with depression and post-traumatic stress disorder and that he had been on anti-depressant medication for the past thirty years. Although he was depressed it is possible that medication was not helpful in the usual way due to the complex nature of the depression and its association with catastrophic grief. He spoke incessantly about the Holocaust and was fixated on Auschwitz and the death of his father and 16 members of his family there. Menachem said that he had been depressed since the end of the Holocaust. Two years ago, medication was prescribed, however, he discontinued treatment. He said that he was unable to stop thinking about the loss of his family during the Holocaust, and was continually sad, six decades later. Both Dave and Menachem's comments reflect the way in which catastrophic grief led to depression that continued into their seventh decade and contributed to a sense of despair.

Anne said that she continued to mourn her mother and sister who died when she was five years old:

Researcher: *Do you think it had something to do with your depression now?*

Anne: *I am sure!*

Anne said that her depression started soon after she arrived in South Africa at fourteen years old. Anne was deeply depressed. Her type of depression appears to have been similar to that described by Garland (1998) as severe melancholia, where in some respects she had identified with her dead mother and had 'died' herself. As such she was consumed by her grief and engulfed by her sadness.

At the time of the interview Isaac was clearly suffering from an agitated depression, which he expressed through his unremitting irritability and rage. He said that his wife and sons had complained about his behaviour to the family doctor, who had suggested anti-depressants. Isaac said that that made him angry as there was *nothing wrong with him!* However, his capacity to self-regulate his rage was problematic.

All these survivors show extreme dimensions of depression as a result of catastrophic grief and continued to experience depression into their old age as described was common in aging adult survivors (Barak, 2013; Barel et al., 2010; Dasberg, 1987, 2001; Joffe et al., 2003; Kellermann, 2001; Wardi, 1992).

5.5.5 Loneliness as an Indicator of Despair in Aging Survivors

The link between depression and loneliness was highlighted by a recent study O'Rourke et al. (2018) who compared the depression scores of two hundred and ninety-five randomly selected aging child Holocaust survivors to aging control group in both Israel and Canada. The Centre for Epidemiological Studies – Depression Scale (Radloff, 1977) was administered. Findings confirm that the early life trauma of the Holocaust affects elevated depressive symptoms in child survivors. Their scores for depressive affect and the absence of well-being were raised when compared to the control group. However, they had good coping skills despite their chronic sadness. Most significantly child Holocaust survivors experienced depression differently when compared to the control group - they reported higher levels of 'loneliness' on the depressive affect scales administered (O'Rourke et al., 2018, p. 666). This finding suggests that loneliness may be a hallmark of depression in child survivors (O'Rourke et al., 2018). Indeed, trauma survivors can feel alone even in the company of others and this has been described as the 'trajectory of loneliness' (Solomon, Bensimon, Grenne, Horesh & Ein Dor, 2015, p. 1) or interpersonal disconnection (Dohary, 2010). This echoes what Herman (1992) describes as the way in which trauma disconnects the survivor from others. Solomon et al. (2015) suggest that loneliness is related to PTSD and is connected to what Lifton (1967) describes as the 'death imprint' which is an experience that involves witnessing death on a massive scale that leaves a permanent impression on the survivor's consciousness. The survivor experiences the world as place of "failed empathy" (Laub & Auerhahn, 1989) as a result of experiencing ongoing trauma and this may lead to a sense of existential alienation that may also extend to a spiritual alienation.

O'Rourke et al.'s (2018) research on depression offers quantitative data that supports the findings of the present qualitative research. Firstly, higher depression scores were found in survivors compared to controls. However, these survivors were also resilient and seemed to manage their ongoing sadness, suggesting that perhaps they use compartmentalisation to help them to function in spite of their ongoing sadness.

Secondly the researchers emphasise the early loss sustained by the child survivors and the long-term effects of raised depression and 'loneliness.' It is possible that this sense of loneliness and existential alienation may be related to catastrophic grief and a sense of ongoing mourning and melancholia. This was seen in Rina, Anne and Lenna who remained attached to their dead parents and struggled to attach to their own children, and Miriam who said that she felt that no one who hadn't "been there" could understand her Holocaust experience.

Finally, raised depression levels and specifically "loneliness" can be understood as contributing to the experience of despair in both resilient and depressed survivors. Although they had compartmentalised their emotional pain, they made it clear that their present families and success did not compensate for their inner turmoil and mourning related to their losses in the Holocaust. Their emotional loneliness and interpersonal disconnection were demonstrated by the way in which they all struggled to share their early loss and trauma with their present families. Although none of them were alone, they were alone in their despair at carrying their trauma and grief, feeling disconnected from others. For some survivors, for example Shmuel, Menachem and Dave, this sense of existential loneliness also led to a sense of spiritual alienation where they also felt disconnected from God. This existential loneliness seemed to be an important theme in aging child survivors related to the trauma and catastrophic grief they experienced as a result of the Holocaust.

5.5.6 Anger as an Indicator of Despair in Aging Survivors

Anger was experienced as a result of catastrophic grief however the child survivors in this study varied in the way they expressed their anger and who they blamed for the loss of family members. Most were angry with the Germans and some were angry with their religious leaders or God. Isaac carried a rage for the Germans which pervaded his present experience and he unleashed his anger at his family, whereas Miriam was angry at religious leaders for not

acknowledging her losses and her anger was expressed more passive aggressively. Shmuel was directly angry with God and this contributed to an overarching difficulty in finding spiritual comfort. It is possible that all these participants were using anger as a defense against their loss, grief and helplessness – however the pervasive experience of anger left an embittered perspective in their present life aging experience.

5.5.7 Survivor Guilt as an Indicator of Despair in Aging Survivors

The experience of survivor guilt can have an all-consuming impact in the present. Child survivors may remain preoccupied with guilt that leaves them with a sense of anhedonia and as a result they may well struggle to fully enjoy aspects of current experience. For example, this was expressed by Lenna who said that she struggled to enjoy what she had achieved because she felt survivor guilt in relation to her brother who died in the Holocaust. Menachem was overwhelmed by survivor guilt in relation to his siblings and this intensified his depression. In both cases the impact of survivor guilt held a sense of torment and blocked full life enjoyment as they felt they did not deserve pleasure that was felt in some manner to have been at the expense of the other. Their acknowledgment of the arbitrary nature of their own survival and the deaths of others served as a kind of ongoing memorial for the latter. Dave and Rina were both plagued with a sense of guilt regarding their father and these feelings complicated their grieving experiences. In all these examples guilt and survival guilt left participants feeling a sense of obligation to the dead, resulting in a complicated sense of despair. In a sense perhaps, reparation could never be completed.

Catastrophic grief that resulted in depression, anger and survivor guilt coloured the different aspects of despair described by child survivors in this study. Although some were depressed and others were largely resilient, the experience of catastrophic grief took all of them at times to deep levels of despair in old age. The 'Trauma Trilogy' identified in child survivors – that of catastrophic grief, anger and survivor guilt – were also recognised as indicators of despair in old age. The difference between those who were overwhelmed by despair and those who were not lay primarily in their differing capacity to compartmentalise. This discussion will now focus on how the experience of catastrophic grief led to the rupture of the self and its impact on the experience of despair in old age.

5.6 Catastrophic Grief and the Rupture of the Self

Theorists and researchers (Benyakar et al. 1989; Cook et al., 2017; Herman, 1992; Klein, 2012; Laub & Auerhahn, 1993; Van der Kolk, 2007) explain that trauma ruptures the self with regard to a sense of cohesive identity, autonomy, mastery/agency and the capacity to self-regulate. This applies to participants in this study in terms of the developmental disruption they endured and the manner in which this left its mark on their identities and personalities in old age.

5.6.1 Lack of a Cohesive Identity

The lack of a cohesive identity in child survivors appeared to stem from the traumatic disruption of their developmental identity during the Holocaust and the damage of a dehumanized identity that they internalized. The male adolescent boys typically felt helpless and impotent and unable to protect their families from death. The females were less vocal about their need for revenge, although all of them viewed themselves as either orphaned or seriously impaired by the loss of their parents and extended families. The lack of self-cohesion was seen in the dual identity that they used to survive, an exterior functioning presentation that hid or belied their experience of internal trauma and grief which they were reluctant to share and which set them apart from others. This was described by Dasberg (2001) as 'splitting' and by Kellermann (2001, 2009) as paradoxical integration in their sense of self, signalling that in fact the self was not well integrated in this respect. The present research confirms the way that many Holocaust survivors appear to have compartmentalised their trauma and maintained a level of adaptive or apparently non-damaged functioning throughout their lives.

The creation of paradoxical integration (Kellermann, 2009) enabled the aging survivors to function alongside a parallel aspect of self where grief and trauma were compartmentalised. In this study this phenomenon was identified in all participants. As a result, child survivors were compromised in their ability to construct a cohesive self. This became a challenge in the final stage of aging and the present research interview gave participants an opportunity to reflect on their lives and retrospectively integrate some of the pain and trauma they experienced as child survivors. It is interesting that survivors fell on a continuum regarding their capacity to reflect on their catastrophic grief and trauma. At one extreme Miriam was extremely emotionally numb and refused to own any vulnerability as her defences were tightly constructed and her emotional

pain compartmentalised. On the other hand, Helene, Shmuel, Rina and Anne were able to express some of the grief they had compartmentalised for decades. Isaac and Menachem and to some extent Dave were able to express their rage at the loss of their families. Lenna was not able to use this opportunity to reflect retrospectively and fearing her defences would be overwhelmed, refused to participate in the study.

5.6.1.1 The Survivor Identity

Participants in the present study expressed their identities as Holocaust survivors in different ways that reflected the way in which their identities had been shaped by this aspect of their life history. For example, Dave and Miriam spent a large portion of their time speaking publicly about their Holocaust experiences. They both said that this was sometimes traumatic and Dave said that sometimes his distress was triggered and he would cry. The constant engagement with Holocaust trauma and the identification with the Holocaust may have been their way of trying to gain some sort of mastery over the trauma. However, most of the other survivors said that they did not like to speak about their Holocaust experiences. Rina, Helene and Anne said that they refused to speak publicly and preferred not to discuss it socially or with their families. At the opposite extreme of Dave and Miriam, Isaac and Menachem never spoke about their complicity with the Germans as they feared the consequences of such disclosure and Lenna did not speak about the Holocaust at all. The participants in this study to a large extent did not like speaking about their Holocaust experiences and kept their loss and trauma compartmentalised thereby holding a split identity or paradoxical integration (Kellermann, 2009). This incapacity to fully integrate their traumatic history compromised their ability to form a cohesive sense of self.

5.6.2 Autonomy

All the survivors gave the appearance of being autonomous and were self-sufficient as a way of surviving their trauma. Having lost any semblance of autonomy during their Holocaust experiences the natural development of becoming an autonomous individual was thwarted. Many Holocaust survivors give the appearance of being autonomous although this may have been a defensive attempt to survive by being self-sufficient and self-reliant. Aging is fraught with a loss of autonomy and a sense of frailty. At the time of the interviews most of the survivors

were in reasonable health with the exception of Anne, Menachem and Isaac. They expressed their sense of struggle at being physically disabled as a result of aging. Dave expressed his fear of becoming dependent. Indeed, survivors survived because of their self-sufficiency and the loss of autonomy is a particularly difficult struggle for those who have had to place such importance on stoicism, stamina and self-reliance in earlier life. In the case of Anne, Isaac and Menachem their experience of physical frailty contributed to their depression.

Autonomy was seen in the manner in which many survivors had attempted to cope alone and remain self-sufficient even within later intimate relationships. Both Rina and Helene said that they felt different in their post Holocaust lives and they did their best to fit in and tried not to attract attention to their difference, keeping aspects of their 'true selves' hidden. Although they formed attachment in their post Holocaust lives, they kept their traumas to themselves. Dave expressed this clearly in the following way: *When I went to the men's camp, I was fourteen and had to depend on myself, and I had to break the dependence of a child from his mother. From that time onwards I only depended on myself…and never depended on people.*
Researcher: *So, you had to fend for yourself and detached yourself from people?*
Dave: *Yes. There are still survivors who keep in touch, cling to each other for comfort. I walk alone I don't need anybody. I was alone in those men's camps. So, I had to look after myself in every possible way and could not depend on anybody, emotionally or otherwise, and have remained that way to this day. I don't have attachments besides my wife, and I was very attached to our small dog that was like our child. The only time I ever cried was in the presence of my dog.* This quote indicates how Dave only felt he could trust his dog with his vulnerability. Even though he claimed to have a good marital relationship he was unable to let down his guard with his wife.

It seems that although many of the participants had successful long-term relationships their capacity for emotional intimacy was limited. For example, Lenna, Rina, Dave and Shmuel had "good marriages" in the context of which they still did not share the severe trauma and loss they had experienced with their spouses. They all expressed that their lack of trust in others and in God isolated them on a relational level. Internally they compartmentalised their emotional trauma and appeared to need others to a lesser degree and most were extremely autonomous and self-sufficient. It is possible that after such intense catastrophic loss they were no longer able to depend on others or fully invest in later relationships including those with God or a spiritual being. The emphasis on a fairly rigid form of autonomy distorted their capacity to rely

on others and this manifested in an exaggerated self-reliance. The sense of mistrust in the other and the need for self-reliance formed part of the survivor identity. This defensive style enabled survival but contributed to a sense of isolation and aloneness and compromised their ability to form close attachments to some extent.

5.6.3 Agency/ Mastery

A key feature of being a victim of trauma is the loss of a sense of agency. Hence reclaiming a sense of mastery is part of the trajectory from victimhood to survivor (Auerhahn & Laub, 2018; Herman, 1992; Klein, 2012). The impact on the development of mastery and agency varied in participants in the present research. It would seem that most of the survivors struggled with a sense of mastery or agency in varying ways. In both Lenna and Anne the loss of agency and mastery manifested in them perceiving themselves as devalued and lacking respect and recognition. For example, they complained that they experienced feeling disempowered in their relationships and felt treated in one case like a 'doormat' and in the other as a 'black sheep'. It seemed that their experience of facing trauma alone without parents made it difficult for them to stand up for their rights. Alternatively, Miriam had a grandiose sense of self and agency. This was seen in her disdainful approach to her own vulnerability where she said that she "does not do depression" helping her to avoid her fear of an extreme helplessness. Miriam's sense of agency was defensively constructed with a grandiose experience of herself as invulnerable.

5.6.4 Self-Regulation

In general, most of the survivors were emotionally blunted and used compartmentalisation/ suppression to cope with their overwhelming feelings and it is argued that this form of suppression was related to their attempt to regulate difficult and painful emotion. It was clear that Isaac struggled to regulate his rage, which he used as a defence against his vulnerability and shame. Anne and Menachem struggled to regulate their unremitting melancholia and were overwhelmed by constant sadness. In addition, PTSD symptoms broke through their attempts at self-regulation and overwhelmed their sense of coping and their ability to focus on the present. Flashbacks or triggers interfered with emotional regulation. In addition, a sense of despair caused by ongoing trauma and grief further compromised their capacity for emotional

regulation as many actively felt a deep sense of sadness, anger and survivor guilt in their lives, continuing into their aging years.

5.6.5 Summary

A compromised ability to form a healthy sense of a cohesive identity, sense of autonomy, agency/mastery and a capacity to self-regulate in old age impacted on the task of integrity versus despair. The present study to a large extent bears out Dasberg's (2001) concern that aging survivors would struggle to integrate their experiences in old age because of the way that they had 'split 'or compartmentalised their trauma. High levels of despair were found in both the resilient and clinical group – the despair was related primarily to their ongoing catastrophic grief, which was also in some instances associated with unfulfilled fantasies of revenge and an inability to reconcile with survivor guilt. This discussion will now focus on the impact of trauma on aging survivors at Erikson's stage of Integrity versus Despair, regarding relationships with others and their relationship with God.

5.7 The Impact of Holocaust Trauma on Relationships with Others

The rupture of the self as a consequence of trauma will impact on the survivor's ability to trust and attach (Herman, 1992). The question of how their Holocaust trauma affected the survivor's attachments in old age will be addressed in this section.

Helene explained that the first time she got depressed after the Holocaust was in the hospital after the birth of her daughter when she was nineteen years old: *When I looked at my baby, I could empathise with the pain my mother felt when she gave me to the authorities to save me. I was alone I didn't have my mother, I was scared of how I would bring her up, I was scared I wouldn't be a good mother. I had no support system; my aunt and uncle were far away. The nurses saw me cry for a few days. When I got home, I did not go into a heavy depression; I never cried in front of my husband. This child bore the brunt of my Holocaust experiences.* The sense of utter aloneness is described by this child survivor, who at nineteen years old, was a mother herself. She had repressed her own catastrophic grief and she was faced with adult responsibilities without support. It seems that her confrontation with her own baby changed her repression of the grief she carried for her parents. She described how she was afraid to attach

and bond with her first child, for fear of further loss – although this experience seems to have given her access to the grief she repressed about her own deceased parents. She claimed not to be suffering from depression at the time of the interview, however it was clear that she had suffered with depression in the past. She said that at the time of the interview she continued to struggle in her relationship with this daughter.

Shmuel was very attached to his family, however, it emerged that he had not shared his Holocaust trauma and grief with them. Dave had a good relationship with his wife, but he reported that he was very much a loner and had struggled to integrate socially after the Holocaust. Miriam did not acknowledge any difficulties in the area of relationships which was in keeping with her dissociation and defence against vulnerability. Anne acknowledged that she never fitted in socially after the Holocaust and said she had a problematic relationship with her first husband. She also struggled with mothering to some extent, particularly with her daughter. Helene said she always questioned her lovability, after being separated from her parents, and was always insecure in her relationship with her husband. She said that after her massive losses she struggled to allow herself to attach. This affected her bonding to her children and in particular to her eldest daughter. Lenna said she often felt used by her family members and she struggled to articulate herself. She said that her children knew she was *mad*. Isaac struggled to trust his wife and said he could not control the way he screamed and shouted at his wife and sons. Rina said she struggled to get on with her only daughter and she was an anxious and over-protective mother to her children. The impact of the Holocaust on the second generation is widely acknowledged (Kellermann, 2001; Klein, 2012; Wardi, 1992).

Although not the topic of the present research, most of the survivors in this study were able to recognise and acknowledge the impact of their Holocaust experiences on their close attachment relationships. Their relationship with their children was complicated with several admitting that they struggled to form secure attachments. Perhaps they were avoiding the pain of potential loss and separation in the future. In addition, most survivors said they did not tell their children about their Holocaust experiences as they feared potentially contaminating their children with their traumatic experiences.

There is the sense that in most instances they formed relationships but kept some part of themselves secret or hidden and perhaps could never be fully vulnerable. It is possible that the extensive defence mechanisms they used also made it difficult for them to fully process their

trauma and grief and therefore they were unable to share their Holocaust trauma within their intimate relationships. Many seem to have made one very significant exclusive attachment to a partner with a particular dependence or intensity – a sense of loyalty that this person was able to live with them despite their damage. However, in spite of this apparent closeness they were not generally able to fully share their Holocaust experience. Perhaps it was easier for them to confide in a researcher as I was outside their family and a neutral person.

5.8 The Impact of Holocaust Trauma on the Relationship to God

Several researchers have indicated that trauma disrupts the survivor's relationship with God (Greif, 2005; Herman, 1992; Juni, 2015; Klein, 2012; Lassley, 2015; Lifton, 1973; Wiesel, 1974). In the present research, the following responses indicated how participants were dealing with their religious beliefs and their relationship to God. There was a continuum of responses. Some believed they were saved by a miracle while others believed that God had abandoned them and in the worst extreme some claimed that they became atheists as a result of their Holocaust experiences. It seemed that all participants had to grapple with reconciling a sense of a benign or compassionate God with the trauma that they endured. Their trauma in the Holocaust seemed to raise profound existential questions that became more prominent as they developed more advanced cognitive capacities as adults which are likely to be very salient at the end of life stage.

Shmuel*: (saying that he attended synagogue) I don't really believe in God, because if he didn't prove himself at Auschwitz then how can I believe in him?*
Researcher*: Do you feel God doesn't exist or that He let the Jews down?*
Shmuel*: It's difficult to say, more that He let them down, but it isn't the only time He let them down; He let them down during the Crusades, the Russian Pogroms and the Spanish Inquisition.*

Shmuel said that he grew up in a religious home and was tormented by the question of why God performed miracles to save the Jewish people in Egypt, by the miracle of opening the Red Sea, yet did not save the Jews from the Holocaust. He said that he had tried to discuss it with Rabbis, however, found that they *ran away* from him and could not provide an answer. He said he did not challenge them, although he has a lot of questions. In keeping with Juni's (2015) observations, Shmuel describes his deep disappointment in God. His religious upbringing may have exacerbated his sense of abandonment and betrayal. His expectation was that if God could

save the Jews in Egypt, he could save the Jews in the Holocaust. *I am sadder about God, it gets harder as I get older.* This quote shows that as survivors get older it becomes more apparent that there is no good explanation for the Holocaust – it was an experience of meaningless loss and suffering.

Helene*: I am proud to be Jewish and being part of a people. I think I am ambivalent about God. I don't think God should be something you fear, rather something you love, but it's difficult for me to love. It's not easy…I loved my husband and children but I don't think there is anything in the world that is close to me.*

Helene said that it was difficult for her to love God in the same way that it was difficult for her to make close attachments. This illustrates Juni's (2015) point about theistic object relations, wherein one's attachment to others is mirrored by one's attachment to God. Most significantly, Helene's capacity to attach was compromised by her experiences of catastrophic loss. Just as she felt unable to be close to her family members, she felt a distance and remoteness from God.

Dave said that the night before the war ended, he prayed with *all his might* After the Holocaust, he ceased to believe in God. He does not believe in the existence of God.
Dave*: If there was a God why did the Holocaust happen in the first place? No, I don't believe. It's as simple as that*
Researcher*: But you said that you prayed on the last night of the war?*
Dave*: After the war, I started to think and question how could there be a God and a Holocaust? The night before the war ended, I couldn't afford to think and question I needed that 'Man Upstairs'. Looking back now I ask what did I have for being a Jew? Two and a half years of concentration camps.*

Dave described the way in which he felt so angry, disappointed and betrayed by God. He reacted by denying the existence of God. As mentioned in the literature review, the experience of a "failed empathy" (Benyakar et al., 1989, Garland, 1998; Gerson, 2009) in the case of Holocaust trauma, has led to a rupture between the self and the other. In this case the 'other' included God. This extends to personal and spiritual relationships (Eagle, 2013; Herman, 1992; Laub & Auerhahn, 1989). God was understood to have no empathy, in allowing this suffering. At times Dave appeared to be angry with God and his claim of being an atheist appeared to be an act of defiance and revenge.

Despite his insistence on being an atheist, Dave told me about the song of the concentration camps, known as 'Ani Ma'amin' (I Believe) a song that Jews sang on the way to their deaths in the gas chambers of Auschwitz. It was introduced by a Hassidic Jew in Auschwitz, and soon it became known as the 'Hymn of the concentration camps'. Dave sang the song beautifully during one of his interviews and subsequently wrote out the English translation for me which reads: "I believe with perfect faith in the coming of the Messiah. And even if his arrival is delayed, I still believe." I wondered whether he was truly an atheist or a man disappointed and angry at God because He had allowed the Holocaust to happen. The song and the story express deep tragedy and heartbreak about Jews who hold onto their faith and hope in God in the face of death. Dave's comments appeared somewhat ironic and paradoxical in that he vehemently claimed to be an atheist and then gave a moving rendition of this song that is considered very holy as it professes one of the thirteen principles of the Jewish faith. I wondered about the loss of a theistic object, when a traumatised believer, such as Dave, moved from praying to being an atheist. Dave's comments mirrored what was said by Juni (2015) where he felt abandoned and betrayed by God. He was clearly ambivalent and continued to participate in Jewish rituals and had a good relationship with his rabbi despite his claim to be atheist.

Miriam said, *I believe I survived because my Catholic nanny prayed for me. I don't pray as such, and I don't know if I can relate to God. I never analyse it, never think of it. Must I condemn God or thank God? So, I never think about it…I once told a rabbi that the Holocaust is not honoured enough. He said it was the 'Kapora'* (sacrifice) *of the Jewish people. That really made me angry…that my father died as a Kapora! I feel the Rabbis push the Holocaust aside. They should have a special day of mourning or a Haggada about the Holocaust* (on Passover Jews read a Haggadah to commemorate the exodus from Egypt*). They think the destruction of the temple is more important than this.*

While Miriam expressed her ambivalence in relation to God, her comment reflects her rage at the lack of recognition of her own and her family's suffering. Her comments about the Rabbis reflected her rage about the futility of her father's death and her feeling that the Holocaust does not receive enough special attention in the religious Jewish world. It was her catastrophe, and she felt that the Holocaust had been minimised and dismissed by religious Jews. It seemed that Miriam was angry with the religious community for not properly acknowledging Holocaust trauma and for trying to positively reframe it in some way. It seemed that she felt more alienated

by religious persons than by God per say. Miriam's theistic object relations reflected her sense of detachment from God. She appeared to acknowledge the existence of God but was disinclined to have a relationship with her God. This ambivalence appears to reflect her anger and disappointment. She was more able to engage her anger with the rabbis who she felt did not prioritise the Holocaust and its victims.

By contrast Rina said: *I have no gripes with God at all and would never say 'why did He allow this to happen?'. God gave humanity a choice and humanity is responsible for what happened during the Holocaust. 'Where was man?' is a very good answer! Although I believe in God, I am not religious. My mother used to say Psalm 23 every night, even in the camp, and I say it every night. I pray for my children and my health.*

It is possible that Rina recited psalm 23 as a ritual to remember her now deceased mother and retain some connection with her. It appeared that Rina's view of God excluded any direct accountability and she placed the moral debt of the Holocaust at the door of the men and women who exercised choice. By placing the moral debt for the Holocaust at the door of humankind Rina avoids feelings of ambivalence towards her God. She believes God gave humankind a sense of agency and he/she used this agency to do evil. The omnipotence of God does not feature in her understanding of why the Holocaust occurred.

Menachem was deeply troubled by spiritual issues regarding God. He said that he is not sure of the existence of God.
Menachem*: In the beginning, I couldn't believe it! Never in my life have I seen such a thing! Babies being thrown from the third floor of a building! So how could I believe in God at all?*
Researcher: *So, what did you believe?*
Menachem*: I believe in God because I read the Bible a lot but I don't know if God really exists.*

Menachem struggled with a belief in a God and his knowledge that such a God could permit the suffering of babies. His comments demonstrate how catastrophic trauma shatters a sense of God's justice (Janoff-Bulman, 1985) and ruptures the connection between the Holocaust survivor and his/her spiritual beliefs. As described by Juni (2015), this rupture exacerbated Menachem's sense of abandonment and confusion. He is left believing in a God but cannot accept that this God could permit the Holocaust.

Anne although significantly depressed, explained that she had a good relationship with God as he had saved her by a miracle. However, she said her brother became an atheist as a result of the trauma they went through. Anne said that she believed in God and sometimes prayed. She said that when they were in hiding her father said *Kaddish* (the Jewish prayer of mourning) for her mother and her sister. She said that although she converted to Catholicism when she was eleven years old, *I remained Jewish in my heart*. It appears that Anne retains a belief in God and retains a sense of Jewish identity. However, she avoids the ambivalence associated with a belief in a God that allows cruelty and suffering.

Isaac said he believed in God, and he believes that *the Holocaust was a punishment for the Jewish people, otherwise, how could something like that happen? Maybe they didn't keep the laws; there is a reason for everything.* He said he came from a religious home and accepted God's will and never felt angry at God. *I believe God saved me in the Holocaust; he saved all of us.* At the time of the interview, he continued to be an active member of his synagogue and felt very connected to his Rabbi. In Juni's (2015) terms, Isaac was rationalising the Holocaust and justifying God's omnipotence. Isaac's religious beliefs precluded him from questioning his God's authority. Nevertheless, Isaac does demonstrate Juni's (2015) splitting in theistic beliefs when Isaac claims that his God saved him from the Holocaust but avoids the reality that his God did not save others.

The findings of this study largely confirm Juni's (2015) description of God as a paternal figure who had failed almost all the participants who believed in God prior to the Holocaust. The majority of the participants felt abandoned and at times betrayed by an omnipotent figure who did not intercede to save their beloved families. Each dealt with this perceived act of abandonment differently, some through a rejection of God, others through rage and disappointment, while yet others detached themselves from God. Most held contradictory or ambivalent positions in their view of God. Some became atheists and some retained faith by different means – for example by splitting human intention and agency from God. Others practiced religious ritual in a way that created a partial commitment, for example by practicing their religion by retaining some parts of belief and rejecting others.

5.9 Indicators of Ego integrity

Although examples of integrity were given under the case history section, a number of common themes will be highlighted in the following section. The themes will cover generativity, resilience and meaning making as indicators of ego integrity.

5.9.1 Generativity as an Indicator of Integrity

Erikson (1982) said that generativity is a good predictor of ego integrity as it is an integral aspect of the preceding developmental phase that involves investing in future generations and this leads to a sense of meaning in old age. The following examples will describe how child survivors were able to attain a deep sense of satisfaction from being parents and grandparents. Rina said that having her four children was *the best thing I ever did*. This was the source of mastery and self-healing for her where she was able to give her children the secure kind of childhood that she missed. Having experienced a loving attachment to her parents, she felt she was able to attach to her children, albeit that she was over-protective towards them. She said she found it very rewarding to be a mother and appeared to have been able to make reparations to her own internal damaged child introject by offering her children a different experience to what she had. She felt her life was meaningful. Significantly, she compartmentalised her own Holocaust experience and did not share it with her children at all. As her mother protected her in the camps by covering her eyes so it seemed that she protected her children from her Holocaust experience by 'covering their ears' and keeping her trauma a secret.

Miriam, Rina, Anne, and Shmuel, spoke at length about their pride regarding their children's academic achievements. Shmuel said that he was especially proud of his son who was well educated and financially successful. He told me that he had a secure marriage and loved his children and grandchildren. It is interesting that although his family had a vague idea about his story, he never shared his traumatic loss of his mother and other Holocaust traumas with them Perhaps, like Rina and others, he was protecting them for fear of contaminating them with his trauma. Also, he tended to compartmentalise his trauma as to expose it would be too traumatic for him. It seemed that he had a sense of having been successful at achieving mastery over his trauma as well as having established meaningful relationships with his wife and children despite his Holocaust trauma.

Miriam also mentioned her children and spoke at great length about them. She said that being a mother and knowing that she had produced four kind and responsible children was extremely gratifying for her. She said that two of her children refused to listen to her Holocaust experiences while the other two were sympathetic towards her. Lenna, Anne and Helene, also mentioned their grandchildren with whom they shared close relationships. Isaac and Menachem were overwhelmed with despair, although both mentioned a glimmer of hope in their ongoing appreciation of their grandchildren. This indicated that their sense of generativity had been well established and provided a sense of meaning for them despite their apparent despair. Having lost their own families, their children and grandchildren had a special meaning for them.

Generativity within the work sphere was mentioned by Shmuel and Lenna who had both built very successful businesses. Miriam and Anne both volunteered to show me the jewellery they had made during their working years before they retired. Dave and Miriam were deeply involved in Holocaust education and hoped to make the world a better place through this. Dasberg (2001) says that these memoirs serve as a memorial for their families and pre-war lives, as well as a heritage for their children. It was evident that the majority of the group felt they had been able to put something into the world of value that they could treasure or feel some sense of accomplishment in having produced something worthwhile and this contributed to a sense of integrity as they looked back over their lives.

5.9.2 Resilience/ Mastery as an Indicator of Integrity

Resilience can be understood as part of ego integrity as it refers to the capacity to adapt in a resourceful way. According to the literature the roots of resilience in childhood are established to a large extent within emotional attachments (Cook et al., 2017; Durst, 2003; Isserman, 2013; Klein, 2012; Mc Farlane & Van der Kolk, 2007; Rutter, 1985). This dovetails with what Erikson (1965) emphasised as contributing to the establishment of trust and hope in infancy. As a result, resilience in old age could be understood to be the resourceful hopeful part of the child survivor. In this group resilience endured across a lifetime and expressed itself as a sense of appreciation of survival in old age that parallels with what Erikson (1965) described as ego integrity. Barel et al. (2010) described resilient survivors as having a combination of good adaption and PTSD symptoms that were moderated by effective defence mechanisms, a pattern that seemed evident in this group of participants. In describing the way that survivors hid their vulnerability and presented a resourceful and dignified face to the world, H. Gordon, (personal communication,

February, 1989) described Holocaust survivors as wearing “silk bandages”. This referred to a physical presentation in such features as wearing of quality clothing and cultivating excellent grooming to achieve the appearance of dignity and respect and to cover their wounds. Indeed, survivors appeared to have largely hidden their vulnerability and did their best to build successful lives to compensate for the devastating trauma, loss and indignity they suffered. The physical attributes of the participants in this study were not mentioned owing to confidentiality and anonymity. However, it was remarkable that most of the survivors took pride in their self-presentation, where great care and attention to detail was evident in their physical appearance. This seemed to echo the idea that survivors could be viewed as displaying a physical expression of the ‘silk bandages. Resilience is another expression of the capacity to triumph over trauma and achieve a sense of mastery. The following discussion of participant material will demonstrate the expression of resilience by participants in this study.

Researcher*: Helene, what helped you survive?*
Helene*: Being loved by my parents I think it gave me strength to face life and not focus on the negatives.*
Researcher*: And you have not focused on negatives?*
Helene*: No, I just don’t think its helpful feeling sorry for oneself. I have never asked why it happened to me*.

Here Helene, who had never been for therapy, credits her early attachments as the basis for building her resilience. This is substantiated by previous research (Cook et al., 2017; Isserman, 2013; Paris, 2000). Helene reported that she had never suffered from depression. She also walked and meditated which she reported calmed her. These examples of her coping style indicate that she had a strong capacity to self-soothe. She reported that reading had been a haven for her. It is a place where she said she could hide her thoughts and feelings. She adjusted well in her post Holocaust years and expressed an appreciation for her life despite the difficulties. In Erikson’s (1982) terms, she seemed to have achieved a reasonable level of ego integration. Helene demonstrated a capacity to adapt in resourceful ways as she was functional, reared her children, had a job, made a home and was a wife. Rina and Miriam also described how they survived the Holocaust because their mothers loved and protected them at all times. Both claimed that this was a major factor in building their resilience. Rina described herself as strong as she had survived cancer twice as an adult. She reported that she also survived two vehicle

hijackings. She describes her coping skills: *as I don't dwell on the past, I move forward. Whenever something unpleasant happens I always think to myself I have been through worse.*

In terms of the importance of early attachments in building personal resilience against life stressors most of the participants in the study had at least one if not two positive attachment figures, as seen in the case histories. Shmuel, Helene, Rina, Dave, and Anne reported that they were very attached to their mothers, while Menachem was close to his father. Isaac and Lenna, both lost a parent before the war, rendering them possibly somewhat less resilient. In the main, however, it was evident from the description of their marriages that most of the participants made good object choices in picking a spouse, except for Isaac and Anne who had both had difficult marriages. Klein (2012), emphasised the "good enough" experience with an attachment figure before the war as a hallmark of resilience, as critical in the survivor's ability to preserve a sense of self and a sense of renewal after the Holocaust. Barel et al. (2010) and Paris (2000) suggest that although child survivors were very traumatised, the perpetrators were strangers, not their parents or people known to them. This allowed them to hold onto internalised good objects, thus preserving a sense of self (Klein, 2012).

Interestingly, all the participants in this study for whom this was salient spoke extensively about the righteous gentiles who contributed to saving their lives during the Holocaust. Non-Jews who saved Jews put their lives at risk and risked being murdered with their families if they were caught. These gentiles offered islands of hope in humanity and served as an empathic other in the psychotic world of the Holocaust survivor (Davidson, 1979; Klein, 2012). Miriam's creative work and hobbies seemed to have helped her to cope with her loss and trauma and as was suggested previously these activities may have been a way for her to connect with her nanny who was an internal object that could soothe her.

Both Rina and Dave attended psychotherapy and said that this experience helped them to cope with their Holocaust experiences and built their resilience. Rina went twice a week for psychotherapy for a period of six months to deal with her Holocaust trauma and consequent nightmares, when she was in her thirties. She reported that after telling her psychiatrist about her Holocaust experiences during the session, sometimes she would just sit and cry as he instructed her to go home and write down everything she had said. According to Rina during the following session he would ask her to read what she had written. She reported that this process was helpful and the nightmares stopped. However, her nightmares returned when her

grandchildren were born. She went back to her therapist who told her to start reading books about the Holocaust, as she had previously avoided anything to do with the Holocaust. She indicated that the content of the books upset her, however her nightmares stopped. She continued: *my therapist said 'It's normal to wish that it didn't happen, you can't change what happened, you are who you are because of your experiences. You need to read books about the Holocaust when you are ready, so you know what happened and you know it didn't only happen to you'* Rina shared how her therapy experience helped her to work through her trauma. Dave said that his therapist helped him to understand that he was deeply traumatised by his experiences in the concentration camps and how this impacted on his long-term experience of PTSD and depression. He said that his therapist helped him to process the horrors of what he experienced.

Shmuel gained a sense of mastery in the camps and he was able to use this experience after the Holocaust. As indicated previously, during his internment he was sent to assist a German engineer who taught him how to weld steel. He proudly told the me that he used this skill to build machine guns in the Israeli army after the Holocaust, and he built machinery in his work in South Africa. Shmuel was very proud of the fact that he had succeeded financially after being a fifteen-year-old penniless survivor after the war. He told the researcher that he did not receive financial repatriation from the Germans due to late registration. He said: *I tell you what! I managed without the Germans!* This comment clearly states his sense of mastery over his persecutors and his trauma.

It seemed that resilience and attaining a sense of mastery was reinforcing for these survivors as they had a sense of accomplishment in spite of their suffering, which may have contributed to restoring a sense of self. This may have added to their sense of ego integration as they were able to view themselves as capable and their lives as meaningful despite great loss and suffering.

Finally, the capacity to play and be creative served as a hallmark of hope, as demonstrated by Rina. She said that in the camp at the age of seven and eight years old she and the other children would play while their mothers went to work: *We used to imagine we were living in a castle, we drew in the mud with a stick, and we used to imagine things. My biggest dream was to imagine growing wings, and I would fly over the camp wall (with tears in her eyes*). It is possible that this ability to play creatively, despite being in a camp provided evidence of hope and resilience that evolved over the course of peoples' life trajectories. I felt deeply moved by

Rina's account as it emphasized how intrinsically deprived and traumatised children in the concentration camps were and yet that their capacity to play and dream was not destroyed. This was seen in all the survivors in the way in which they were able to invest in life despite their damaged histories and to have carried some sense of having overcome or transcended adversity. With the kind of hindsight and review that aging brings participants were able to more deeply own the fact that they were indeed survivors.

5.9.3 Making Meaning

The trauma literature as well as the literature on aging emphasises the importance of making meaning in order to be able to integrate and transcend life changing experiences. (Aarts & Op den Velde, 2007; Frankl, 1962; Herman, 1992; Klein, 2012). The following testimony described the manner in which participants found a sense of meaning in their trauma.

Lenna expressed her ongoing spiritual connection with her family:
Lenna*: When I visit Auschwitz, I feel my family around me.*
Researcher: *So, you believe that souls exist after death?*
Lenna: *I do believe the soul continues living after death. I think people who went through the camps, we got to believe that, otherwise we would all go nuts. To imagine you lost everything that was dear to you, close to you, and there is nothing left of them.*
This comment shows that the hope of reunion with the deceased in the afterlife persists alongside the catastrophic loss endured across the lifespan.

Dave had devoted considerable effort to meaning making, despite having been diagnosed with both depression and PTSD. Dave said*: not all Germans were bad, some saved Jews. A German SS woman saved me…This same woman was responsible for the deaths of many women that she had beaten to death. In all of us, there is a devil and an angel, a good part and a bad part I know this because I saw it in myself. I was capable of looking after my younger friend in the camps and shared food with him and looked after him and was also responsible for cruelly beating up a Jewish boy who betrayed us to the guard. In certain conditions, I could become very hard and cruel, and in other conditions, I could just about save people's lives.* Here Dave attempts to reconcile the cruelty and kindness of the German guard who saved his life, in part by recognising his own propensities towards aggression.

Dave appeared to have a deep level of wisdom from surviving this experience as evidenced in his observation: *There is good and bad in every person, and certain circumstances will bring out one aspect or another. Everybody has a devil and an angel in them*. He felt it was a priority that he told his story, and he hoped that children would learn tolerance from his experience and make the world a better place. *My mission is to tell the story on behalf of six million.* I was struck by Dave's expression of appreciation of the kind of internal splits in personality observed by Melanie Klein, one can be both a *devil and an angel*. His intuitive understanding of the split in himself and the split in others was both honest and deeply insightful. This acknowledgement of both good and evil is consistent with a depressive position stance.

Dave also struggled to grasp the reasons for the Holocaust: *It happened because of hatred. And because people were induced to hate, I don't believe that there is a race which is supremely bad. Which is what everybody after the war believed. 'Germans monsters', they regarded us Jews as monsters, sub-humans; which I knew was not the case. I also knew if there were such things as sub-humans, the only ones who had conclusively proved that there were sub-humans were the Germans because what they did was sub-human.*

Shmuel said: *for eighty percent of Germans, Hitler was God, and I hate them. But not all Germans were bad. There is good and bad in every nation; there were good Germans and bad Jews*. He said that he gleaned no wisdom from the Holocaust. *I just had to grow up and do what I needed to do*. Here, Shmuel expresses his sense of meaningless in the catastrophe associated with the Holocaust. Given that he was one of the more resilient participants in the present study it is interesting that he found no meaning in his suffering. Another interpretation would be that he thought finding meaning was futile. He focused on building and creating and this distracted him from his pain. His sense of meaning was to focus on mastery and build his business.

Here we see that both Dave and Shmuel were struggling to integrate contradictory aspects of human motivation and actions. They were in a position where they had seen the best and the worst of human behaviour and they were able to entertain a non-categorial and somewhat ambivalent perspective towards the perpetrators.

Miriam expressed her sense of meaning in the following way:
Miriam: *The minute you hate; you want to harm another person. Hate caused the Holocaust! Hitler hated the Jews! My philosophy is that if you hate, it makes a misery of your life. If you*

hate it kills you, you can't live a normal life. The more that people know about the Holocaust, the better for the next generation.
Researcher: What do you want the next generation to know?
Miriam: Be cautious about man's evil.
Here, Miriam was describing that for her, the Holocaust destroyed her sense of trust in the world, and she carried this wariness about the existence of evil in humankind into her old age. Her sense of meaning was to be prepared for the potential evil in the other and to attempt to quell hateful sentiments in the self. She recognised the destructive impact of human hatred and how it damaged both the individual and his/her projected enemy.

Anne says that the wisdom learned from her experiences is self-restraint with regards to aggression. This was an interesting response as Anne was involved in a difficult marriage for years and it is possible that her trauma ruptured her sense of identity, leaving her with a sense of herself as a victim. Perhaps she was unconsciously afraid of the rage she could unleash in response to her catastrophic loss of her mother and sister. It is possible that she repressed her rage as a result.

Miriam, Rina, Anne, and Shmuel, spoke at length about their pride regarding their children's academic achievements. For all of them, this was a source not only of generativity but also of meaning. Lenna, Isaac, and Menachem also mentioned their children with pride. Dave and Miriam were deeply involved in Holocaust education and hoped to make the world a better place through this. Participating in such educational endeavours appeared to allow them to generate new meanings as they spoke and also to see that others could draw useful and important life lessons from their past suffering. This created a different layer of meaning for them.

Both Isaac and Menachem were unable to articulate any sense of meaning at all. Perhaps it is because the trauma of the Holocaust had caused such severe ruptures in their identities (Benyakar et al., 1989; Herman, 1992). They were overwhelmed with despair; however, both mentioned a glimmer of hope in their ongoing appreciation of their grandchildren.

As an additional element of meaning making survivors in this study were asked how they felt about having living under the Apartheid regime, given that this dispensation also contributed to enormous human suffering and was based on relations of oppression, dehumanisation and

stripping of rights. All participants said that they empathized with the oppression of black people. For example, Miriam said she felt very critical of how unfairly black people were treated in South Africa. When she voiced her criticism to her matric teacher, she recalled that he had warned her: *If you talk like this and someone hears you, you will be arrested.*

Miriam*: If you take it globally there was a parallel between Apartheid and Nazi Germany but compared to what we went through there was no parallel.*
Researcher*: Are you saying that the discrimination was a parallel, but when you look at the mass murder there was no parallel?*
Miriam*: Of course. In South Africa, there were no gas chambers or crematoria. Mandela knew why he was going to prison. He risked his life for his people. The Jews did nothing against the German government.*
It was evident that Miriam had been able to identify with apartheid victims but also felt that there were clear differences both in the nature of oppression suffered and the form of resistance to this. There is some recognition here of the universality of human suffering but also of historical and contextual distinctions. Since reflections on living under Apartheid did not emerge as a strong feature of participants' testimonies across the group it is difficult to make any further general observations about the perceived relationship between Holocaust and apartheid related abuses and consequences.

From the interviews it was evident that the survivors in this study were able to experience some sense of meaning- making. In the literature review, it was argued that survivor's struggle/d to make meaning, owing to the catastrophic characteristics of the Holocaust and the fact that the cruelty and inhumanity of the events in the camps and beyond defied comprehension (Aarts & Op den Velde, 2007). It is clear from the present study that most survivors were able to find and express some sense of meaning, as expressed by both Frankl (1962) and Klein (2012). It would appear that having a clinical diagnosis of depression and PTSD does not preclude survivors from making meaning. Klein (2012) said that some survivors were able to salvage a sense of self that was not destroyed by Holocaust trauma and perhaps the capacity to make meaning is some evidence of this. It is possible that some survivors (such as Menachem and Isaac) are totally shattered by their trauma, as described by Barak (2010) to the extent that they are unable to salvage any meaning at all, while others have some degree of resilience and are able to attempt to think about or reflect upon their Holocaust experiences in a way that produces some meaning, as mentioned by Valent (1998) and Hass (1995). Nevertheless, there was a wish

in some to retain fidelity to experience and to preserve and convey memories rather than to distance from such. Several saw the legacy of their stories as a testimony for others in the hope that it would potentially prevent further suffering.

5.9.4 Resilience versus Vulnerability in Child Survivors

The loss of health and functioning in aging needs to be considered as an important factor when assessing the functioning of survivors, as suggested by Aarts and Op den Velde (2007).

Frailty plays a large role in aging. Anne and Isaac and Menachem had serious difficulties with their health and mobility. This needs to be taken into account when looking at their general coping. Physical frailty is a risk factor for depression and PTSD in the aged (Aarts & Op den Velde, 2007). This also has significance for survivors who have depended on their bodies to survive. For them, weakness, dependence, and vulnerability associated with old age are a severe threat to their identities as survivors. The loss of health and autonomy could be linked to the severe despair seen in Isaac, Menachem and Anne. The other participants were in good physical health.

Despite being a community selected sample, half of the group interviewed had received psychiatric intervention and were on medication. Dave and Menachem received anti-depressant medication for depression and PTSD. Isaac said that his doctor had suggested anti-depressants, but he refused to take them as he *didn't believe in it*. Anne had been prescribed anti-depressants but was resistant to taking them. Rina had received psychotherapy for her ongoing nightmares. The relevance of this is that half the group were clinically representative of what Kellermann (2001) describes as suffering from both PTSD and depression. The other half were a generally high functioning resilient group, as described by Valent (1998). The criticism of previous studies on survivors is that they focused on only clinical populations who presented for help, and the more resilient survivors were generally overlooked (Fishman, 2014).

The self-selected, volunteer, community sample of this study seemed to represent both resilient survivors and those from a clinical population. Even though this was a small group of survivors each one represented a type described in the literature. For example, Shmuel and Lenna could be described as very successful and resilient survivors, as described by Valent (1998). However, Lenna was so traumatised that she was unable to share her story, whereas Shmuel spoke of deep

levels of despair despite his resilient functioning. Miriam, Helene and Rina also fall into the resilient category as they lived lives where they coped and functioned well. As per Dasberg (2001), these survivors lived parallel lives where they appeared highly functional on the outside but internally, they expressed intense suffering related to their Holocaust experiences, demonstrating an inside/outside split where they compartmentalised their trauma. Research showed that these kinds of survivors could appear and in fact operate in a highly functional manner at the same time as suffering from high levels of PTSD symptoms (Cohen et al., 2001). In contrast, Dave, Anne, Menachem, and Isaac, represent the clinical group who suffered from diagnosable PTSD and depression, as also described was common amongst this population in the literature review (Elran-Barak, Barak, Lomranz & Benyamini, 2016; Kellermann, 2001). Findings in the present research suggest that although three survivors had diagnosed PTSD (Dave, Menachem and Isaac), all survivors suffered from PTSD and complex traumatic symptoms. However, some were deeply depressed in such a way as to compromise daily functioning while others were highly functional and resilient. Of those in the resilient group it appeared that they all carried deep levels of despair regarding the unresolved catastrophic grief that they had successfully compartmentalised. Indeed, it appeared that the capacity to successfully compartmentalise was the distinguishing feature when comparing vulnerable versus resilient survivors.

6 INTEGRITY VERSUS DESPAIR ON A CONTINUUM

When trying to conceptualise the variance of survivor resilience versus vulnerability in old age, it would seem that their negotiation of Erikson's (1982) stage of Integrity versus Despair falls on a continuum. For example, the survivors who had some level of ego integrity also demonstrates areas in which despair was prominent. For example, both Helene and Rina were resilient and appreciative of their lives, however, both had pockets of deep despair and catastrophic grief regarding the loss of their parents and siblings. Shmuel, although very successful on the outside, was deeply despairing about the loss of his family and his disappointment in God. On the other hand, Dave, although diagnosed with depression and PTSD, was able to express some appreciation and meaning in his life. Despite the fact that there was significant despair in his world, there were also pockets of meaning and wisdom. Both Anne and Menachem were deeply depressed and despairing. However, Anne was able to express her gratitude about her happy second marriage, and Menachem was also able to

acknowledge that his wife was a huge support in his life. Lenna, although very successful, expressed much inner despair. Yet, her pockets of hope were expressed in her wish to live in Israel. Isaac was raging, and deeply despairing about his life but retained a small amount of hope in expressing his joy about his grandchild. From this perspective, pockets of hope were indicators of some ego integrity, as described by Erikson (1982).

From the understanding gleaned in this study, it would seem that Dasberg (2001) was correct in saying that survivors are faced with their defences and struggle to face the pain of their past in the process of integrating their experiences of loss and trauma in old age. Two of the survivors in the study, Anne and Menachem, were deeply depressed and despairing. They had few defences against their pain and were overwhelmed by it. Isaac coped with his overwhelming pain by being in a state of paranoia or rage; it seems that rage was his defence against his pain. The other survivors supressed or compartmentalised their pain about the Holocaust. Dissociation, compartmentalisation and repression were identified as the defences most often used. However, as just indicated, there were markers of wisdom and resilience, even in the most depressed survivors. Conversely, there were pockets of despair in the most functional and resilient survivors. Integrity versus Despair is understood as a continuum, whereby there is an extreme at each polarity. It is potentially helpful to understand the position of Child Holocaust survivors as falling at different places on this continuum.

All the survivors in this study had some difficulty with the aging process as it brought into focus their catastrophic grief stemming from losses sustained during the Holocaust. This was in addition to the other affective impacts they carried discussed in previous sections of the discussion, as well as the complex traumatic stress symptoms that many of them had experienced for decades. Aging comes with the loss of youth, mobility and health. Financial security and health are certainly protective factors against despair, as are psychological factors of resilience in relation to early attachment. Survivors have a sense of mastery that is lodged in their identities in which they needed to rely on their wits, physical stamina and social supports to survive. It was difficult for survivors to lose the capacities that had previously contributed to their sense of mastery and survival. This was observed regarding Isaac's rage at his failing health, Anne's despair at her difficulty walking, and Menachem's despair at his worsening financial position. In Garland's (1989) terms, present losses and traumas echo early traumas, and the loss of mastery may feel unconsciously tantamount to the loss of survival for these child survivors.

Hope is a central affect in revival (Klein, 2012) and aging (Erikson, 1982). Each of the survivors in the study expressed some hope. For example, Lenna hoped to emigrate to Israel, Helene and Rina hoped to spend time with grandchildren, Dave hoped to educate more children about the Holocaust, and Isaac spoke of his hope of seeing his grandchild who lived overseas. Even in the most despairing survivors, the hope of attachment featured. Thus, reading off this population, Klein (2012) was correct in his emphasis that hope, agency, survival, and attachment are central to survival. Erikson (1982) made the link between hope at different periods over a person's lifetime, beginning in establishing trust in infancy, to holding onto hope and wisdom in the closure of old age. It would seem that within the paradigm of Integrity versus Despair, hope and hopelessness are on a continuum. This is especially apparent in the case of child survivors. All the survivors in this research expressed deep despair and hopelessness regarding their losses, no matter how well they functioned. However, for some this pain was more actively present and more pervasive than for others. As indicated earlier, it seemed that the capacity to compartmentalise unresolved or unresolvable grief was a mediating factor in how well they functioned.

Mc Farlane and Van der Kolk (2007) mention that trauma survivors feel betrayed by humankind and abandoned by God. Aarts and Op den Velde (2007) questioned whether Holocaust survivors were able to make meaning, in view of their catastrophic grief and levels of severe traumatisation. It was clear that resilience and the capacity to make meaning are not necessarily linked. As previously discussed, the capacity to be resilient is based on strong defence mechanisms that often block the capacity to feel. The capacity to make meaning varied in this study. Some of the most resilient participants said they were unable to make meaning of their suffering, yet their mastery was evident in their high level of functioning. Conversely, some of the depressed participants in the study were able to articulate a personal capacity to make meaning despite struggling to function or being impaired because of PTSD/ depression. In this respect it seemed that resilience was not necessarily a prerequisite for the capacity to make meaning. Rather, enduring suffering and wisdom gleaned from life itself was perhaps necessary to establish and create a sense of meaning.

7 REFLEXIVITY AND COUNTERTRANSFERENCE

Reflexivity can be understood to constitute an exploration of the intersubjective space between the researcher and participants in particular kinds of research. From this perspective, the personal values and history of the researcher have an impact on the research (Berger, 2015) that may be important to examine in reviewing the form that a research study takes. I shared a religious and cultural background with the survivors as I am both Jewish and Ashkenazi in lineage. In addition, I had two grandfathers who had lost close family in the Holocaust so I understood something of the impact of unresolved mourning and lack of closure. My immersion in the community and personal family loss in the Holocaust contributed towards insight into and empathy for the world and culture of the survivors. It is also likely that I was affected by the level of traumatic countertransference I experienced in conducting the study as I could in some way identify with the survivors, as mentioned may be the case for researchers by Wardi (1992) and Kellermann (2001). They describe the way in which trauma is passed down the generations and can resonate in the form of related images and affects.

While conducting the study, not only during the interview process, but also particularly when transcribing the material, I became powerfully affected by the testimony such that I experienced what I understood to be vicarious traumatization (McCann & Perlman, 1990). I had nightmares related to the content of peoples' stories and found myself disturbingly preoccupied with accounts and images. I experienced anxiety and sad mood at points, finding my own beliefs about humanity's capacity for destructiveness and care challenged. One of the concrete consequences of this vicarious traumatisation is that the study project stalled for a period and it required considerable determination and working through of the impact of the research process on my psyche for me to continue. While I had anticipated at the outset that conducting the study would prove emotionally taxing, I had no comprehension of quite how challenging the process would prove to be.

I am aware that I still carry projections of massive horror and that albeit indirectly, I became a witness to man's inhumanity and capacity for evil as to some extent are any readers of this material. Hearing Lenna's description of the screaming in Auschwitz, Shmuel's description of Jews chocking to death on mud in a stampede in Blechemmer concentration camp, and Miriam's description of the liquidation of the Dvinsk Ghetto was horrifying, and the imagery associated with these events is haunting. However, when I was with the participants my

professional identity and my defences were in focus. I found the interviews deeply meaningful and was most grateful to the participants for their testimony. The struggle was in the writing up of the study. In keeping with Laub's (1992) description of the overwhelming nature of Holocaust material, I became paralysed in the face of writing about overwhelming suffering. Indeed, the writing up of the testimony was more painful in some way than the interview process as I was silently alone with the testimony. The gravity of the loss and trauma was clear and palpable. Also, I did not have the distraction of needing to remain empathic and attentive to the participants and my defences were lowered. Sometimes I would 'forget' the horrors of the testimony and was reminded on my return to reading the material. The projections that I received in the interviewing process were reactivated in the process of transcribing and writing up the research. However, I was aware that I bore some responsibility to the participants to justify their participation in the project and this was one of the factors that assisted me in remaining motivated to complete the thesis.

As part of the ethical guidelines for conducting the project I was assisted with frequent supervision and trauma debriefing in the course of the present research, inputs that proved invaluable in helping me to continue to do this difficult, yet meaningful work. Thus, in many instances research supervision sessions took the form of containment and debriefing rather than academic reflection and task orientation. This underscores the importance of trauma debriefing in the process of trauma research as countertransference experiences can be extremely difficult (Eagle, 2013; Herman, 1992; Laub, 1992). As Laub (1998) suggests it may have been inevitable that I shared "the journey into the eye of the hurricane" (p. 1335). I understood that I needed to receive many of the traumatic projections of both horror and catastrophic grief and to serve as a witness to the unbearable experiences of the survivors. Gerson (2009) emphasises the importance of being a witness to the hopelessness of the Holocaust survivors, and that this interaction lessens the load of their aloneness in their suffering. In this regard I aimed as far as possible to retain the stance of being an empathic witness.

Over time I came to more fully appreciate that in the intersubjective space that the extended interviewing created, transference and countertransferential dynamics were coloured with the experiences of Holocaust trauma. Most of the survivors developed a positive or in some instances even idealised transference in relation to me. This may have been related to their attempts to re-introject a good enough container into their internal worlds Eagle (2013). In speaking about their life trajectory, before, during, and after the Holocaust, the participants

were offered the space to integrate and evaluate their pre-Holocaust, Holocaust, and post-liberation experiences. The extended interviews offered participants the opportunity to express their trauma and grief, an opportunity for catharsis, and in that way the interviewing process may have had an unintended therapeutic function. The research process appeared to have a containing and interpretive function (Eagle & Long, 2009). This may have enabled the survivors to integrate some of their traumatic experiences. Long and Eagle (2009) observes that at times, participants may consciously or unconsciously use research interviews as therapeutic opportunities. In the present study for example Menachem spoke of the horrors he saw and Isaac confessed to being forced to hang other Jews in the Ghettos – in this way they were able to share with me the shameful secrets that they had carried alone for decades. The anonymity of the research and the neutrality of the researcher as a significant person in their lives facilitated this process. In addition, both Helene and Rina cried about the loss of their parents in a manner that seemed intense and to some extent cathartic for them, again appearing to use the presence of theme as researcher in a constructive and therapeutic manner.

Most of the participants expressed their gratitude to me for having the opportunity to unburden themselves during the research process. Auerhahn and Laub (2018) note that the restorative process inherent in giving testimony is related to the fact that it allows survivors to regain agency, transform anger and hate, and also re-establish a shared subjectivity that makes an empty traumatic world feel three dimensional and full again. It is possible that survivors in the present study felt contained because their testimony was heard by an empathic witness and also because I asked detailed questions about their lives in a more comprehensive manner, trying to build up a picture of them as people who had histories prior to and post their time in the camps. As part of the interview process, I asked participants about their early attachments and attachment figures before the Holocaust. This description led to reminiscing which may have put them in touch with early good objects and may have added to their gratitude and their sense that they benefited from the interviews. This substantiates what Auerhahn and Laub (2018) describe as a critical process whereby Holocaust survivors are able to think about pre-Holocaust love objects so that they can remember and re-experience themselves as “someone who can be loved” (p. 61). This view was also echoed by Durst (2005) who said that when working therapeutically with survivors it is important to get them to remember the love that they received from significant others before the Holocaust, allowing for some integration of good and bad experiences.

Although the transference related dynamics that appeared evident during the interview process were dominantly positive there were also some exceptions to this. Some negative transference appeared with Miriam, who told me in an aggressive tone that I would *never understand what it feels like to be a Holocaust survivor.* My response was to say *You are correct I can never understand.* In this way I sought to acknowledge her anger and her sense of isolation in carrying the enormity of her trauma. Miriam was enraged and indignant that her trauma had separated her from others. I used my clinical skills in the service of containing the projections and projective identifications of the participants (Long & Eagle, 2009) where necessary or apparently helpful as in this instance with Miriam. However, I was as mindful as possible not to overstep the boundaries between researcher and therapist even when pulled to do so on occasion. For example, Shmuel phoned me on three occasions imploring me to write a book about him and his experiences. He was aware that he would soon die and feared he would be forgotten and his life be rendered meaningless. It was very difficult to resist this kind of pressure and to be reassuring but not to respond to this form of pressure. Again, research supervision was helpful in this regard and it was immensely helpful to think collectively about some of these unanticipated ethical dimensions of the study and the level of personal relationship that many participants experienced and sought to continue in some way.

Eagle (2013) emphasises that idealising the therapist may enable the survivor to repair their own internal container that had been shattered by the trauma but cautions against over-valuing this aspect since it is the task of the therapy to ultimately enable introjection of this kind of relational quality. Laub (1992) writes about the emotional bonding that takes place in the process of taking testimony from Holocaust survivors. He speaks about the emotional holding by and investment of the listener, a person who needs to be sufficiently present such that authentic narration can occur. Felman and Laub (1992) explain that in the process of giving testimony survivors begin to process their loss and mourning. From this perspective, the listener becomes a witness to the grief of the survivor. This happened for me with the research participants. For example, when listening to Helene sob inconsolably for hours, I became a witness to raw grief. This also happened to a lesser extent with Rina, who briefly cried when she spoke about her father. There was a sense of maternal reverie as mentioned by Eagle (2013) is sometimes important in trauma work, where I felt that I was listening to the cries of the children within the aging survivors. This crying was an acknowledgement that the grief had endured for decades and that parental loss had always remained a significant aspect of life experience. Although Shmuel did not cry, his sadness about his parents was palpable, and he

eloquently expressed his longing for his *Yiddisher Mamma*. I felt his deep sadness. There were many other examples of being witness to intense grief, horror and torment across the interviews of having to bear the feeling states that were evidenced by participants as a form of respect for what they had endured and what they were willing to share with me. In addition to tolerating the affective impact of the interview process and subsequent data transcription, I was also aware of my own meaning systems becoming challenged through the process.

Laub (1992) states that working with survivors raises issues about life, death and meaning. I was distressed by the existential sadness associated with the spiritual disconnection and disappointment in God, as expressed by Menachem, Shmuel and Isaac. The spiritual rupture that can be caused by trauma was mentioned by Herman (1992), frequently this kind of experience is also accompanied by a great sense of loss of faith in a benevolent God (Juni, 2005). This dynamic worsened the sense of loss and aloneness expressed by the survivors and was deeply sad to witness. I engaged in a parallel process of trying to understand the spiritual impact of this trauma on my own belief systems. Supervision was an anchor and helped me to understand the impact of hearing the testimony on my own spiritual beliefs. The necessity of supervision is underscored for researchers who bear witness to traumatic testimonies as it becomes difficult to navigate the existential questions related to profound human cruelty and suffering, especially in cases of intentional human inflicted trauma.

I am aware that my cognitive schemata more broadly have in fact been altered as a result of the immersion in the Holocaust testimonies. For example, whenever it rains, I am reminded of Rina's crying and despair about her father *dying in the mud*. The meaning structures and schemata are changed as a result of the trauma therapist's, or in this instance, the researcher's experience of vicarious traumatisation. This concept is the same as Wilson and Lindy's (1994) understanding of traumatic countertransference. While as a clinician I have leaned towards a Winnicottian oriented object relations, perspective, in the process of this research, when confronted by man's capacity for evil, I became more convinced of the death instinct, as described by Freud (1920) and echoed by Laub (1992). For Laub (1992), Freud's understanding of Thanatos is well documented. When I allowed myself to comprehend the horror and death in genocides, and the fact that these continue to occur, I have become more open to the idea that humankind holds destructive, aggressive and breaking down potentialities as linked to the death instinct. Despite this, I also have a renewed appreciation for the role of hope and the capacity for growth and meaning (Frankl, 1962; Klein, 2012). As mentioned by Janoff- Bulman

(1985) my assumptions about the world were shattered or altered to some extent, and a parallel process occurred, where I was faced with my own spiritual search as a result of hearing the Holocaust testimony. I found no answers – just deep gratitude to have witnessed the paradox of both despair and hope in hearing survivors' accounts of their own existential struggles.

My research trajectory and the final writing of this document was both enormously demanding and enormously meaningful. Despite the difficulty, I felt very privileged to have interviewed the child survivors and very grateful for the way in which they confided in me. My meaning structure gave me a new hope in the concept of attachment and its importance in resilience. Finally, I realised what Eagle (2013) meant when she said that the trauma therapist has to hold onto their own good objects for dear life in the face of the horror and trauma. I found that I had a renewed appreciation for my own good objects and a revival of understanding of hope and attachment. I had a definite sense of the importance of being an empathic listener and its critical aim of offering trauma survivors an experience of being heard, as described by Laub (1992, 2005). Empathy and feeling heard may on some level lessen survivors' hopelessness and despair. My experience in this research is that pain and grief, no matter how catastrophic, needs to be witnessed as this is therapeutic in some manner. The process of completing this research honed my skills as a therapist as I became more adept at hearing themes presented in the narrative of my clients. In addition, I had a renewed understanding and appreciation of the therapist's role as a witness. Krell (2014) explains from his perspective as both a child survivor and a psychiatrist: "No survivor truly expects to be understood. Our need is to be heard" (p. 7). He continues that after all the development and sophistication of psychotherapy – "it all still comes down to the wounded teller and the healing listener." (Krell, 2014, p. 7). Gerson (2009) who quotes a trauma patient says, "I would be entirely hopeless if I could not be truly hopeless with you" (p. 1354). In other words, the empathic listener offers some capacity for reparation, in the world of the trauma survivor, whose trust in the world has been ruptured leading to a sense of existential loneliness and despair.

8 LIMITATIONS OF THE PRESENT RESEARCH

This sub-section offers some evaluative commentary on this research project.

One possible limitation of the study was my over identification with the survivors that sometimes led me to feel traumatized by the material and impacted my ability to complete this research over a shorter period of time. However, given the nature of the project the delay between collection of data, analysis and write-up did not compromise the key findings and in fact allowed me to achieve a degree of distance and reflection that was considered helpful. As just discussed in the reflexivity section, being Jewish and having lost ancestors in the Holocaust made me close to the research participants experience and this appeared to be both a strength and a limitation. I could link with and empathize with the participants, however there were times that their testimony was very difficult to process as a researcher and to think about in terms of the overarching objectives of the research study. Fortunately, I have two supervisors who were able to help me to think about the data and view it from a researcher's perspective. This was helpful in facilitating a process where I managed to process the data and to identify key themes and offer observations from a more abstracted perspective.

A second limitation of the research concerned the processing of the very large volume of data that emerged from the extensive interviews and it was difficult to do justice to all of the information generated. It was necessary to be selective in choosing what to prioritise such that only the most relevant and dominant themes were explored. Again, the co-analysis of the transcripts by the two supervisors of the project assisted in refining the findings and foregrounding what appeared most important.

Owing to the small sample the generalizability of the findings is necessarily limited, as is commonly the case in this kind of qualitative research. Having said this, a great depth of data is yielded from this kind of depth interviewing of a highly selected participant grouping. Given the difficulty in locating child Holocaust survivors it was gratifying that nine survivors were located in South Africa who were willing to be interviewed. From the presentation and discussion of the findings it is evident that there was a range of experience across the group but also that there were clear points of similarity. It is recognised that to refer, for example, to a more resilient and a more clinical sub-population in such a small pool may be problematic. However, commentary of this kind is presented with caution in the thesis and is related back to

literature that speaks to other such patterns in Holocaust population groups that have previously been studied.

There is a fine line between extensive qualitative research interviews of a sensitive nature and engaging in a therapeutic relationship as has already been discussed. In some respects, the challenge of sustaining boundaries in this particular research endeavour threw up both ethical and perhaps methodological challenges. As far as possible I engaged empathically with participants while still holding onto my role as researcher. It was difficult for me to do justice to the data and abstract and analyse the emerging themes while still holding onto my concern for the participants and my fear of dehumanizing or minimizing their pain in the name of research. Again, supervision helped me to debrief and enabled me to engage with the data and complete the research. Hopefully it will be evident from the discussion that I engaged respectfully and professionally with the participants and the research process throughout.

It is also recognised that in presenting the case histories and the cross-case themes separately there was a degree of overlap in coverage of some of the material and constructs. Nevertheless, it was deemed that this was a useful way in which to attempt to condense the many hours of interview data in such a way as to do justice to the participants' life stories and to provide the reader with a backdrop against which to consider the core themes that emerged in the cross-case analysis. Attempts were made to reduce repetition as far as possible although it is acknowledged that there are still overlaps across various section of the thesis.

9 SUMMARY AND CONCLUSIONS OF THE PRESENT RESEARCH

This retrospective study aimed at to describe and explore the long-term impact of the Holocaust on child survivors as they reached old age. More specifically the focus was to explore the impact of Holocaust trauma on the developmental trajectory of child survivors and its long-term effects across the life cycle. At the time of the research interviews all of the child survivors interviewed for the purposes of the study were in Erikson's (1965) eighth stage of Integrity versus Despair, and the impact of Holocaust trauma was understood within this context.

Common themes indicated that all the participants in the study experienced some form of developmental disruption and suffered from Child Survivor Syndrome as described by Dasberg

(2001). They were all deprived of aspects of 'normal' childhood and exposed to ongoing deprivation, horror and loss. Significantly in many instances they lost parental figures at early stages of life. In addition, those that survived with a parental figure observed damage done to them leaving child survivors with anxiety about the capacity of parental figures to protect them from harm. They were compelled to engage with and take in a highly persecutory environment and developed various kinds of defences to do so, some of which proved long lasting and to some extent counter-productive in later life. However, the present study confirms previous research (Klein, 2012) that showed that strong early attachment prior to the Holocaust built resilience in child survivors. Keilson's (1979) research was also confirmed that child survivors who had a supportive post Holocaust environment were also more likely to be resilient.

Participants within this community-based sample were both 'vulnerable' survivors who formed a clinical sub group (many of whom had formal psychiatric diagnoses) and 'resilient' survivors who functioned well in terms of general life adaptation. All child survivors in the present study, both 'resilient 'and 'vulnerable' described PTSD symptoms that they endured several decades after the Holocaust. The PTSD symptoms can perhaps be likened to 'shrapnel' from a bullet that remains lodged in the body and is impossible to remove, serving as a reminder of the trauma even if it does not necessarily compromise daily functioning or overall health. The findings of this study dovetailed with those of previous researchers who also established the presence of enduring PTSD symptoms in both 'resilient' and 'vulnerable' survivors (Barak, 2010; Brom, 2001; Durst, 2002; Cohen et al., 2001; Joffe, 2003). Although all survivors had symptoms of PTSD, they differed in intensity. Some participants had full-blown PTSD whilst others only had some related symptoms. Within this sample symptoms of PTSD persisted across the lifetime trajectory to a greater or lesser extent in all participants. However, the 'vulnerable' survivors who were part of the clinical subgroup in this study had more severe PTSD symptoms and also had a dual diagnosis of PTSD and chronic depression, in keeping with what was observed by Kellermann (2001). Herman's (1992) construct of Complex Traumatic Stress was useful with reference to child survivors. This diagnostic construct underscored the long-term impact of trauma on the personality make up and defensive styles of child survivors. However, the catastrophic loss experienced by all survivors, especially child survivors, could be added to her diagnostic criteria. In addition, her emphasis on the bond between the persecutor and the victim was not relevant with reference to all participants in the present research. Indeed, although there are similarities between child abuse and child survivors of the Holocaust, there are also big differences. Child Holocaust survivors mostly had secure attachments to their

parents and were tormented by strangers, enabling them to hold onto a more stable and secure sense of self (and caretaker figures) that built resilience as opposed to having to struggle with the difficulty of integrating contradictory experiences of abuser caretakers. In addition, in the relation to CPTSD it was noteworthy that child Holocaust survivors did not appear to engage in addictive behaviours such as substance abuse and few displayed evidences of having engaged in repeated abusive relationships. Thus, they did not fit the full picture of C-PTSD.

A ubiquitous finding of the present research was that all child survivors described the massive losses they endured as children and their ongoing grief and lack of closure regarding such losses in their old age. Witztum and Malkinson (2009) suggested that Holocaust survivors be understood through the lens of traumatic bereavement. As discussed in the thesis the magnitude of losses and the violent or dehumanizing circumstances of the dying of attachment figures created particular difficulties as did the lack of preparation for leave-taking. It is proposed that the term "catastrophic grief" be used to describe the experiences of child survivors as they suffered from multiple traumatic bereavements, associated with a range of complex emotions and memories. The term catastrophic grief appears to capture something of the extent and intensity of the loss in the context of a Holocaust catastrophe. All the survivors in this study described the presence of catastrophic bereavement in their old age as was evident in the intensity of their affective expression, preoccupation with the manner of peoples' leave taking and dying and the guilt they carried in many instances for having survived. The experience of catastrophic grief had an impact on the self in terms of the formation of a cohesive identity, autonomy, mastery and emotional regulation. Child survivors continued to mourn their parents and siblings into their old age. The present research proposed that survivors appeared to present with a 'Trauma Trilogy' of catastrophic grief accompanied by anger and survival guilt that appeared to have endured across the life trajectory (Amir & Lev Wiesel, 2003; Durst, 1995). The 'Trauma Trilogy' is important because some survivors presented with strong affects of anger and survivor guilt, however when these emotions were deconstructed during the interviews, what lay beneath was an anger and/or survivor guilt that related to the catastrophic grief they experienced.

Findings of this research demonstrated that in the stage of Integrity versus Despair indicators of despair were continuing grief and vulnerability to depression as well as compromised spiritual beliefs and complex relationships to religion and God. It must be emphasized that the extent of the catastrophic grief intensified the survivors' sense of despair in old age and the

disconnection from others and God left them with a sense of existential loneliness. This sense of despair and loneliness was found in both resilient and depressed survivors. This research substantiates previous research that demonstrated that child survivors have high levels of loneliness (O'Rourke et al., 2018). In addition, the 'Trauma Trilogy' catastrophic grief, anger and survivor guilt were strong indicators of despair in aging child survivors. However, it was also noteworthy that all survivors mentioned that they were able to glean a sense of meaning and satisfaction from their children and/or grandchildren, indicating that later life human attachments could yield a sense of renewal and hope.

Some of the debates regarding the apparent resilience of Holocaust survivors was outlined in the literature review (Barel et al., 2010; Hass, 1995; Vallent, 1989). As predicted by Dasberg (2001), child survivors in this study grappled with issues of aging. This appeared to be related to the suppression of their grief, as well as the loosening of the split between their outer adaptation and inner turmoil. The present study confirmed Dasberg's (2001) explanation of a vertical split where survivors carried significant internal or hidden distress and yet externally displayed adaptive functioning. The participants described vivid recollections that were visceral and had a strong sensory immediacy. This suggested that their trauma related memories were still very much 'alive' and it appeared that the trauma was compartmentalised and walled off in the psyche. This was also evident in the way that the catastrophic grief and traumatic memories were encapsulated in a survival shield that endured across decades and served as a defence mechanism. This study confirmed and reinterpreted the split as described by Dasberg (2001), reframing this defensive style as the compartmentalisation of the trauma as this term seemed to best fit the presentation of the participants. The integration of their mourning and Holocaust trauma was a complicated process in the final stage of aging particularly because it had been kept shut out of conscious view for so long. This group seemed to function in line with the paradoxical integration described by Kellermann (2009). In normal circumstances the use of the kinds of defences associated with splitting, dissociation, repression, suppression and compartmentalisation may be viewed as 'unhealthy' as they block access to emotional trauma that then remains unprocessed. In the case of child Holocaust survivors, however, these defences appeared to have been functional in blocking out unbearable trauma and catastrophic grief not only at the time of the original events but also in subsequent life, enabling outwardly adaptive adjustment and functioning. Suppression was aided by post war environments where there was an injunction not to speak about Holocaust experiences. The survivors' resilience and adaptation in their present life was generally remarkable given their historical experiences.

However, they retained Holocaust related damage and both the experience of complex traumatic stress and of catastrophic grief contributed to the experience of despair in old age. As children, the tragic losses they sustained destroyed their overall sense of trust in a benign and lawful world. This caused them deep and persistent sadness. The metaphor of 'silk bandages' (H. Gordon personal communication, February, 1989) is used to describe the way in which they hid their wounds and went to great lengths to preserve their sense of dignity in the outside world. What lay beneath the 'silk bandages' was the encapsulation of profound suffering and loss, some of which became more prominent as they moved into end of life stage.

Herman (1992) described the way in which horrific trauma is unspeakable and there is a sense that repression operates at a group level as the group or community is unable to process and metabolize the trauma. This climate of group and personal repression helped the child survivors to focus on functioning while their trauma and grief remained unprocessed. Historically, psychology had not reached popular culture and there were few mental health services available to help survivors to deal with trauma. In addition, Danieli (1984) describes how in the decades after the Holocaust mental health workers did not unpack Holocaust trauma and unintentionally supported the 'conspiracy of silence'.

The present research opens an inquiry into the role of research in exposing what has been compartmentalised or split off. The nature of the research interviews facilitated a process of unpacking the supressed trauma and grief in some survivors who had compartmentalised their trauma for decades. Perhaps their knowing that they were talking to a clinician helped them to feel a sense of safety and because it was 'research' they did not feel stigmatised about speaking to a professional. Those who spoke expressed their gratitude as it allowed them to unburden themselves of the trauma and grief that they had repressed and/or suppressed for decades. According to the follow up with participants in this study none were negatively affected in the sense that they reported research related traumatisation. The participant who refused to tell her story was not pressurised and her silence was respected. It is possible that participants volunteered for this study as it was a final opportunity at this late stage of life to tell the truth of their life story as there was a parallel process occurring where they were in any case reflecting on their personal history as a developmental task of old age. This process of reflection is part of Integrity versus Despair and it is possible that the research offered the child survivors a structure and a platform to integrate their experiences of both the traumatic and positive aspects of their lives. This research offered them an opportunity leave a legacy in contributing towards

the understanding of child survivors in the Holocaust. The confidentiality offered some of them an opportunity to tell the truth for the first time about events that they found difficult to acknowledge. The research offered an opportunity of 'final confession' for some survivors and the opportunity to speak openly and have an empathic but non-personally related listener to 'bear witness' to their story. As such, one of the findings of the research was that survivors reported that they benefited from giving testimony which substantiates what Auerhahn and Laub (2018) emphasized as the value of giving testimony.

Kellermann (2009) points out that exploring Holocaust trauma presents a paradox in that survivors represent a community who have been deeply traumatised and at the same time offer an example of resilience and hope. The capacity of survivors to have a sense of hope, meaning and wisdom in old age, may be linked to a sense of early trust established in relation to attachment figures (Klein, 2012). This helped them survive and revive and hold onto a sense of hope and gratitude, despite their catastrophic loss. As Erikson (1982) says, basic trust lays down a sense of hope in needs being met. The task of old age is to glean a sense of wisdom and hold onto appreciation for a life well lived. The horrors of the Holocaust were inflicted by strangers, not attachment figures. The glimmers of hope and appreciation indicate that in some survivors there was a remnant of self that survived the trauma, owing to early attachment (Klein, 2012). However, it is also because of the influence of early attachment that catastrophic grief continued over decades. The ability to compartmentalise was the mediating factor that enabled some to be more resilient than others. However, the experience of despair compromised their capacity to achieve full ego integration – as predicted by Dasberg (2001).

Findings of the study underscore the importance of attachment on multiple levels. Firstly, aging survivors who had a good sense of early attachment showed a capacity for resilience, hope and creativity in building their lives after the Holocaust. However, secondly, it was also apparent that the rupture in attachments, caused by the loss of parents and siblings in the context of the Holocaust, led to an experience of catastrophic grief that impaired subsequent life quality.

The ongoing sense of loss, trauma, loneliness and feeling like a refugee in a strange land is expressed by Auerhahn and Laub (2018) and was to a large extent substantiated by the findings of this research:

> The dead continue to be acutely and painfully absent. Homelessness and utter aloneness continue to haunt the survivor, even if he or she was able to build a family, a community. and a home. The traumatic experience remains unfinished between the survivor and the perpetrator (Laub & Auerhahn, 2018, p. 59).

10 RECOMMENDATIONS

The struggle of aging survivors has been highlighted by the present research. Owing to the complex traumatic stress, depression and catastrophic grief endured by child survivors, geriatric services should offer special psychotherapeutic services to meet their needs. An empathic ear could help them to express and process their trauma and grief. It can begin to assist in working through some of the issues related to ego integrity versus despair. We can extrapolate that severe trauma experienced by aging child survivors should be monitored over the lifespan. Special psychosocial services are needed for aging child Holocaust survivors to help them to process their loss and trauma in their final life stage if they wish to do so. In addition, psychiatric services should screen them for depression and PTSD. Casework services should check in on survivors who live independently and offer practical services and emotional support with the acknowledgement that they are a group who carry deep levels of despair despite their apparent resilience.

This research highlighted the vulnerability of child survivors of the Holocaust. This knowledge can be extrapolated to all child genocide survivors who experience complex traumatic stress and catastrophic grief. Protective factors include a supportive environment after the trauma, as described in the literature (Herman, 1992; Keilson, 1979). Results show that there is a high risk for depression and PTSD and services should focus on providing support and psychotherapeutic help for child genocide survivors who are in need. In addition, they are at risk over the course of the life cycle and need ongoing monitoring.

The important benefit of giving testimony was a finding of the present research. It is suggested that Holocaust survivors and genocide survivors be afforded the opportunity to give testimony to an empathic witness should they so choose.

It is suggested that more qualitative research is conducted on child survivors as well as second and third generation survivors. This is because checklists are unlikely to capture the depth of the impact of intergenerational trauma. Qualitative research is likely to highlight issues such as the impact of living with those suffering from complex traumatic stress and catastrophic bereavement. In addition, the interview process can facilitate a climate where survivors are encouraged to offer testimony as the researcher is there to 'bear witness' to their story.

Health care providers who work with survivors should be educated about their sensitivities and special needs. Community leaders and religious leaders could benefit from understanding the impact of Holocaust trauma, or genocide on the spiritual world of the survivor, to offer to help them to voice their distress and spiritual dilemmas.

The needs of second-generation survivors should receive attention. Being the child of a child survivor leaves the second-generation child vulnerable to multiple distress. Special therapeutic services should address these issues and additional research needs to be encouraged.

11 INTERVENTIONS

As a function of the ethical consideration of the present research, Jewish community services generously sent me to Amcha in Israel for a week in 2005. I spent time with Dr Natan Durst, and the psychologists and social workers at the different centres of Amcha in Jerusalem, Haifa, Beer Sheva, and Tel Aviv. The focus was on understanding the therapeutic needs of Holocaust survivors. In addition, I was exposed to the different social and community services offered to Holocaust survivors in Israel. This was an invaluable experience, and it sensitised me to the therapeutic needs of survivors. Upon my return, I helped Jewish Community services establish the Friendship Forum, an outreach initiative that was organised to assist survivors in the Jewish community. This social group was modelled on Amcha's social groups that offer entertainment and relevant lectures for survivors, aiming to break social isolation and build unity.

Under the auspices of Jewish Community Services' Chevra Kaddisha, I ran a training program for social workers and psychologists in the community. This training focused on the therapeutic needs of Holocaust survivors and their second-generation children. I was contacted by the

Holocaust Museum Director and asked to set up a social group for survivors in Cape Town. This also involved training a group of professionals to work with survivors and second-generation persons. This community work and training of professionals in Johannesburg and Cape Town was designed to meet the ethical requirements of the study, ensuring that services were available to address the psychological needs of survivors, should they require therapy after the interview process was complete. After the establishment of the Holocaust and Genocide museum, the social group for survivors was taken over and run by volunteer staff. The social group continues to meet every six weeks. I ran a discussion group session for survivors called 'Hope'. Some of the participants from the present research participated enthusiastically and moving comments on survival and despair emerged from the discussion.

It was interesting that Miriam, Dave and Isaac reached out to me and the other participants were able to terminate contact with me or to bond to therapists who were assigned to them. I thought that perhaps the extended research interviews served an integrating function for the participants. Laufer (1988) explained that trauma causes a split between the pre-traumatic, traumatic and post-traumatic self. Perhaps the in-depth, extended interviews offered some level of containment and integration. Possibly, after exposing their vulnerability, these three participants needed to keep ongoing contact, as they felt some level of containment and understanding was offered to them. In 2017 on completing the data collection and analysis dimensions of the present research I approached Johannesburg Jewish Community Services and appealed to them to offer a psychosocial program to address the needs of Holocaust survivors based on the findings of this research. They conducted a needs assessment and agreed to set up a special psychosocial service for Holocaust survivors. This service has been operating for the past six months and caseworkers have reached out to all the known 30 survivors in Johannesburg. I met with a leader in the Jewish Community who offered to make a donation to assist in setting up services for Holocaust survivors in Johannesburg.

In addition, I contacted the Claims Commission and wrote to them about my research. In response they sent forms for a fund they offer to help aging survivors to maintain themselves independently. I assisted Jewish Community Services in completing some of these forms for survivors. The Johannesburg Jewish Community Services have now formalized a service for Holocaust survivors which includes medical and dental assistance, psychiatric consultations and psychiatric medication for those suffering from PTSD and depression, visits from a case worker, nursing care, physiotherapy and financial assistance and lifts from a driver. This service

is aimed to help survivors live independently with dignity in their aging years. In addition, the case workers offer to hear testimony from the survivors who wish to speak about their Holocaust experiences. As a result, this research has served as catalyst for initiating psychosocial services for aging Holocaust survivors and highlighted their special needs in their final developmental stage. At present I am supervising and debriefing the two case workers who are also hearing testimony as part of the psychosocial support they are offering to survivors and I have been able to draw upon my own experiences of conducting this research, in order to support them through this difficult process. It is my privilege to be involved in this important work.

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APPENDIX 1 POST TRAUMATIC STRESS DISORDER

Since the participants in this study were interviewed whilst the Diagnostics and Statistical Manual, fourth edition (DSM IV) was in use, it will be utilised for further discussion on PTSD, in this chapter. The diagnostic criteria for PTSD (309.81), are as follows:

A. The person has been exposed to a traumatic event in which both of the following were present:

- The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others

- The person's response involved intense fear, helplessness or horror

Note: In children, this may be expressed by disorganised or agitated behaviour.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

-Recurrent or intrusive recollections of the event, including images thoughts or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

-Recurrent distressing dreams of the event. Note In children there may be dreams without recognisable content.

-Acting or feeling as if the traumatic event was recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note In young children, trauma specific re-enactment may occur.

-Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

-Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:

-Efforts to avoid thoughts feelings or conversations associated with the trauma

-Efforts to avoid activities, places or people that arouse recollections of the trauma

-Inability to recall an important aspect of the trauma

-Markedly diminished interest or participation in significant activities

-Feeling of detachment or estrangement from others

-Restricted range of affect (e.g., unable to have loving feelings)

-Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

-Difficulty falling or staying asleep

-Irritability or outbursts of anger

-Difficulty concentrating

-Hypervigilance

-Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if

-Acute: if duration of symptoms is less than three months

-Chronic: if duration of symptoms is three months or more

Specify if

-With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

(American Psychiatric Association, 2000, p. 427-429)

APPENDIX 2 MAJOR DEPRESSION

Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which

may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

APPENDIX 3 QUESTIONNAIRE

INTERVIEW SCHEDULE – POTENTIAL AREAS AND ISSUES TO EXPLORE

1. **BIOGRAPHICAL AND INTRODUCTORY DATA**

Name: _____

Age: _____

Occupation: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed

How many years _____

Number of Children: Ages: _____

Number of Grandchildren: Ages: _____

What age were you when the Holocaust began? _____

In what country did you live? _____

In which concentration camps where you imprisoned: _____

For how long? _____

How old were you at the time? _____

Were you in hiding for a period of time? _____

Please tell me about this. _____

Where do you live now? _____

How good is memory of recent events? _____

How clear is your memory of the war years? _____

What do you feel about participating in this study? _____

2. PRESENT LIFE

Tell me about your present life. _____

Possible probes

Work _____

Health

Family life

Hobbies

3. HOLOCAUST EXPERIENCES

When did you first begin to talk about the Holocaust?

Probes:

The years of silence

The emotional effect of talking about the Holocaust

4. PRE-HOLOCAUST LIFE

Please describe your family life before the Holocaust began?

Probes:

Relationships with parents, siblings, extended family members

Happy memories

Sad memories

Trauma or difficulty in pre-Holocaust life

Coping at school

Friends

5. EXPOSURE TO TRAUMA AND LOSS DURING THE HOLOCAUST

Tell me about your experiences prior to and in the concentration camp.

Probes:

Losses experienced

Most traumatic experiences

Cruelty witnessed

Significant relationships in the camps

Religious beliefs

6. AFTER LIBERATION

Please tell me about your experiences when your camp was liberated?

Probes:

Death march

Who liberated you

How were you treated

Which relatives had died

Were you able to grieve

7. EMMIGRATION TO SOUTH AFRICA AFTER THE WAR

What did you experience as a now emigrant in South Africa after the war?

Probes:

Environment

School

Emotional coping

Family adjustment

Political situation

8. BUIDING A LIFE AFTER THE HOLOCAUST

Please tell me about your experiences in building a new life in South Africa?

Probes:

Marriage

Children

Work

9. FAMILY RELATIONSHIPS

How did your Holocaust experiences impact on your family relationships?

Probes:

Quality of relationship with spouse/children

Was the Holocaust discussed with spouse/ children/ grandchildren

10. PSYCHIATRIC HISTORY

Have you ever consulted a psychiatrist/ psychologist/ counsellor – if so, Why?

Have you ever suffered from anxiety/ depression?

If so, what symptoms do you have?

If so, how did you manage to deal with it?

Is there a family history of depression anxiety i.e. mother, father or siblings?

Have you received medication for anxiety/ depression?

Have you received psychotherapy?

11. LIVING IN SOUTH AFRICA IN THE PRESENT

How are you affected living in South Africa now?

Probes:

Emigration of children

Crime

12. AGING EXPERIENCE

How have you coped with getting older?

Probes:

Recent experiences of losses

Retrospective view of the Holocaust

- clear memories
- mourning of losses
- emotional triggers
- Symptoms i.e. Bad dreams
- wisdom and meaning gained over a lifetime

Vera Reitzer – Holocaust survivor said “As I get older I am more in Auschwitz than ever before”, can you relate to this comment?

13. CLOSURE

How have you experienced this interview?

APPENDIX 4 INFORMED CONSENT FORM

INFORMED CONSENT SHEET

I have read the subject information sheet. I am aware of my rights and I am willing to participate in the study/

_____	_____
SIGNED	DATE
_____	_____
WITNESS 1	DATE

APPENDIX 5 ETHICAL CLEARANCE CERTIFICATE

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

R14/49 Farber

CLEARANCE CERTIFICATE	PROTOCOL NUMBER M050729
PROJECT	Integrity Versus Despair: The Experience of Aging Child Holocaust Survivors in South Africa
INVESTIGATORS	Ms T Farber
DEPARTMENT	SHCD/Psych010U
DATE CONSIDERED	05.07.29
DECISION OF THE coMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon applicatiön.

DATE 05.08.29 CHAIRPERSON .....

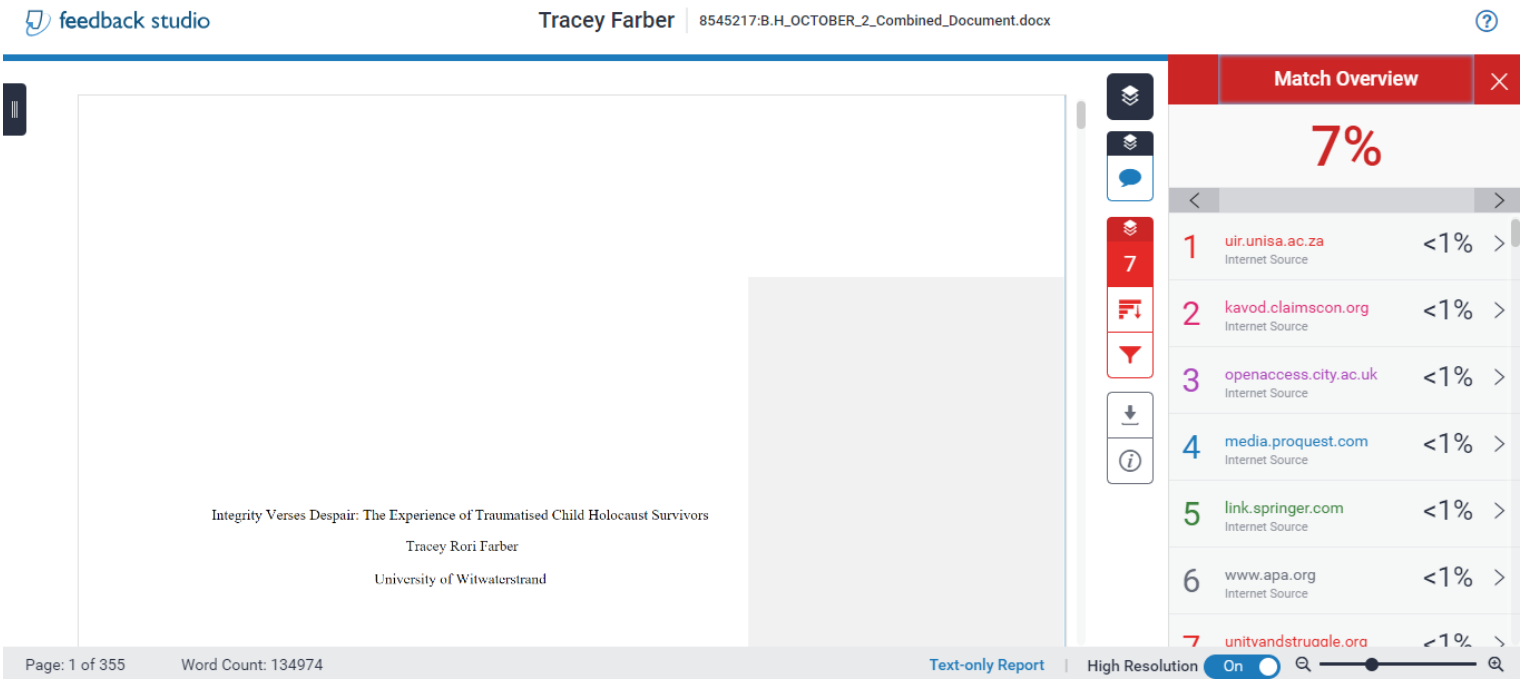
(Professor PE Cleaton-Jones)

*Guidelines for 'informed consent' attached where applicable cc: Supervisor :

Prof G Eagle

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY retumed to the Secretary at Room 10005, 10th Floor, Senate House, University.

IfWe fillly understand the conditions under which I am/we are authorized to carry' out the abovementio[ned] research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly. progress report.

APPENDIX 6 TURNITIN PLAGAIRISM REPORT