

# Understanding Narrative as an Integrating Process in Psychotherapy with Holocaust Survivors

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Aging Holocaust survivors present special issues to the psychotherapists or counselors with whom they work. The survivors are in a unique position as they reach old age and move towards the end of a natural lifespan. According to Erikson's stages of psychosocial development, these survivors, like other seniors, are wrestling with the psycho-social conflict of "integrity vs. despair". For this group it is particularly difficult for several reasons. Their despair is overwhelming and spans the generations of their lives. The survivors, in their 80's and 90's, are unlikely to have buried and mourned their grandparents, or watched their parents mourn the loss of their own parents in any coherent way. The need to formulate and tell a cohesive story integrating their fragmented lives and selves becomes more intense in the face of their own mortality and the pressing desire to share and connect with their families. The ambivalence between burdening the next generation and unburdening the self can manifest as intolerable tension and anxiety which the therapist is placed in the position of containing.

In this presentation, using a case vignette and literature review, I hope to illuminate special concerns that occur in providing psychotherapy to this population, and demonstrate how to remain attuned and supportive in the course of developing integrity, cohesiveness, and a more secure attachment that will alleviate shame and despair.

Since AMCHA, with the JDC and the Brookdale Institute did such a wonderful job, in cooperation the World Council of Jewish Communal Service, in producing a conference and book on this subject entitled *A Global Perspective on Working with Holocaust Survivors and Second Generation* (1995), edited by John Limburger. I will draw from that literature and focus on some newer paradigms used in the treatment of trauma which involving biological, developmental and social components.

When we do counseling or psychotherapy with Holocaust survivors most of our general theory and practices hold true; but there are specific areas to be aware of that may require special attention. As clinicians we are trained to pay attention to the individual: as communal workers we pay attention to the individual in the context of the community. As Jewish community workers we have a particular connection to this group who represent a traumatic part of our collective history of victimization and triumphant resilience over trauma. As practitioners of Judaism, in whatever form, we are aware of the 5<sup>th</sup> commandment to Honor Our Mothers and Fathers. Whether these aging survivors are the age of our parents, grandparents or peers we will be impacted by all of this as our subjectivities meet in the treatment room. They have stories to tell. As we help them co-construct their narratives, we promote healing as well in the generations that follow.

Aspects of trauma that are not metabolized or integrated may be enacted or dissociated. I will illustrate this primarily by focusing on the treatment case of an aged woman.

When we meet a patient it is important to note how and why this person came to you. In her article entitled "Individual Counseling Techniques with Holocaust Survivors," Judith Hassan, the Director at the time, of a Holocaust Survivor Center, is well aware of this. She notes that the setting is focused on mutual support without the stigma of victimization. Yet, she also observes that it may take many years for someone to come forward and ask for help. These are self referrals, usually motivated people who have developed some level of trust. Many of our communities have such settings. Some elderly may be referred by concerned family members, physicians or friends. For this group it is noteworthy that they may be dependent and compliant, or grateful for the care. Care given or offered specifically through the Jewish community carries with it all the associations to the Jewish community that can be listened for, understood and worked through as part of the healing. This might include the positive feeling of being cared for by the extended family, or a greater level of trust related to perceived common values and background; or perhaps on the darker side, conscious or unconscious resentment of past failures or shame about Jewish institutions both here in the present, or from an earlier time in Central Europe. Hassan observes the importance of the décor being "non-clinical", that there be light and air in contrast to their experiences of hiding or encampment. Durst notes that trauma has different effects depending on the age it occurs and therefore generalizations should be avoided and that proper care can bring relief through mourning while lack of it reinforces the trauma and becomes a chronic state.

I am a clinician in private practice although I had worked as a clinician for the Jewish Community for over a dozen years. I see more survivors and their successive generations in this setting and I believe it is precisely because I am not part of an institution and my office looks more like a living room or comfortable study as most private consulting rooms does. It is bright and airy. They come by choice and have a sense of status and control. The referrals are to a specific name from a known person enhancing the likelihood of trust.

Hilde, the 71 year old woman whom I shall focus on, is an example of such a referral. She was referred by her son's therapist in a nearby state. This son and his siblings were concerned about their mother's depression, irritability and denial following an episode of caretaking her husband whom she was told was suffering neurological impairment due to syphilis. The therapist hinted that Hilde's son would be willing to pay for his Mom if needed. Hilde does not trust the organized Jewish community; she wants privacy; she wants the ambiance to be "nice", although she does not feel she deserves it. She wanted the person and place to be Jewish in order to feel understood, although this is not always true for her.

As we all learn in psychotherapy or counseling 101, it is imperative to establish a therapeutic alliance. The therapist must be prepared to actively listen to what is often a story characterized by painful losses, anxiety, fear, anger and longing that may be presented coherently but frequently is told in a fragmented or affectively blunted manner, used because it has to be defended against or represents dissociated trauma. At times the tale may be told with extremely intense emotion. Our job is to provide a holding environment (Winnicott) and function as a container(Casement) hopefully providing the secure base as described in attachment theory

(Bowlby), to repair or compensate for earlier attachments that have been damaged or perhaps ambivalent or insecure to begin with. Our goal is to be empathically attuned, to facilitate the co-construction of a coherent integrative narrative that helps the patient regulate affects such as shame and anxiety. Through the interaction they will be reduced and connection and hope increase.

### Course of treatment.

Hilde has been in weekly therapy with me since August 2004. Time has been taken off to visit children if there was a new grandchild or when she was too ill, which is infrequent. Hilde drove herself to her first interview. She presented as an articulate, well groomed conservatively dressed, heavysset woman, who looked her reported age of 71. She speaks with an American mid-western accent. Although ready and eager to engage, she had difficulty focusing on herself. Her affect and story would shift whenever I simply reflected back any comment that could be perceived as disloyal to family problem and would even deny what she had just said. Regarding herself, she was far less kind. She reported that her children viewed her as too angry and engaged in too much “Loshon Hora”. She feared they were right. Yet, in some ways I detected pride in her declaration that she is more than candid in expressing her thoughts. “Oh, I’m bad!” she would sometimes say with a twinkle in her eye.

Although clearly depressed and anxious, she rarely described herself in those terms. Maintaining her self-esteem has been difficult, when she expressed any anger or disapproval of any of her primary attachments. Sometimes she relishes her role in the community and family gladly, while at other times she hates herself for it. She has used me as a sounding board and secure base where she can vent fears and anger without fear of repercussions. She appeared to gain pleasure trying to figure out my connection to Judaism being amazed when I am aware of concepts and practices of the Orthodox, which I am clearly not part of, yet do not denigrate. Perhaps this enabled her to suspect this would be my reaction to her. She shared her feelings of being “dumb, and too critical.”

Initially, her focus was on her daughter Rena, a mother of 2 young children, apparently trapped in an abusive marriage to a man in danger of losing his professional license for unethical behavior. Yet Hilde seemed more upset about her daughter’s anger and temper tantrums. Her daughter’s taunting response to her was the comment, “I learned everything from you.” Hilde suspected this was true. She was less concerned about her other 3 children. Hilde emphatically declared that she had wonderful family, yet she feared that under stress, Rena might become abusive to her grandchildren. Hilde would vacillate between saying she couldn’t watch when she visited Rena, that her daughter was a wonderful mother, while Hilde herself was an awful mother. Also, Hilde wanted to explore whether she could find meaningful employment since she was sometimes bored, and money was tight.

Additionally, Hilde reported difficulty sleeping and having a history of recurrent breast cancer which was currently in remission. She was medicated with Xanax prn prescribed by her gastroenterologist and Femora by her oncologist.

She wished to pay for her therapy with her Medicare and supplement.

Prior to gathering a formal history, I was aware that I was dealing with a woman for whom attachment and fulfilling her role as a good mother and wife has been paramount. However, she felt shame and failure as she blamed herself for her own difficulties. She sought to be accepted by me as a “good person”, who doesn’t see or especially say “bad” things about others. Therefore she felt conflicted about showing me her self-perceived flaws. Yet she wanted me to help her with those self states and help her with her family.

As I noted that Hilde is a likeable woman who has been through much suffering and became fragmented, when something shameful was exposed. I found myself feeling similarly fragmented as I listened to her. She checked to see if I could safe and supportive for her, Could I contain her negativity and dissembling, or like her, would I have negative feelings about her and her family that I would try to hide rather than help? Her initial presentation told me to be both gentle and straightforward. Hilde, minimally, has been deceived and betrayed. She is strong but vulnerable. If confronted too quickly she would fragment; if I simply reassured I might temporarily reduce the anxiety but would be giving the message that I could not tolerate those affects, and therefore not help her tolerate and work through her terrible feelings. I became prepared to hear that she has had conflicts and possibly trauma around attachment. I shared with her that she has been dealing with a great deal of pain regarding her family and herself which no one seemed to want to hear about. I told her that I hoped that she understood that this (my office) was a place where saying “bad” things would be held within the walls, where they could damage no one. She had feared that her expressions of anger would result in abandonment.

Hilde’s story emerged in bits and pieces. I wondered if the gaps and re-edits were due to lack of sleep, a medical condition related to some form of dementia or dissociation. After checking, I found no evidence of a medical issue despite sleep difficulty. The only place that fragmentation or memory problems occurred was in discussing her personal situation. Furthermore, with memory loss related to aging processes, long-term memory usually functioned better than short term memory, and this wasn’t happening.

Each session contained some enactment of her story and childhood in symbolic or literal form. While at the same time she shares her anger towards other authority figures, such as rabbis, mayors and doctors. When her oncologist failed to return a phone call she wondered if he had stopped liking her, given up on her or wanted more money. With me, she has been the good girl who always has arrived on time and behaved politely, making sure that I’m getting paid. .As she told her story, I tried to put it together with her in an attempt to understand and create order, integrating affect and cognition. I mirrored her thoughts and feelings. According to (Schore) pp473, mirroring and attunement serve to regulate the patient’s internal state, inducing a secure attachment that will support a working alliance. I have reminded her that she expects to be exploited or abandoned because it has been her experience. We have spoken about to what extent people in her life, including myself fit or don’t fit this picture. I have been careful to maintain the treatment frame regarding money and time.

This is Hilde’s history:

She is the second daughter of an upper middle-class business family, in a major German city in 1933. She remembered shadowing her Mom and sister, who was only 2 years older. Hilde was

expected to behave. She had lots of toys to play with and special clothes to wear for visiting. At age 6 ½ she remembered being dressed up in fancy clothes and being sent with her sister and favorite doll to go on a trip without her parents or little brother. It was the Kindertransport, a program by which Jewish children were allowed to leave Germany, Czechoslovakia, Austria and Poland between November 8 and 9 of 1938, Kristallnacht, and the outbreak of the war in September 1939. Hilde and her sister were among the 10,000 children who were sent to boarding schools and foster care in England after a 50 pound sterling bond was posted.

Somehow her parents were able to get out of Germany and reunite with their daughters and within a couple of years, and immigrated to Chicago. Hilde remembered life there as being awful. Her family was poor; her parents didn't speak the language well. She felt ostracized and ashamed of herself and them. They were often angry and preoccupied. Hilde had some difficulty paying attention at school. Nevertheless, she did graduate from high school and was introduced to a young rabbinical student whom she married. She supported him through another master's degree. Although he was pleasant and well educated, he had difficulty holding jobs and the family lived in at least 5 cities. They have been in New Jersey for the past 20 years. He has been out of the Jewish communal field for many years and sells insurance. He is apparently not too successful, especially since the neurological event.

She felt her husband was kind early in the marriage but their sex life and his patience seemed to have waned as time went on. Hilde blamed her tendency to be outspoken for her husband's job losses.

Her idealized sister, a successful real estate agent, remained in Chicago and is married to a wealthy man. She has academically and financially successful children.

Hilde has found her orthodox "way of life" meaningful and beautiful, yet she is skeptical about lay and spiritual leaders, and a group she calls the "frumke bumkes". She considered them "hypocritical phonies," concerned about earning Mitzvoth to show off or glean benefits for only themselves. Hilde has attended her synagogue regularly, cares for her dog husband and grandchildren. She visits the sick. **"People who lose their mother's, she says, "always take care of others and I do."**

Last May, life became very stressful. Since the beginning of treatment two of her children have moved far away to different cities, and she has had 3 new grandchildren within the past year.

Her sister's blood cancer re-emerged; a childhood friend died. This friend, who was very intelligent and married to a prominent Jewish man, was most important to her because she was the first person who did not view Hilde as the low class immigrant she saw herself to be. Hilde's metastatic breast cancer returned with significant symptoms twice. She recognized symptoms that the physician may not have. She has wondered who really cared. She had some concern that she might be dying... and she felt that she couldn't go on without older idealized sister.

During this period and without warning or preparation, Hilde brought in a Story Board she had made. "Look at this", she quietly commanded as she placed it on my shelf and stared at me. The poster was filled with newspaper articles about the Kindertransport and a large picture of two

very well dressed little girls walking away holding each other's hands with their heads bowed down. Lowered heads are the body language of sadness and shame. I empathized with and reflect the shame of the children. Next to this photo were portraits of the two little girls with wide eyes and no smiles.

I looked at it and felt anxiety and tears welling up which did not overflow. I was feeling Hilde's feelings, and I knew that she knew it. "Tell me about it", I stated softly. "I was so scared, and so sad and so brave when I held my sister's hand.

Hilde: All of Germany saw this paper.

GK: "You counted on your sister when your parents sent you away".

Hilde; "Yes, I always have, even now sometimes, she is all I have...I don't know what I would do with out her".

GK: "...and now you also feel like that frightened child as you both fear the unknown in your illnesses and your futures."

Hilde nodded and wept. "You know, no one really wants to look at that thing" she said pointing to the board. "Yet you felt it was important to show it to me, you wanted me to understand what you have been going through", I said. She had felt that perhaps they had been sent away because they were bad. Within the transference/countertransference matrix, I suspect I became the sister who had become her mother, who possessed love and acceptance and the threat of shame and abandonment. I did not leave; I tolerated her pain and anger; I did not see her as a bad girl.

This vignette also contains an example of what Daniel Stern calls a "present moment", in which we are conscious of each other's subjectivity, that can later be verbalized and breaks through the ordinary pattern. It passes below consciousness and organizes it on a higher level. It is temporally dynamic. (p35).

This Story Board is often referred to in our continued work. Hilde has continued to come for her sessions and is able to stay focused on her needs and feelings. Her relational descriptions are less fragmented as she realizes that her angry daughter is very attached to her, and her another daughter and sister are no longer idealized but viewed as whole objects. Her self-esteem is improving.

## **Conclusions**

Unresolved shame results in depression. Trauma that is not metabolized induces vulnerability to anger and intense anxiety. By developing a working alliance, the therapist mirrors and contains affect thereby regulating it, reducing despair and emotional fragmentation of chaos and increasing integration.

Hilde's grandchildren and the children who referred her will benefit from her healing. Affect and integration or lacks of it are passed down the generations through relationship and narratives. The second generation may enact their parents experience symbolically. Third generation authors such as Jonathan Safran Foer and his wife Nicole Krause may want to integrate the lives and histories of their families before the Holocaust. As the survivors can be aided through therapy they will experience integrity rather than despair.

Bearing witness to the personal narrative of a trauma in a safe setting has long been viewed as helpful to the recovery of trauma victims such as Holocaust survivors. Hopefully, this paper has illustrated that it is not only the telling that is therapeutic. The ability of the listener to be a secure new object with whom to attach, as well as functioning as a container for strong affects of shame, anger and grief are a necessary part of the healing process. The therapist must be attuned to the present moment of the patient as well as the past (history) that is part of this present for integration to occur. The emerging narrative must emerge and be co-constructed in the therapeutic dyad in order to maximize healing. These narratives are of value to the community. But if we are as careful in attending to affects and intersubjectivities then both narrator and listener will be changed for the better.

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