HEBREW UNION COLLEGE - JEWISH INSTITUTE OF RELIGION

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WORKING WITH CHILDREN OF HOLOCAUST SURVIVORS
THE THERAPIST'S RESPONSE

A Thesis submitted in partial
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by

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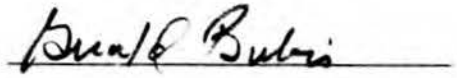
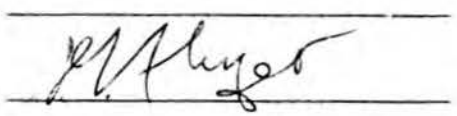
The Thesis of Robin Estelle Moss is approved.





ABSTRACT

This thesis explores clinical issues relating to therapists working with children of Holocaust survivors. Ten social workers from three different Jewish agencies in the Los Angeles area were interviewed. They varied in age, psychotherapeutic orientation and extent of experience.

The findings indicated that most respondents did see the factor of a client being a child of survivors as significant and relevant to treatment. More than half the respondents claimed awareness of actual or potential countertransference reactions. Manifestations of such reactions included feelings of sympathy, anger, resentment, and annoyance toward the survivor parents, guilt and shame for the Holocaust, identification with victims of the Holocaust, and excessive protectiveness of the client. Several of those who had such reactions stated that since they were aware of them at the time they felt confident that they were within their control and therefore did not have potential to thwart effective treatment.

More than half the respondents had read some about this client population but nearly all were interested in learning more through reading and a training program were their agencies to offer one.

Recommendations for such training programs are included at the end of the thesis.

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INTRODUCTION

It has been nearly forty years since the last prisoners of Nazi death camps were released. The children of the Holocaust are now themselves the parents of adolescents and young adults. A recent resurgence of interest in the Holocaust as one of the most significant catastrophic events in modern history has brought this legacy of survivors into focus through the various forms of media.

A great deal of literature is now available revealing the lasting physical, emotional and psychological scars left on the lives of those who survived the heinous persecution. Autobiographical accounts by such well known authors as Bruno Bettleheim and Viktor Frankl, and clinical writings by such outstanding practitioners in the mental health profession as H. Krystal and W. G. Niederland clearly show that the suffering of those who survived did not cease with the end of World War II. Recently, literature has emerged asserting that the far reaching ramifications of such a catastrophic trauma as the Holocaust affect even those who were not directly involved, especially the families of Holocaust survivors and more specifically, their children.

My interest in the effects of these events on subsequent generations was first aroused when I spoke with Lennard Lieber, national director of Parents Anonymous. I contacted Lieber pursuing information regarding the incidence of child abuse in the Jewish community. He informed me that he knew of few incidents of physical abuse or neglect on the part of Jewish parents, but that he was aware of many cases

where Jewish children had suffered psychologically as a result of their parent's attitudes and behavior. Lieber went on to tell me about the far reaching effects of the Holocaust on the children of survivors as transmitted actively or passively by their parents. He shared with me an article entitled "To Be Noble, I Have to Suffer Too," by Helen Epstein.[1] Epstein, a child of two survivors, recounts her experiences and those of others like her obtained from hundreds of interviews conducted with adult children of Holocaust survivors. These individuals described their experiences of reliving their parent's agony and suffering. Some spoke of feeling especially isolated and different because of their parent's experiences, while others grew up believing that everyone's parents were Holocaust survivors. There were those who were named after lost relatives and struggled with two identities, while others became the butt of their parent's suppressed aggression and hostility.[2]

To obtain more information about children of survivors, I spoke to Ben Pomerantz, a social worker for Jewish Family Services. Ben is a child of Holocaust survivors and the author of "Children of Survivors of the Holocaust: Perceptions of Their Need for Social Work and Community Services."[3] It was Ben who directed me to relevant reading material and helped me to focus on the particular topic of this study.

In the course of my reading and discussion I became convinced

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[1]Helen Epstein, "To Be Noble I Have to Suffer Too," Los Angeles Times, 19 June 1977, Sec. 6, p. 3.

[2]Ibid.

[3]Ben Pomerantz, "Children of Survivors of the Holocaust: Perceptions of Their Need for Social Work and Community Services" (M.S.W. thesis, University of Southern California, June 1977).

that any individual ready to confront the phenomenon of the Holocaust wholly and honestly, must also be willing to confront his or her own feelings in response to it. This means that one must grapple with the realization that each of us and our respective families were spared by a stroke of fate--regardless of whether we were born before, during, or after the Holocaust. For some, such a realization may well engender "survivor guilt" of varying intensity.[4] I decided to explore how such feelings, if experienced by therapists, might affect them and consequently their treatment of survivors and the families of survivors.

This study specifically focuses on therapists and their therapeutic relationships with children of Holocaust survivors. Four questions emerged from my initial research.

1. Do clinical workers in Jewish agencies know about potential second generation effects on children of survivors? If so, what is the extent of their knowledge?

2. Through what means do these workers learn that their clients are children of survivors; do the clients identify themselves as such or do the workers uncover the fact? If the latter, is it as a result of the worker's ability to identify second generation effects, or the result of his collecting background information?

3. Do these therapists experience any reactions or biases which could potentially interfere with effective treatment of children of survivors? If so, what are these biases, commonly referred to in

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[4]According to Gustav Bychowski, feelings of survivor guilt are characterized in the questions: "Why am I the one who survived?", "Why didn't I save them?", "Why was I saved myself? They were better than me." Gustav Bychowski, "Permanent Character Changes as an After Effect of Persecution," in Massive Psyche Trauma, ed. H. Krystal (New York: International University Press, 1968), p. 75.

clinical literature as countertransference reactions, and how do they deal with them?[5]

4. Have these therapists, or any member of their immediate or extended family, been involved in any Holocaust related experiences, and if so have these experiences affected their perceptions of, or attitudes toward children of survivors and their families?

The attempt to pursue answers to these questions resulted in a research design using a focused interview with workers from three different Jewish agencies. Two of these agencies were children's services agencies and the third served a wider range of clients in the Jewish community.

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[5]For explanation of countertransference see pp. 13-14.

CHAPTER I

SURVIVORS AND CHILDREN OF SURVIVORS

Survivors

It is impossible to fully appreciate the clinical implications of the Holocaust experience on survivors unless one considers the historical, cultural, social, and other human implications as well. Analyzing the impact of these experiences "objectively" in light of the extreme persecution and maltreatment these individuals have endured is a difficult task indeed.[1]

An attempt is made here to outline the range and describe the kinds of symptomatology experienced by many survivors.[2] The collective symptomatology is commonly referred to as "survivors syndrome."[3] Other names used to refer to this symptomatology include "concentration camp pathology" and "post concentration camp syndrome."[4] Survivor syndrome, the term used henceforth, has been a frequent psychiatric finding characterized by a chronic state of tension, vigilance, irritability, depression, unrest and fear, usually accompanied by sleep disturbances.

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[1] W. G. Niederland, "Clinical, Social and Rehabilitation Problems in Concentration Camp Survivors," Journal of Jewish Communal Service (May 31, 1965):186.

[2] It should be noted that most research available is somewhat skewed in that it focuses on those survivors who sought out medical and/or psychiatric treatment, or applied for restitution, on the basis of their continued suffering.

[3] Idem, "The Problem of the Survivor," Journal of the Hillside Hospital 10 (1961):243.

[4] Idem, "Clinical Social, and Rehabilitation Problems," p. 186.

anxiety, dreams and nightmares.[5] Other symptoms recurrently cited in the literature include guilt, anger, apathy, suppression of affect and the inability to form close emotional relationships.

A considerable number of survivors suffer from somatic symptoms ranging from rheumatic, neurological aches and pains to psychosomatic diseases such as peptic ulcer and colitis, often accompanied by hypochondriacal symptoms. In more severe cases, there may be personality changes and fully developed psychotic or psychotic-like disturbances with delusional or semi-delusional symptomatology.[6]

Families

Although many survivors' families appear to be healthy and well functioning, research seems to indicate that some do show disturbance or pathology, including a deterioration in the organization of the family and problems on the part of the parents in the setting of limits for the child; such problems include rigidity, ineffectualness, and difficulty with relating appropriate limits to the needs of the child. The reason cited for these features is the parents' preoccupation with their traumatic past, which leaves them with limited emotional resource to meet the normal emotional needs of their children.[7]

Children

Lipkowitz states, "It must be anticipated that the psychic scarring of the survivors will have noxious effects upon the

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[5] Ibid.

[6] H. Krystal, Psychic Traumatization (New York: Little Brown, 1971), p. 12.

[7] Pomerantz, "Children of Survivors," pp. 5-6.

development of their children." These effects are a consequence of impaired parental functioning often observed in survivors; survivor parents are often preoccupied with danger, which causes them to be overprotective towards their children. Such overprotectiveness communicates the message that the world is a dangerous place, thus causing their children to cling to them.[8] Constant warning of impending danger also causes many children of survivors to become phobic and still others to be in constant conflict with their parents.[9]

Parental overprotectiveness is also tied to the parents' difficulty in letting the child separate. Lipkowitz explains that in order for healthy development to take place, there must be a gradual progression of the infant from the original state of symbiosis to the separation and individuation stage. This process needs to be cued by the mother. The survivor mother, however, who may be experiencing feelings of tension, fear and guilt, is more likely to give cues for continuing symbiosis instead. If she is chronically depressed and withdrawn, she cannot inspire basic trust and consequently she inhibits the child's capacity to accept the reality that symbiosis cannot be maintained.[10] The implied or expressed expectation that the child provide meaning for the parents' life further adds to the child's difficulty with separation and individuation.[11] It is as though it is

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[8]Marvin Lipkowitz, "The Child of Two Survivors: A Report of an Unsuccessful Therapy," Israel Annals of Psychiatry and Related Disciplines, II (1973):141.

[9]Bernard Trossman, "Adolescent Children of Concentration Camp Survivors," Canadian Psychiatric Association Journal 13 (1968):121.

[10]Lipkowitz, "Child of Two Survivors," p. 152.

[11]Trossman, "Adolescent Children," p. 122.

the child's responsibility to compensate for the parents' manifold losses. This overwhelming sense of responsibility precludes normal, healthy adolescent rebellion.[12]

Barocas points out that many survivor parents encourage the child to become an extension of themselves. Their use of the child as a transferential object forces a destructive identity upon the child, causing the child to act out some aspect of the parent's neurosis that the parent most wishes to deny, such as repressed aggressive impulses. As a result, the survivor parents derive some sort of vicarious gratification.[13]

Included in the results of the wish for their children to become extensions of themselves is the tendency by survivor parents to put a great deal of pressure on the children for performance, stressing academic achievement and economic success. As a result, many children of survivors experience examination anxiety, impotence and guilt.[14] These reactions experienced by the child are related to the various mixed messages they have received and can lead to ego splitting.[15] One message such a child receives is that he or she is expected to achieve. However, at the same time the child feels a sense of guilt for surpassing the parent if he or she does so. This guilt, in turn, bears a

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[12]Ellen Switzner, "The Miracle of Survival," Family Circle, December 1978, p. 50.

[13]Harvey and Carol Barocas, "Manifestations of Concentration Camp: Effects on the Second Generation," American Journal of Psychiatry 130:7 (July 1973):820.

[14]Trossman, "Adolescent Children," p. 122.

[15]S. M. Sonnenberg, "Workshop Report on Children of Survivors," Journal of the American Psychoanalytic Association 22 (1974):203.

strong resemblance to the parents' sense of guilt for having survived.[16]

The impotence experienced by the child of the survivor may also have other causes, one being that some children of survivors have difficulties with identity formation, especially if the same sex parent has been severely damaged by his or her experiences.[17] Oedipal resolution is often impeded because of this factor. It has been noted that the better the parents have dealt with their concentration camp experiences and the more successful they have been in resolving their guilt and coping with their depression, the easier it is for their children to form parental identifications.[18]

There are many other ways in which the children are affected by their parent's experiences. In some cases, the child becomes an object of the parent's identification with the aggressor. As Helen Epstein reports, "When our fathers were provoked by our misbehavior, some of them shouted 'idiots,' 'fools,' 'swine,' the same epithets the Nazi guards used against them."[19]

In an unsuccessful attempt to resolve their overwhelming experiences, some survivors use their children as audiences for the relentless recounting of their past suffering. As one child of survivors recounts, "It seems they never talked to us except to say what the Germans did to them." Others learned about their parents' experiences

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[16] Trossman, "Adolescent Children," p. 122.

[17] Ibid.

[18] Sonnenberg, "Workshop Report," p. 203.

[19] Epstein, "To Be Noble."

through more passive means of communication; a young woman comments, "I always knew that my parents were in concentration camp. The fact that it wasn't talked about made me know more. All I had to do was look at my mother's face and I knew I had better not ask questions. . . ."[20] Those children who did not get the whole story were left to fantasize their own conclusions.

In some cases, children were quite blatantly used as replacements for lost love objects. They were not only named after dead relatives, but also told the "name stories" that went with the names. As one woman puts it, "I used to say, 'My name is Serifka from Orhay.' I was never in Orhay, which is in Poland, in my life. My grandmother lived there. This was my identification. My grandmother reincarnated."[21] Such "resurrection fantasies" force the child into a mold of identity formation that reflects the parental expectations that the child be like the lost relative.[22]

Survivor parents also communicate various mixed messages that may result in their children's preoccupation with their confused identity as Jews. On one hand, survivor parents may manifest a reaction formation against the rage at having been victimized as Jews. On the other hand, many survivor parents communicate a hostile attitude towards the Gentile world for having allowed the Holocaust to take place. Either of these may result in an exaggerated ethnic identity or rejection of any connection to their Jewishness.[23]

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[20] Ibid.

[21] Ibid.

[22] Sonnenberg, "Workshop Report," p. 202.

[23] Trossman, "Adolescent Children," p. 122.

Rustin has found some consistency in the self descriptions made by children of survivors who claim to be depressed, angry, looking for affection, guilt-ridden and confused.[24] In the more severe cases, the children present psychiatric features bearing a close resemblance to those that characterize survivor syndrome.[25] Frequently these symptoms first appear when the child reaches the age that the parents were at the time of their internment.[26] Included in these symptoms are auditory and visual hallucinations of their parents' experiences. Other symptoms include headaches without organic cause, other hypochondriases, severe and long lasting depression and anxiety and a tormenting sense of guilt.

A study of thirty children of survivors admitted to Hillside Division of Long Island Jewish Medical Center in New York showed that many unconsciously reenacted their parents' concentration camp experiences. Dr. Sylvia Axelrod, inpatient service chief at Hillside, states that many of these children have grown into paranoid, suspicious, manipulative and assaultive adults. Approximately one-third of those included in her study were found to abuse drugs and alcohol.[27]

In summary, many children of survivors incur a great deal of difficulty and suffering as a result of their parents' Holocaust

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[24] S. L. Rustin and F. S. Lipsig, "Psychotherapy with the Adolescent Children of Concentration Camp Survivors," Journal of Contemporary Psychotherapy 4 (1972):86.

[25] Baracos, "Manifestations of Concentration Camp," p. 820.

[26] Sylvia Axelrod, Ofelia L. Schnipper, and John H. Rau, "Hospitalized Children of Holocaust Survivors: Problems and Dynamics" (Unpublished paper presented at the 131st annual meeting of the American Psychiatric Association, Atlanta, Georgia, May 8-12, 1978), p. 4.

[27] Axelrod et al., "Hospitalized Children," p. 12.

experiences. The most common symptoms that the children manifest include difficulty in separating, confused identity, depression and a painful sense of guilt.

There are some differing speculations in the literature as to how many children of survivors manifesting such symptoms are in need of therapy and actually seek treatment.

It must be clearly stated for survivors, as well as their children, that not all of them manifest all, or even some of the symptoms described above. However, it is known that many do, and it is reasonable to assume that there are even more who suffer such symptoms, but do so quietly rather than reach out for help from any community resources. Consequently, it is impossible to reliably determine the numbers of those suffering from the various symptoms described herein.

CHAPTER II

THE THERAPIST'S RESPONSE

Research indicates that there is a lack of consensus among mental health professionals regarding the definition of countertransference. Definitions range from a limited "classical" type to a broader more "totalistic" type. The classical type defines countertransference as the unconscious reaction of the therapist to the patient's transference as a result of the therapist's past intrapsychic conflicts.[1] The totalistic type would include all conscious and unconscious reactions of the therapist to the patient, his or her material, family members or significant others. Those adhering to the classical definition see countertransference as something inherently wrong that needs to be overcome. While those subscribing to a more totalistic definition tend to view countertransference as reactions in need of attention and resolution, they also consider them potentially useful in gaining greater understanding of the patient.[2]

For the purpose of this paper, countertransference shall be defined as a therapist's reaction to a client, his or her material,

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[1]Greenson defines transference as the experience of feelings, drives, attitudes, fantasies and defenses toward a person in the present [the therapist] which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood. Explorations in Psychoanalysis (New York: International Universities Press, Inc., 1978), p. 201.

[2]Otto Kernberg, "Notes on Countertransference," Journal of American Psychiatric Association 13, pp. 38-39.

family members or significant others that originates on an unconscious level as a result of that therapist's past or present unresolved conflicts. It is this researcher's belief that although such reactions can be useful in gaining greater understanding of the client, they can also potentially thwart effective treatment. Such would be the case when countertransference reactions were beyond the realm of the therapist's awareness and control and thus could trigger inappropriate treatment interventions.

Greenson asserts that therapists can and do have countertransference reactions to any or all the people significantly related to the patient, including spouse, lover, children, parents or friends.[3] Such responses may be recurrent and characterological or acute and episodic.[4] Rabkin reminds us that anyone doing family therapy will experience "strange eruptions of infantile images and ideas into his or her consciousness, and that these eruptions are as varied as the personalities of the therapists who experience them, as they come from a diverse range of unresolved family relationship conflicts.[5] Racker says that an analyst who sees and understands something about a patient that seems significant but does not interpret it must consider internal emotional factors if such an abstraction is not objectively

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[3]Ralph Greenson, Explorations in Psychoanalysis (New York: International Universities Press, Inc., 1978), p. 507.

[4]Robert Langs, Psychoanalytic Psychotherapy, 2 vols. (New York: Jason Aronsen, Inc., 1972-1974), 2 (1972):290.

[5]Leslie Rabkin, "Countertransference in the Extreme Situation: The Family Therapy of Survivor Families," Group Therapy, eds. L. R. Wolberg and M. L. Aronson (New York: Stratton International Corp., 1975), p. 165.

justified.[6] For social workers whose clinical procedure may not be characterized by interpretation, other manifestations of countertransference may include avoidance of certain material, inappropriate or excessive anger toward, or nurturing of, a client, and overprotectiveness of one of the client's social set.

All workers, at one time or another, are subject to countertransference reactions of which they are unaware. When such awareness is lacking, the therapists can obviously do nothing about it. There are those who ignore or deny such reactions; perhaps they are not ready or willing to confront their own conflicts. Others may equate countertransference difficulties with incompetency, and, not having come to terms with their own shortcomings, avoid confronting themselves. Such lacking awareness, avoidance, and denial are potentially damaging to the therapeutic process.

While countertransference reactions within the conscious awareness of conscientious workers tend not to be destructive to the therapeutic process, they may nevertheless be distressing to the therapist. Among those aware of their own countertransference difficulties, some may very well know how to deal with them. Such approaches will be discussed later.

Therapists: Their Response to Survivors and Their Children

During the last decade, mental health professionals have begun to address the issues of countertransference with regard to working with survivor families. Regarding survivors themselves, Esther

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[6] H. Racker, "Countertransference and Interpretation," Psychoanalytic Clinic Interpretations, ed. Louis Paul (New York: The Free Press of Glencoe, 1963), pp. 220-221.

Appleburg has found that clients "mentioning" having been in concentration camps is often not picked up by workers. She cites Dr. Niederland's observations of the helping professions to bear out the same findings.[7] If this is the case for survivors, how much easier it must be to "overlook" the Holocaust experience as a significant factor in the lives of children of survivors. As Dr. Axelrod points out, minimal reference to countertransference in the literature on treatment of children of survivors may be in itself a manifestation of the problem.[8]

In preparation for the Jerusalem meeting of the Association for Child Psychoanalysis, Judith Kestenberg sent out a questionnaire containing the following:

> (1) Have you analyzed children of survivors of Nazi persecution? If so, (a) what ages, (b) how many, (c) would you be willing to present this material [at the conference]?
>
> (2) Do you feel that the problem of children of Holocaust survivors is neglected, and should it be put on the national and international program?
>
> (3) Do you think there are distinctive features of children of survivors which are rarely seen in the average analytic patient. . . ?

Kestenberg's endeavor revealed a variety of responses, ranging from great interest to forgetting the questionnaire. She claimed that a vast majority displayed an amazing degree of indifference to the problem. She seems to feel justified in generalizing that the psychoanalysts themselves resist unearthing the frightening impact of Nazi

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[7] Esther Appleburg, "Holocaust Survivors and Their Children," in The Jewish Family, ed. N. Linzer (New York: Commission on Synagogue Relations, 1970), p. 110.

[8] Axelrod, "Hospitalized Children," p. 10.

persecution on children of Holocaust survivors.[9]

Such resistance on the part of the therapist to deal with the Holocaust material has also been among the findings of Axelrod's study at Long Island Jewish-Hillside Medical Center.[10] Hillside has had a special unit for children of survivors since March, 1977. Dr. Axelrod says, "We found that prior to 1976, we had paid minimal attention to the patient's survivor child status. It was either omitted from the usual family history or mentioned briefly. Little or no relevance was assigned to it."[11] Axelrod feels that the lack of awareness of the importance of this factor is probably a reflection of countertransference problems. She points out that lack of reference or minimal consideration to such background information was found in 33 percent of the charts.[12] "Even after becoming alerted to the possible significance of being a survivor child, we often found it difficult to intervene because of countertransference problems."[13] The evidence that Axelrod points to is the anxiety, hostility, repression and avoidance exhibited by her staff in response to discussion of Holocaust material. Such attitudes are manifested in verbal responses like, "All that happened 30 years ago--how can it have any significance now?" and acts of behavior such as referring child of survivor patients to the child survivor group while at the same time omitting such family history from the

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[9] Kestenberg, "Psychoanalytic Contributions," p. 313.

[10] Axelrod, "Hospitalized Children," p. 3.

[11] Ibid.

[12] Ibid., p. 10.

[13] Ibid., p. 3.

charts. Another behavioral manifestation is the tendency of staff members to repeat survivor patient patterns of overindulgence and overinvestment with patients who are children of survivors.[14]

Axelrod goes on to say that it was only with "increased experience and understanding of our own reluctance to deal with our own feelings about the Holocaust [that] it has been possible to begin to openly discuss some issues with these patients and their parents."[15] Children of survivors themselves attest to therapists' apparent avoidance of Holocaust related issues. According to Helen Epstein, "The shrink never asked" is a comment commonly cited by children of survivors.[16]

Some discussion of the dynamics of countertransference in the therapeutic relationships with children of survivors, and consequently the survivor parents as well, does exist in the literature.

One belief shared by many is that the therapist is unable to comprehend the devastating enormity of the Holocaust, and as a result, has difficulty coming to terms with, or even being able to listen to what it was like. Appleburg cites a situation in which a client who is a survivor might say, "I was in Bergen Belsen . . . but you wouldn't understand." The worker responds with "No, I wouldn't." Such resistance interferes with the therapist's ability to make a more appropriate response such as, "Tell me, so I can try to understand,"--a response that he or she would be likely to feel comfortable making in

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[14]Ibid., p. 11.

[15]Ibid., p. 3.

[16]Epstein, "To Be Noble."

other circumstances.[17]

As Rabkin puts it, ". . . the desire [of the therapist] to hear his [the survivor's] truth is countered by his need to ignore him." Rabkin goes on to say, "What the parents have to tell and what the therapist must hear if he is to come to any deeper understanding of the desperate situation in which the family lives, shakes the foundations of his ironic, resigned, or blind attitudes toward evil and human extremity." Rabkin then adds, "We cannot fully acknowledge extremity."[18]

Related to the dynamic just discussed is another one: that due to the therapist's own resistance to the uncovering of information related to the Holocaust, a kind of collusion of "nondiscussion" with the parents and children of those families who keep the material secret may occur.[19] In many cases, therapists will justify this with rationalizations such as: the parents would not be able to tolerate such discussion without adverse effects, or, the parents have suffered enough.[20] As Axelrod indicates, such rationalizations may well contain some truth, but they are "nevertheless likely projections of the therapists' own unconscious wishes to remain unaware of their feelings about the Holocaust."[21] Axelrod has found, too, that in other cases therapists have decided to see the entire family only rarely or not at all, because otherwise it would be much more difficult to prevent Holocaust

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[17] Appleburg, "Holocaust Survivors," p. 110.

[18] Rabkin, "Countertransference," p. 171.

[19] Kestenberg, "Psychoanalytic Contributions," p. 314.

[20] Axelrod, "Hospitalized Children," p. 11.

[21] Ibid.

issues from being raised.[22]

Another significant area of countertransference concerns the therapist's experience of some form of survivor guilt. Rabkin explains that in a sense the therapist is a survivor as well, although he or she has survived in a different time and place while the survivor parents were actually witness and subject to the persecution. The difference between them, Rabkin contends, gives rise to a "discomforting ambivalence."[23]

Identification with the aggressor on the part of the therapist is another dynamic that may come into play. Krystal warns that the child-of-survivor patient's transference may cause the patient to identify the therapist as the aggressor and therefore the therapist needs to be watchful of tendencies to give in inappropriately to the patients' needs as a reaction formation.[24] In this therapeutic context, the survivor parent, as a result of the concentration camp experience identifies with the Nazi aggressor, and his or her child in turn becomes "the victim." In assuming such a role, the child of survivor provokes others to assume the role of aggressor. The therapist, rather than transferentially assuming such a role, unconsciously defends against it through reaction formation.

Facilitating the much needed emotional separation of children of survivors from their parents is a difficult task that may also precipitate countertransference. Unresolved conflicts about separation

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[22]Ibid.

[23]Rabkin, "Countertransference," p. 170.

[24]Krystal, Massive Psychic Trauma, p. 218.

and loss within the therapists themselves plays a significant role with respect to this. Rabkin points out that the crisis of separation which the older therapist may be going through with his or her own children may be exacerbated by an attempt to facilitate the separation of the child-of-survivor client. The younger therapist, on the other hand, "stands between his own separation and those which will follow in course."[25] What makes the task even more difficult for the therapist is his or her compassion for the parents' need to hold on to their children. The conflict is described thus: "The therapist who cannot or will not experience the extremity of the survivor's need for restitution, or who refuses to confront the life threatening ambivalence of the survivor's separating child, may find him [or herself] implicated in a cycle of desperation, indecision and death." Many therapists fear the power to "cause" the parents depression, psychic demise or death.[26]

The therapists' wish to avoid causing the parents any more suffering is described in the findings of Harris and Jody. Their study explored factors influencing the decision making process of agency personnel at Vista del Mar regarding survivors as potential adoptive parents. They cite two responses of interviewed workers: (1) not wanting to add to the survivor couple's suffering by refusing the couple adoptive children and (2) experiencing a desire to make restitution to these survivors for the suffering they had endured, by accepting them as adoptive parents. Although there did not seem to be any consistency in the responses of the interviewers, there was evidence of conflict on

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[25]Rabkin, "Countertransference," p. 173.

[26]Rabkin explains that to many survivors separateness/separation signifies death, "Countertransference," p. 173.

the part of the workers regarding (1) taking special risks in accepting Holocaust survivors, (2) being flexible in their considerations by weighing the couple's strengths over their weaknesses, and (3) dealing with their own internal pressures. These pressures included feelings of guilt, pity, empathy, and a desire to make restitution for previous deprivation and loss.[27]

It is important to point out that the various dynamics of countertransference described here tend not to manifest themselves in isolation, but rather tend to occur simultaneously with others, weaving an intricate web. As a result, the therapist may experience "countertransference anxiety of a depressive nature, focused on the danger of having hurt the parents, or of a paranoid variety with an apprehension about potential contempt, assault and abandonment by the parents."[28]

In order to assess the full significance of the countertransference factors thwarting the uncovering of Holocaust materials and creating difficulties in dealing with it, it is important that the following be noted.

First of all, many therapists do not know about second generation effects and therefore do not pick up clues that would be indicative of them. This is especially likely to occur if the therapist does not take a family history or intake procedures do not routinely include the gathering of such information. Without the knowledge of second generation effects, a therapist would not be alert to the possibility that certain difficulties of children of survivors are related

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[27] Judith Harris and Judy Jody, "Factors Involved in the Decision Making" (M.S.W. thesis, Hebrew Union College, 1974), pp. 42-44.

[28] Rabkin, "Countertransference," p. 171.

to their parents' experiences. This may even occur in situations where the worker is aware of the parents' survivor background. As Kestenberg found in response to her questionnaire mentioned earlier, some therapists were startled by the questions because it never occurred to them to link their patient's dynamics to the history of their parents' persecution.[29]

An even greater danger than not seeing the factor as possibly relevant or the lack of awareness of second generation effects, is the danger of incorrectly diagnosing a child of survivor patient as a result of misinterpretation of the presenting symptomatology, or an excessive need to classify a case too readily. Lipkowitz states that the presenting picture of a child of survivor patient might easily have led him to a premature diagnosis of schizophrenia. Only after finer dissection of the delusions were they revealed to be depressive rather than schizophrenic in origin.[30]

Axelrod and her staff found that such misdiagnosis is not uncommon. Of thirty patients admitted to Hillside Hospital, twelve had received only one evaluation; of these, eleven were diagnosed schizophrenic. Eleven of the twelve were later reevaluated and of these eleven, seven diagnoses were changed: five to "major affective disorder" and two to "borderline personality."[31]

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[29]Kestenberg, "Psychoanalytic Contributions," p. 313.

[30]Lipkowitz, "Child of Two Survivors," p. 142.

[31]Axelrod et al., "Hospitalized Children," p. 4.

Dealing with Countertransference

Emphasis has been placed on the importance of self-awareness in dealing with countertransference reactions. To bring such reactions, which originate on an unconscious level, to consciousness, and then to deal with the material brought forth, is a major challenge for the therapist. There is no one recipe, though Rabkin seems to feel that most approaches to countertransference tend to be cookbook approaches characterized by "excessive manipulation."[32]

Nonetheless, several noted clinicians do offer a few guidelines for the recognition of, and ways to deal with countertransference reactions. Robert Langs for example, asserts that in dealing with countertransference reactions, the primary goals are: to recognize them when they occur, to limit their extent, frequency and effects on treatment, to be aware of their influence on oneself and the patient, and to analyze and resolve them as quickly as possible, without burdening the patient with any of this information.[33]

Since the first step is to recognize countertransference reactions, Greenson advises the therapist to ask the questions: (1) "Is what I'm thinking, feeling, etc., in keeping with the patient's material or behavior?" and (2) "Is my intended intervention potentially helpful for the patient or to serve my own needs?" Greenson adds that all intense emotional reactions are suspect and therefore should be subject to scrutiny.[34]

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[32] Rabkin, "Countertransference," p. 164.

[33] Langs, Psychoanalytic Psychotherapy, 2:298-299.

[34] Greenson, "Explanations in Psychoanalysis," p. 514.

Langs warns that the countertransference can be very disruptive when the therapist is unaware; it can contribute major roadblocks or lead to total failure of the therapy.[35]

Some indicators of countertransference that a therapist may use as a guide for self scrutiny are: (1) forgetting appointments or patients' material, (2) periods of stalemate, boredom or sleepiness, (3) rigid feelings and attitudes, and (4) the absence of feelings or attitudes.[36]

The more subtle forms of countertransference are more dangerous because they are more difficult to detect. Persistent or undue protectiveness, chronic or unyielding good naturedness, and benevolence, are possibly all indicators of a mothering countertransference. On the other hand, constant boredom, forgetfulness, coldness, aloofness or indifference are all indicators of a warding off hostile countertransference reactions.[37]

The therapist must recognize his or her own transference-based reactions without undue guilt, for only then can they be used adaptively to deepen understanding of the patient and to further therapy.[38] This is particularly true because usually there is a reality stimulus to the therapist's reaction, and therefore, every self-awareness of the therapist contains a clue to the fantasies, conflicts and behavior of

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[35]Langs, Psychoanalytic Psychotherapy, 2:299, 307.

[36]Greenson, "Explanations in Psychoanalysis," p. 514.

[37]Ibid.

[38]Langs, Psychoanalytic Psychotherapy, 2:294.

the patients.[39]

For those who desire a more structured approach, Greenson offers several steps for dealing with countertransference:

First, the therapist must be aware that any response to the patient may contain elements of countertransference.

Second, the therapist must question him or herself as to whether a given reaction or attitude is predominantly therapeutic or countertransferential in nature. It is helpful to find out what in a patient's material triggered the reaction.

Third, the therapist must analyze him or herself by introspection and free association in order to find the source of countertransference and the unconscious motives to hurt or help a client.

Fourth, the therapist needs to consider whether a particular reaction is isolated or part of a pattern.

Finally, if the therapist has difficulty assessing him or herself it is recommended that he or she seek outside assistance from a supervisor or therapist.[40]

In summation, the solution to the therapist's countertransference is through self-awareness, self-analysis, insight, and working through past and present personal conflict. Failing that, a therapist "closes the hole at one end [of the dike], only to find another leak."[41]

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[39]Ibid., p. 375.

[40]Greenson, "Explorations in Psychoanalysis," p. 578.

[41]Robert Langs, Bipersonal Field (New York: Jason Aronsen 1976), p. 401.

CHAPTER III

METHODOLOGY

This is an exploratory study of countertransference and related issues, as experienced by social workers in Jewish communal service agencies in their treatment of children of Holocaust survivors.

For the purpose of this research project the terms "survivor" and "child of survivor" are defined as follows:

"Survivor" refers to any individual who has lived through the concentration camp or work camp experience, lived in hiding, participated in a partisan or other resistence group, or masqueraded as a non-Jew during the Holocaust.

"Child of survivor" refers to any person borne of a survivor parent who either was born after the Holocaust or has not him or herself been subject to persecution or maltreatment during the Holocaust.

As noted earlier countertransference shall be defined as a therapist's reaction to a client, his or her material, family members or significant others as a result of that therapist's past or present unresolved conflicts.

The Interview

In order to elicit as much information as possible, the focused interview was the instrument of choice. An interview guide (Appendix C) was designed to include both structured and open-ended questions. The more structured questions were designed to gain

personal background and other concrete information, while those more open-ended attempted to tap less specific and more subjective information such as countertransference reactions.

Although a pretest was used, the person on whom the interview guide was tested had only very limited experience working with children of survivors and, therefore, could only assist on the wording and other structural aspects of the interview guide.

The following primary areas of interest served as the basis for the specific questions used in the interview guide (Appendix A).

-- Through what means did these clinical workers first learn that clients were children of survivors; how, when, and in what context?
-- Were there circumstances in which these therapists saw this factor as significant? If so, what were they and why?
-- With regard to these issues, how significant did these workers feel it was that the client was a child of survivors?
-- How did these workers feel they handled these cases? In retrospect, would they have done anything differently, and if so, what?
-- Were these workers aware of any biases or countertransference reactions toward this client population? If so, what were they, how did they manifest themselves and how did the worker deal with them?
-- Did the workers' past, as related to the Holocaust experience, contribute to the above, and if so, how?
-- Did the workers see any distinctive features that particularly characterized this client population?

-- Did these clinical workers know about second generation effects of the Holocaust? Are they familiar with any of the literature about children of survivors? Are any of them interested in learning about what has been written?
-- Would these workers be interested in training sessions or seminars concerning this client population? If so, what would they like to see included?
-- Do these workers have any impressions about their colleagues' interest in such training programs?

Agency Descriptions

A total of ten social workers from three different Jewish agencies in Los Angeles with counseling services available to children of survivors were interviewed. Two of these agencies, Vista del Mar and Jewish Big Brothers, offer services specifically for the children, while the third agency, Jewish Family Service, serves clients of all ages.

As one worker from Jewish Big Brothers pointed out, this agency's goal is to prepare the child to accept a relationship with a Big Brother. Therefore contact usually focuses on working through feelings of disloyalty toward the deceased or absent father. However, there are more extensive counseling services available if the child and/or his family needs them. Counseling in this setting tends to be short term or task oriented.

Vista del Mar is a residential treatment center and as such has a totally different context than that of either Jewish Big Brothers or Jewish Family Service. Here the environment itself is used as an

important therapeutic tool and much attention is directed to the present experiences of daily living and interactions. There are regularly scheduled sessions for each child to see a worker at least once a week. The client population of this agency ranges from mildly disturbed to severely so, short of "in need of hospitalization."

Of the three agencies, Jewish Family Service handles the widest range of clients in terms of age and, consequently, types of problems, though it does not treat any severely disturbed clients; such clients are referred elsewhere. In addition to these therapeutic services which tend to be short term in nature, the agency also provides various concrete services.

Respondents

In order to locate workers in these agencies with experience in working with children of Holocaust survivors, a short postcard questionnaire (Appendix B) was included with a letter (Appendix A) introducing the researcher, and describing the purpose of the study. This questionnaire contained questions to establish (1) whether the respondent has had experience working with children of survivors, (2) if the response was affirmative, an estimated number of such clients with whom the worker has had contact in the last six months, last year, and in total during his or her practice, and (3) what would be preferred times of availability for an interview.

The letter with enclosed postcard questionnaire were sent to all the full-time social workers on staff of each agency: twenty-one from Jewish Family Service, fifteen from Vista del Mar, and nine from Jewish Big Brothers.

Interviews were to be arranged with ten workers in all: six from Jewish Family Service, two from Vista del Mar and two from Jewish Big Brothers.

Of the twenty-one Jewish Family Service workers contacted thirteen claimed to have had experience, four had not, and four did not respond at all. Among the fifteen workers contacted at Vista del Mar, there were six who stated they had experience, four who claimed to have had none and six who did not respond. Among the nine workers of Jewish Big Brothers, five responded affirmatively, one negatively and three did not respond. Only one respondent of all the respondents who claimed to have had experience, indicated that she was not available for an interview.

Due to the researcher's time limitations, the ten respondents were selected partly on the basis of promptness in replying to the postcard questionnaire and availability for an interview.

With regard to Jewish Family Service and Jewish Big Brothers, an attempt was made to vary the location of the workers, since these agencies do have more than one office location. Thus, three of the six Jewish Family Service workers interviewed were from the West Los Angeles office, and two from the central office in Los Angeles. Of the two Jewish Big Brothers interviewed, one was from the Van Nuys office and the other from the Eastern area. As indicated earlier, Vista del Mar has only one location.

Another factor taken into consideration in the selection of respondents was the researcher's desire to vary the amount of worker experience with regard to treating children of survivors. In view of this, amount of experience was divided into three categories: workers

who had treated one to three child of survivor clients were classified as having had little or limited experience; workers who had treated four to six such clients were designated as experienced or having had "some" experience; and workers who had treated more than six such clients were classified as having had extensive experience. As a result of this consideration five respondents interviewed had had limited experience, three had had "some" experience and two had extensive experience.

A few of the workers who responded to the initial inquiry expressed interest in participating in the study. One said, "Glad to help," and another, "Interesting idea for a study."

All workers contacted for interviews were very responsive and cooperative. The researcher was well received by all at the time of the interview.

Interviews took place in all but two of the workers' offices; of the remaining two, one was interviewed at her home and one at the researcher's home. Duration of interviews ranged from half an hour to an hour. All interviews were taped with the respondents' permission and notes were taken during the interviews.

Analysis of Data

Only the overt verbal responses themselves were analyzed, as the researcher felt that analysis of non-verbal responses would tend to be too vulnerable to the researcher's subjective bias. Even so, the researcher realizes that the verbal responses do constitute highly subjective data and can only be viewed as such.

Limitations

1. It is important to point out that the subjective data gathered were affected by the extent of conscious awareness, selective recall and the ability of respondents to reconstruct past experiences and recapture accompanying feelings and attitudes. In view of these limitations, it is recognized that the data gathered from the ten respondents interviewed cannot be considered conclusive, nor can they be generalized to a broader universe.

2. In order to provide the broadest latitude for respondents' replies, the workers were not provided with an operational definition of the term countertransference. Therefore, each worker responded to the term in the context of their own understanding. As a result, there is a lack of consistency of the term's meaning from worker to worker and researcher to worker.

3. Although a conscious attempt was made by the researcher to administer questions in an objective manner, it is possible that certain biases or other messages may have been communicated that may have affected the responses of the interviewees. Having said this, the researcher feels the need to lay out her strong conviction that the Holocaust experience of the survivor parents will inevitably have some significant effect on the personality development of the child, although this does not necessarily connote adverse or debilitating effects. Furthermore, the researcher feels a need to acknowledge the bias she experienced towards one worker who

(a) knew nothing about second generation effects and saw no possible connection between survivor parents' Holocaust experiences and their children's problems.

(b) discounted the possibility that the Holocaust experience that parents endured had rendered them incapable or damaged in their ability to be effective parents,

(c) seemed to project his own discomfort and unwillingness to discuss Holocaust material onto children of survivor clients.

4. Quite obviously, only those workers who were aware that they had worked with children of survivors could be contacted for discussion of possible countertransference reactions. The possibility does exist that some of the workers claiming to have had no experience with children of survivors may, in fact, have had some although they were quite unaware of this piece of information about their clients' background, due to a variety of reasons. One such reason might be an extreme countertransference reaction itself: if a worker unconsciously fears or avoids Holocaust material, he or she may fail to pick up certain clues or explore certain issues which might uncover the avoided material. This is an unavoidable limitation of this study.

5. Two social workers at the West Los Angeles office of Jewish Family Service had, at the time of the interviewing process, been involved in running groups for children of survivors. The fact that these two workers are running such groups may in itself be a sensitizing force to Jewish Family Service workers, particularly those working at the West Los Angeles office. One worker interviewed did acknowledge this to be the case.

6. A few questions designed to gather further information related to workers' reactions proved to contribute relatively little significant information to the topic. The questions referred to include:

(a) How do you feel about working with children of survivors?

(b) Did you find any ways in which working with children of survivors was different?

(c) Can you think of any ways that the knowledge that these clients were children of survivors affected your perceptions of or reactions to them as clients?

(d) Did you find your role as facilitator of these clients' separation more difficult due to the nature of the parents' past experiences and present needs?

It is interesting to note that paradoxically these (a-d) are all questions which explore the workers' awareness of countertransference. The fact that these questions did not produce a great deal of information confirm the idea that explanation of unconscious material by direct question is quite difficult if not impossible.

CHAPTER IV

FINDINGS

Description of Respondents

Ten respondents were interviewed, all of whom were social workers. Among the ten, there was some range in years experience as a social worker. Experience ranged from eight months to twenty-eight years, the median being fourteen years.

Most workers described their training as psychodynamic or analytic, yet claimed to utilize more than one particular kind of therapeutic approach at present. Other approaches mentioned include: Gestalt, Transactional Analysis and Ego Psychology. Many labeled themselves as ecclectic. With few exceptions, most workers interviewed had been involved in some form of therapy for themselves.

Half of the respondents had been with their present agency for ten and one-half to sixteen years, while the other half had been there for eight months to eight years. The mean number of years is 8.6 with 12 as the mode. Half of those interviewed have worked for another Jewish agency prior to their current employment.

Identification of Children of Survivors

The fact that a client was a child of a survivor became known to the workers in one of the following ways, in order of frequency:

(1) If the child was young, or the parents were involved in treatment, the parents brought it up.

(2) The fact was revealed at intake when background information and family history was gathered.

(3) The fact became known as a result of the worker taking a family history as a routine part of treatment.

(4) The worker surmised the fact, either as a result of awareness of second generation effects or from some intuitive sense, and then checked out his or her suspicion with the client.

(5) The client identified him or herself as a child of survivors at some point in time during the course of treatment.

Generally, the fact tended to come up rather early in the treatment process through one of the aforementioned means. Once revealed, the therapist was usually the one to bring it up for discussion if he or she deemed it relevant or appropriate.

Most of the children of survivors the respondents worked with ranged in age from ten to twenty-five years, with the majority in their late teens at the time of entering treatment.[1]

Treatment Issues

The presenting problems and emerging issues with regard to these clients varied, except for issues of separation and individualization which were characteristic issues for all of these clients.[2] Parents' overprotectiveness, guilt related to parents, and discrepant value systems from those of parents were also common themes in

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[1]The two very experienced workers spoke in very general terms and therefore did not discuss specific client's ages.

[2]Several workers commented that these issues are not at all uncommon for clients of this age group, regardless of family background. Differences that may exist between these clients and others their age may be quantitative rather than qualitative.

treatment.

A few workers did not consider the fact that a client was a child of survivors to be particularly significant or relevant to the individual's treatment. One of these, a worker from the residential setting, claimed, "What happened twenty, thirty, years ago isn't relevant in helping the family to deal with the kid." Talking about it [the parents' experiences] would almost give [the parents] a rationalization to continue to be ineffective." This worker felt it most important to focus on "here and now" daily activities.

Those workers who did not feel the factor was relevant tended not to bring it up for discussion at all. However, one such worker did say that, on one occasion, he did discuss the factor a bit with one boy in order to enable him to better understand his father's behavior. When asked how it affected treatment, he replied that it did seem to undermine the boy's pathology a bit.

Another worker who did not see the factor as relevant and tended not to discuss it had referred a woman to a group for children of survivors, as the client had expressed such an interest, but the worker never discussed the Holocaust-related material in individual therapy.

However, this same worker admitted that she probably is "not sufficiently sensitized to the 'whole thing' to ask certain questions and pick up certain clues." This may account for her not identifying more clients who may have been children of survivors and for not discussing the material with those who had been identified as such. The worker herself said "There may have been more that I haven't known."

The remaining workers did see the factor as relevant and significant, with several of them going so far as to qualify their

affirmative reply with "very," "absolutely" and the like. One worker commented at the beginning of the interview that after receiving my letter, she began to think about the survivor parents, their experiences and their children. That is when she realized that the child's problems had a lot to do with parents' experiences. All of these workers felt there were times when the issue needed to be explored, and if the clients did not bring it up, the workers did. The only exceptions were when therapists were working with very young or very disturbed children and did not feel the children were capable of understanding such material.

There were a few workers who considered it absolutely essential to discuss the factor. As one worker put it, "I think it is always important. Secrets in Holocaust families are like a wall for the child. . . . The client needs to break this wall. You [the therapist] need to help the child realize this." Later, she summarized thus, "A gap [created by secrets] is an experience you go through but it doesn't register." These gaps, she feels, need to be filled in.

Another worker stated that the issue of concentration camp experience of the parents is part of the child's history and therefore needs to be dealt with. Speaking more about the survivors themselves and then about their children, she said, "I've always been open and encourage clients to talk about their experiences . . . to put it on the table . . . for them to see that other people don't see it as a stigma attached."

The last two workers who had extensive experience working with children of survivors added that, though they feel it is important to bring up the issue, they tend to bring it up in "little pieces," and

that they judge each situation differently.

Nearly all the workers who saw the factor as relevant seemed to feel it was important for child of survivor clients to understand their parents' behavior and attitudes in the context of their experiences. As one worker put it, "It was a factor they needed to understand, although it didn't make it [their parents' attitude or behavior] right or any easier."

Most of the respondents did not change the direction of treatment once the factor was known. Having worked with one or two child of survivor cases initially, few made any changes in treatment plans with subsequent clients of this population. One worker did note a change in treatment with child of survivor clients but attributed the change to her getting her Master's degree in this country and further training in psychotherapy. Before doing so, she reflected, she handled such things "much too superficially."

Another worker, who did not find out until after two or three treatment sessions that a client was a child of survivors, found that there was a change in the treatment process because the new knowledge did explain a great deal of the client's difficulties. This worker then shared these insights with his client who in turn found them startling, but later, helpful.

One of the workers who had not seen the factor as relevant and tended not to bring it up, replied in response to the question about change of direction of treatment, "This may sound wrong, but I don't think so."

Most workers felt they had handled the cases as well as could be expected under the circumstances of the parents' resistance or the

child's pathology. They said they would not handle the case much differently now, if given the chance. One worker did say she would have liked to have had the client in treatment longer. A second said the same but added that she would have related the termination of treatment to Holocaust-related losses. A third worker stated that he would have brought the factor to the fore sooner. One other worker, who first replied she would not have handled the case any differently, said after a moment of thought, "Maybe he [the client] should have had a male therapist."

Countertransference Reactions

Since, as stated earlier, workers were not given any particular definition of the term countertransference, it is important to emphasize here, that findings were gathered within the context of the workers' understanding. Responses will be analyzed from the framework of understanding held by the researcher.[3]

With the researcher's definition in mind, it can be said that more than half of the workers did indicate awareness of actual or potential countertransference reactions, while the remainder claimed that they did not experience any such reactions. It should be again noted that the only countertransference reactions that can be claimed or discussed are those that can be brought to conscious awareness.

It is also important to note that some workers did mention strong emotional reactions to Holocaust material other than that directly related to treatment with children of Holocaust survivors. Such reactions may or may not have contributed to countertransference

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[3]See Chapter III, pages 13-14 above.

difficulties in dealing with children of survivors. Workers shared their emotional reactions to Holocaust material occurring both in and outside of the therapeutic arena. Several of them mentioned that they experienced difficulties working with the survivors themselves. One worker told of an incident in which a survivor client during one session of treatment, pulled out a picture of the mounds of dead bodies. The worker's reaction, as she put it, was one of a feeling "walloped in the gut." She called the incident bizarre and said, "it gets you." When questioned about her response, she replied, "It throws you out of a professional stance."

Another worker said that she did tend to reach out more to survivor clients than to others, encouraging them to come to treatment.

An example from outside the therapeutic arena came from a worker who, in discussion of the TV program, "The Holocaust," mentioned that she had decided not to watch it as she had made an earlier decision not to watch any more Holocaust programming because it was too much for her. She had also been reluctant to let her children watch the program until her husband convinced her otherwise.

Still another worker made reference to the program, saying, "I don't like to watch it . . . when you see it visually, it can be pretty hairy." Emotional reactions such as these are common and likely to be experienced by anyone in such instances. However, they may be indicative of potential vulnerability to countertransference reactions.

As intrapsychic dynamics vary from individual to individual, so do the reactions. Reactions of the six workers claiming to have experienced them include the following:

Worker 1:

> . . . I found two things happening: I found myself being sympathetic to where the parents were, and at the same time angry with the fact that they weren't really amenable to changing for their kinds. . . . It was very hard for me to deal with those two factors because on the one hand I felt some guilt about my anger and on the other hand, I knew that my anger was justified.

This worker also described how the Holocaust had affected his own family of origin in that some of his relatives, especially his grandfather, had been victims. His grandfather's tragic death as such a victim, and other such tragedies caused his parents to turn away from Judaism to another religion and therefore, not raise him as a Jew. It was only as a result of the worker's later personal life experiences that he began to identify as a Jew and become actively involved in the Jewish community. When asked if these personal experiences affected his work with children of survivors, his reply was that the question was an interesting one, but difficult to answer. After further thought he said, "I think I'm past it. I think I could deal with it with a lot less countertransference than I did at the time."[4]

When questioned whether such countertransference was something he was aware of at the time or rather in retrospect, he replied that he sees now how it could have affected him then. He adds that there are other factors that have contributed to minimize these countertransference effects now. One factor is that he now has six more years experience as a therapist than the five he had then; the second is that he has been in therapy since then. The latter has enabled him to be more in touch with himself, and therefore much less prone to unconscious

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[4]This worker had dealt with children of survivors a few years prior to the interview.

countertransference reactions that might impair effective treatment.

Worker 2:

> I felt some pulling back in myself in terms of . . . irrational kind of shame or guilt in myself for what had happened. . . . How can I ever understand what that experience was about? . . . I was aware of some feeling of annoyance, resentment, anger, that the parents were putting a tremendous burden on their kids because of what they'd lived through. . . . The anger toward the parents was really anger toward the Holocaust.

Worker 3:

> I didn't want to talk about it [the Holocaust experience]. It was hard for me. I felt that I wouldn't be able to separate myself from their experience and that I would get terribly upset--not just empathetically, but that I would identify with it too much.

When the researcher asked whether these reactions affected treatment, the worker replied, "Well, I hope not. I was aware of it. I tried not to let that creep in. I'm sure it did at times, but not in a big way because I was aware of it and how I felt."

This worker also stated that whereas she would push non-survivor parents to stretch their capacity for parenting, with regard to parents who are Holocaust survivors, she felt she could not because: (1) She did not feel they were changeable ("It would be like accusing them for being short"), and (2) she felt that whatever adjustments they had made had been necessary for their own welfare to be able to cope. Later discussion revealed that although this worker would probably not be inclined to stifle a survivor parent's discussion of Holocaust experiences, she might be reluctant to encourage it, even if it might be therapeutically beneficial. At the same time, she also said that there was value in anything that could enable her to feel for and with

her clients. This worker also claimed to have taken more time in careful planning of treatment for the children of survivors than other clients.

Worker 4:

> I guess that I have certain expectations of clients which is that they be clients, and I felt that change was something that was very, very difficult and foreign for both [survivor] families, and that was difficult for me.

After describing parents as manic, fast talking, well defended, loosely organized and quite disturbed, the worker commented,

> it was more than just viewing them clinically that way. . . . I think I did have some negative countertransference, mainly to this father [of a boy who had run away "underground," imitating what his father had done during the war].

Later in the interview she said,

> . . . I said negative, talking about countertransference . . . you know that's not really true. With this little boy's mother, I think I am very saddened. When she talks about it [her Holocaust experience], I think it probably does get in the way . . . but I also see she's going to lose him [her son] unless there's some change.

Worker 5:

> I'm sure there's considerable--[countertransference] . . . I had survivor guilt as a Jew. I would have been Anne Frank's age; certainly that was an important factor in my life, and in my reactions. So, I'm sure there must be some over-identification.

Worker 6:

> . . . with the children there's something in common they all evoked, something peculiar; they evoked tremendous nurturing in me, combined with anger and repulsion. It's really weird, I don't have such opposites together . . . and these are not just words. . . . I found myself very mothering toward Saul.[5]

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[5]The name of the client has been changed for the purpose of confidentiality.

> He calls me a lot. Of all people, I've given him my home phone number. There's two others [clients] that I have, but they're clearly suicidal. Saul is depressed, but not suicidal. Anyway, I sometimes spend forty minutes on the phone with him--without minding, and he seems to expect it . . . and I don't get angry. And yet, at the same time, there's something repulsive about him. . . . I feel like I'm sticky afterwards.
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> I feel like they're [child of survivor clients] milking me . . . like I'm a big breast they're just draining. And yet I have more energy for them even when I didn't know [they were children of survivors].

This worker's ambivalence is further reflected by his saying at one point, "I find myself so patient!" And, at another speaking of his anger, "Once in a while, I just feel really drained and irritated!" Responding to these clients' lack of appreciation, he says, "I get really pissed . . . who the hell are they?" And adds, "All these people are so withholding and yet they need you, so, in one sense, it's flattering."

About the survivor parents, the worker comments, "It was almost like having a hallucination in a really intense session; I'd see a monster. . . ."

Four workers claimed that they did not experience countertransference reactions, at least none that they were aware of. Two of these four accounted for their lack of such reactions by the fact that they had dealt only minimally, if at all, with Holocaust-related material. One of these two added that another reason for the lack of countertransference was that the Holocaust, at least indirectly, had been so much a part of her growing up. She and her parents had written "affidavits" for relations in Europe, and on occasion, housed those who had been fortunate enough to escape to the United States. When asked whether feelings about her own family and related experiences were

activated in treating a child-of-survivor client, she replied, "Not so much. . . . I guess I've dealt with it." She then added, "I think it would be harder for those who weren't aware [of what went on during the Holocaust]." At a later point in the interview, this same worker said, "I know that it was an accident of fate that we [she and her immediate family] were here and they other relatives [were there] in Europe ."

Another worker who claimed not to have had any difficulties in the area of countertransference does say in reference to her listening to discussion by survivors of their experiences, "It is pretty shaking. . . . It's not very pretty [the descriptions]." This worker says she dealt with her potential countertransference in her own therapy. As she explained, "How does one deal with one's anger? Like many of my colleagues, I have been in psychoanalysis. . . . I think I needed to deal with all these issues . . . about the unfairness . . . separation, loss . . . whatever."

This worker did comment that as a supervisor, she did see other workers who have difficulities dealing with Holocaust material. She feels most of them are afraid of such material. She pointed out, ". . . you must be aware of one thing--if you're afraid of the content that comes out, you can't work with people like that."

One worker who claimed not to have had any countertransference difficulty stated that she related to one child of survivors client in a positive cultural sense. As a child of German Jewish immigrants herself [though not actually survivors] she felt more able to identify with the client's cultural and generational differences. This worker, too, has dealt with many of her own problem issues in her own therapy.

At least one of the four workers who claimed to have had no

countertransference reactions did, in fact, demonstrate some possible evidence of having such. The reason this worker cited for refraining from discussion of Holocaust related material was, "The kids tend to think of the Holocaust as a cowboys and Indians thing." In response to a question whether any clients had ever actually said that, the worker replied, "No." At another point in the interview, the same worker added, "If we spoke about the Holocaust, we would have alienated or emphasized the differences of these kids. I think there was the element of 'oh, here it comes again, or, we've heard that before!'" When the researcher asked whether such attitudes had ever been actually expressed, the worker's reply was "No, . . . but I felt that in terms of what we did, it was not directly related." Such accounts suggest possible projections on the part of the worker.

In addition to asking workers to describe their countertransference reactions, workers were asked how they dealt with them. The most common response was that they remained aware of them, and by so doing, were able to keep them in abeyance and not let them interfere with effective treatment to any significant degree. A couple of workers added that they discussed their responses in supervision. One worker also shared her frustration with the survivor parents. While another worker said, "I just tried to tone down doing their work for them."

As indicated earlier, specific questions relating to worker's reactions yielded very little significant information. In response to the question on workers' feelings about working with children of survivors, most said it was no different from working with other clients. However, the researcher noted that at least four workers did mention at

one point or another during the interview that these clients were particularly likeable or "favorite" clients.

The second question whether workers found any differences working with this client population turned out to be redundant, as most replied, "No," though one worker said she found these cases to be more interesting. Another common response was that workers did find these cases to be particularly challenging. As one respondent explained, such cases were not easy, but she felt especially committed and did like the challenge they offered.

In response to the third question, most workers did not feel that the knowledge of the factor that clients were children of survivors affected their perceptions or attitudes toward the client, though the few who felt it did thought it did so in a constructive way. As one worker put it, it gave him "a handle" on the case. A few stated that the awareness of the parents' experiences made them more sensitive to, and aware of, potential problems that the child of survivor client might be experiencing.

As to the fourth question, whether workers found their role as facilitators of the child's separation to be more difficult due to the nature of the parents' past experience and present need as survivors, the workers answered the question on two different levels. Most workers did claim that their task as such a facilitator was more difficult because the parents were resistant to letting go and were not working to make a good separation. However, responding to the more personal side of the question--whether the workers themselves had more difficulty--there was a different quality in the replies. One worker clearly said she did feel herself unable to push the parents to do their

part in working for the separation from their children. She considered this inability of hers to be due to her awareness of the severity of the parents' trauma. Another worker indicated some ambivalence, and finally replied, "No, not really. I guess partially because I feel the only way they [parents] can retain the child as a love object is if they allow the child to grow and separate." This worker did indicate during the course of the interview that she was quite touched and saddened by hearing about the mother's concentration camp experience which she felt allowed her to be more understanding.

Distinctive Features Identified by Respondents

When workers were asked whether they could identify distinctive features of children of survivors, several claimed they could, while others said they could not. One worker who could not discern distinctive features did say he could discern a common theme regarding the parents. He described the theme as an implied attitude by the parents of "look what we've been through . . . we're not going to invest more energy in our children's problems." He felt their attitude was one of "sitting back, and letting things happen," of not taking any responsibility, not interacting, and not trying to deal at all with the problems. He added that they seemed to try to avoid confrontation at all costs.

Among the workers who described what they discerned as distinctive features, the most common was the difficulty these clients had in separating from their parents. This characteristic was mentioned by nearly all the workers, including those who did not see distinctive features per se. While many of these workers felt this characteristic

was a function of the clients' developmental stage, several felt that it was more intensified due to the nature of their parents' experiences.

Two other distinctive features commonly cited were the difficulty to trust and feelings of guilt. Beyond these features just cited, there were differences among workers as to what they perceived as common distinctive features. What workers perceived to be characteristic features included the following:

-- Passive aggressive, withholding, lacking initiative, unable to complete tasks, having a tendency to sabatoge endeavors, parasitical, dull, droopy and dismal, rigid, oblivious, and isolated from feelings.

-- Out of "sync" with other children of today, with regard to physical appearance and speech patterns: a definite physical, audible, and generational culture conflict.

-- Feeling responsible for their parents' reactions, unable to express anger, especially to "fragile" parents whom they feared to damage.

-- Ambivalent object relations, difficulty being open to others, and difficulty establishing meaning in their lives separate and apart from their parents.

-- Difficulty dealing with parents' overprotectiveness and demands for closeness.

Treatment Modalities

In some interviews, workers offered their opinions regarding appropriate treatment approaches.

Both workers with extensive experience felt very strongly that family therapy was not the best approach. One stated that survivor families tend to be too massively defended. One worker felt Gestalt and Transactional Analysis to be inappropriate treatment methods because they did not tap into defenses which she feels is needed to produce change. A few workers did mention they felt it important to try to do family therapy but did not achieve much success.

Some workers discussed their views on those children of survivors who never enter treatment. Several of them felt that they probably had sufficient ego strength to become well-functioning adults. A couple of workers felt that all children of survivors would benefit from therapy, or if not therapy per se, then at least a family life education group with other children of survivors. One worker said that she doubted that many children of survivors were capable of reaching their full potential as well-functioning adults without confronting the issue. She said these comments about children of survivors in this country because she did feel that in Israel there is less need for treatment or family life education groups for survivor families because Holocaust experiences and issues are dealt with much more openly.

Familiarity with Relevant Clinical Literature

Towards the end of the interview, workers were asked whether they had done any reading about this client population. More than half replied that they had done some, but for the most part, some referred to one or two articles. Both workers with extensive experience have done considerably more reading than the others, and have their need to do still more.

With only one exception, all interviewees expressed a desire or interest to learn more about this client population. Responses ranged from a casual, "Yes," to an emphatic "Yes!", "Absolutely!" The one worker who had not seen any clinical significance of the factor did express interest in the results of this study.

Training Program

Nearly all respondents said they would be interested in a training program, were their agencies to offer one. One worker even responded, "Sure, I'd be the first to enroll!" Those interested also offered some ideas as to what should be included in the program as well as how it should be run. There were, of course, differences of opinion as to what the emphases and approaches for the program should be. One worker wanted it to be more educationally oriented while most of the others wanted a more clinical emphasis using literature and case material. One of the latter also stated that he would like to include discussions of Holocaust experiences with survivors themselves.

One worker felt that in order for such a training program to be worthwhile, it should be run weekly or bi-monthly for a long time--perhaps even a year--rather than one short course or seminar. Although such a training program cannot be made mandatory, this worker felt that it should be.

Another suggested that the program should be run by someone who is very experienced in working with this client population and geared to a high level for those already working with survivors. She added that it might be necessary to run the program on two levels: one for inexperienced workers and one for experienced ones. Workers stated that

they would want the following addressed or included in the training program:

- Educational information on the Holocaust itself.
- "Topnotch" clinical material.
- Discussion of the strengths and weaknesses of survivors and their children. As one worker indicated, "We only see the extremes."
- Sensitization of workers to the severe trauma that survivor parents endured. A couple of workers would like to hear survivors themselves talk about their feelings and experiences in order to better understand them and their children.
- Discussion of compensations, over-compensations and other defense strategies that survivor parents employ, the effects these have on the children, and how these defenses should be dealt with.
- Discussion on loss, especially severe and manifold losses as that experienced by the survivor parents, and how to deal with it in treatment.
- Addressing of the question whether or not effects of the Holocaust on the survivors are reversible.
- Discussion of the similarities and differences of the effects on victims of the Holocaust to victims and their children of other long term trauma or disaster.
- Discussion of ways in which the survivor syndrome is passed on to subsequent generations and how this cycle can be broken.
- Discussion of ways to deal with the resistance of this client population and their parents.
- Discussion of approaches to facilitate separation and individualization of survivor children from their parents, deal with the resistance, and to minimize the ill effects on the parents.
- Explanation of the pros and cons of family or individual therapy, as well as of long term or short term therapy, for children of survivors.

In response to a question, many workers stated that they did not really know, but they thought their colleagues tended to be aware of and sensitive to the needs of this group and probably would be

interested in a training program or seminar about this client population.

Summary

In summary, workers became aware that clients were children of survivors through one of the following ways in order of frequency: parental identification, as a result of a worker surmising the factor and then confirming it with the client, and client self-identification.

Although presenting problems and emerging issues differed among these clients, difficulty around separation from parents was the most marked issue of commonality.

Most workers saw the fact that clients were children of survivors to be relevant, and of these several considered it important enough to discuss and explore further in treatment. Most of those who saw the factor as relevant indicated awareness of actual or potential countertransference reactions. These reactions manifested in feelings of sympathy, anger, resentment, and annoyance toward the survivor parents, guilt and shame for the Holocaust itself, identification with victims of the Holocaust and excessive protectiveness and nurturance of the child of survivor clients. Among those who neither saw the factor as relevant nor claimed any potential or actual countertransference, there seemed to be some indication to the researcher of possible countertransference nonetheless, in one case by virtue of the worker's total unwillingness to consider the possible relation between the client's behavior or problems and the fact that he was a child of survivors.

Once aware that a client was a child of survivors, most workers did not change treatment plans. Regarding their own awareness of

potential or actual countertransference, most workers felt that it did not interfere with effective treatment since they were aware and could keep such reactions in abeyance.

Nearly all workers expressed some interest in learning more about second generation effects and an opportunity to share and discuss the advantages and liabilities of various treatment approaches.

CHAPTER V

FINAL CHAPTER

The long lasting effects of the Holocaust on the lives of survivors have made their impression on the lives of survivors' children as well. Nearly all children of survivors have had to grapple in some way with the fate and outcome of their parents' horrendous experiences. For some, this has led to feelings of inadequacy, guilt, anger, and fear. For others, there are problems of identity as Jews in a non-Jewish world or as bearers of names of those killed unmercifully in the prime of their lives. There are even some who experience the same symptoms as their parents did while in the camps, including auditory and visual hallucinations, psychosomatic symptoms such as headaches, colitis, and severe and long lasting depression.

Although a good many children of survivors have adequate ego strength to be well-functioning adults, able to confront and resolve their own conflicts satisfactorily, there still remain a sizeable number who would benefit from professional help to enable them to deal with some of the conflicts, symptoms and struggles that face them as children of survivors. They need to understand their parents, to know about their lives, so that they can move on to fulfill their own needs and live in a way that is personally meaningful and satisfying to them. Clinicians are in a position to help facilitate this move so that these children of survivors can return to their parents in a healthy separate adult way.

Such a task is not an easy one for a clinician. The Holocaust is a trauma well beyond the comprehension of most people, and as such may cause even the best of therapists to inhibit discussion of it, become frightened, over-identify with its victims, ignore it, discount it, forget it, or become enraged. Reactions such as these have the potential of thwarting effective treatment.

It is the professional judgment of clinicians such as Kestenberg, Axelrod, Rabkin, and Appelburg--that the Holocaust experiences of a client's parents should be considered a potentially relevant and significant part of that individual's history, and dealt with accordingly. To do so, the therapist first needs to be aware of the existence of this piece of the client's background. Such awareness may require familiarity with second generation manifestations. In addition, a therapist needs to be aware of his or her own reactions to the Holocaust, its survivors, and their families. If a therapist is so aware, he or she can prevent such reactions from interfering with effective treatment.

The exploratory study, "Working with Children of Holocaust Survivors: The Therapist's Response," addresses questions relating to how mental health professionals, namely ten social workers from some Los Angeles Jewish agencies, are dealing with this client population, and their role as therapists. It was this researcher's hypothesis that, although all therapists are subject to countertransference reactions as varied as the personalities of therapists themselves, survivors, children of survivors, and the Holocaust related material they present, particularly tends to elicit such reactions due to the highly charged nature of the Holocaust itself.

Some of the specific questions addressed in the study and resultant responses follow:

I. How did these workers come to know that their clients were children of survivors?

There were a variety of ways that clients were identified. Listed in order of most to least common they include:

-- Survivor parents sharing this information when they were involved in the treatment process, especially where a younger child or adolescent was the "identified patient."

-- Workers learning about it at the time of intake.

-- Workers collecting family history information in the course of treatment.

-- Workers surmising it and then having it confirmed by the client.

-- Client's self-identification.

Generally the factor tended to emerge rather early in the treatment process.

II. Do these workers see the fact that a client is a child of survivors to be relevant to the individual's issues of treatment?

Although a few did not see the factor as relevant, more than half did and felt it important enough to explore and discuss further. The few who did not see the factor as relevant seemed to indicate that they had not seriously contemplated the significance of such a factor, and as a result did not discuss any material related to the Holocaust with their clients. This raised the question by the researcher as to whether these workers were avoiding such discussion.

III. Did any of these workers experience difficulties themselves working with this client population in the way of counter-transference reactions?

Workers described their various reactions in the following ways:

-- Experiencing conflicting feelings of anger, sympathy, resentment and annoyance toward the survivor parents.

-- Awareness of various internal feelings of anger, sadness, etc., that were actually feelings toward the Holocaust itself.

-- Feelings of shame and guilt about the occurrence of the Holocaust (those workers who were at least old enough to be young adults at the time of World War II).

-- Over-identification with the victims, for example, with one of the Holocaust's most remembered victims, Anne Frank. (One worker was aware that Anne Frank would have been her age had Frank not been killed.)

-- Difficulty talking about the Holocaust and related events.

-- Becoming excessively available and nurturing to the child of survivor clients even when it was not clinically warranted.

Generally, workers claiming such reactions felt that since they were aware of them such reactions did not thwart effective treatment.

IV. Did workers find any common features among this client population?

Those characteristics cited as common features by most of the clinicians were:

-- Difficulty around individuation and separation from parents.

-- Ambivalence or difficulty in the ability to trust others.

-- Feelings of guilt.

Some of the characteristics cited as common features by

individual workers included:

-- "passive aggressive, withholding, lacking initiative, unable to complete tasks, having a tendency to sabatoge endeavors"

-- "parasitical"

-- "dull, droopy and dismal"

-- "rigid"

-- "isolated from feelings"

-- "out of 'sync' with other children of today with regard to physical appearance and speech patterns"

-- "feelings of responsibility for parental reactions, and thus unable to express anger, especially to survivor parents perceived as 'fragile'"

-- "ambivalent object relations"

-- "difficulty establishing meaning in their lives separate from parents"

-- "difficulty dealing with parental overprotectiveness and demands for closeness"

V. How many workers knew about potential "Second Generation Effects?"

More than half of those interviewed indicated that they had done "some" (minimal) reading about this client population, but for most awareness of such was limited.

VI. Were workers interested in learning more?

Nearly all workers interviewed expressed the desire and interest to learn more and felt that a training program or seminar about this population would be worthwhile. Many offered suggestions as to what they felt should be included if such a training program were to be offered. Some of their comments have been incorporated into the recommendations which follow.

Recommendations

Although the sample for this research project was a small one and therefore may lack statistical significance, it may be speculated that the findings herein are indicative of workers' responses and lack of knowledge in other Jewish agencies that serve children of survivors. With this in mind the following recommendations are put forth.

1. The researcher proposes an in-service training program for Jewish counseling agencies that would address potential second generation effects of clients, and countertransference reactions of therapists in the treatment of children of Holocaust survivors. Three subject areas of primary importance should be addressed in such a program.

   a. Information about the Holocaust itself, the horrendous experience that survivors endured, and the subsequent long-lasting effects ranging from the never-ending reoccurrence of painful memories to more severe symptomatology collectively referred to as "survivor syndrome." This can help a therapist to better understand survivors so that he or she can better help children of survivors to understand their parents and confront their parent's experiences, especially in those cases where the parents themselves don't talk about it with their children.

   b. Information about therapist responses that are likely to be evoked by Holocaust-related material; vulnerability to countertransference reactions and how best to minimize their deleterious effects on treatment. Awareness is half the battle in trying to minimize the negative effects of therapist reactions

trying to minimize the negative effects of therapist reactions in therapy, as many outstanding clinicians concur.

c. Information about the possible second generation effects, how to recognize them, and how to evaluate their possible relatedness to any given client's problems. Also, information regarding common treatment difficulties that arise when working with this client population and their families.

Such information would enable therapists to more easily identify children of survivors and facilitate the client's exploration, confrontation and resolution of issues and conflicts related to the parent's experiences. Therapists would also have the opportunity to learn about and discuss advantages and liabilities of various treatment approaches in order to best serve this client population.

2. It is recommended that those Jewish counseling agencies in cities with large Jewish populations where there are likely to be significant numbers of survivors and children of survivors seriously consider offering a training program addressing the areas proposed above. The most suitable format would be one including presentation of information as well as opportunity for sharing, support and peer consultation in an on-going fashion for some extended period of time, perhaps six to eight weeks. For Jewish agencies located in cities of lesser Jewish population, where there are likely to be fewer survivors and children of survivors, it is proposed that a one-time seminar be offered to stimulate awareness, and that

pertinent resource material be made available upon request.

In summary, if the Jewish community is to avoid the perpetuation of the debilitating effects of the Holocaust from generation to generation, we, the agencies of the Jewish community, must do all we can now to serve the needs of survivors and their families as effectively as possible.

APPENDICES

APPENDIX A

INITIAL LETTER TO POTENTIAL RESPONDENTS

This letter is an attempt to enlist your aid in a research project I am doing for the Double Masters Degrees of Jewish Communal Service and Social Work. I am presently a student at Hebrew Union College.

My study is an attempt to explore the experiences of clinical workers working with children of Holocaust survivors.

First of all, I would like to get some idea of the frequency with which workers have had professional contact with children of Holocaust survivors.

Secondly, I would like to explore the experiences of the workers in greater depth.

For the first part, I would appreciate your filling out the enclosed card in order to facilitate the second part. Please indicate a convenient time for me to contact you.

Should you have any questions, I can be reached at the following number in the evenings: 839-7460. On Tuesdays and Thursdays I can be contacted at the Freda Mohr Multi-Purpose Center for Senior Citizens at: 655-5141.

Many thanks for your assistance to me and hopefully to the Jewish community as well.

Sincerely yours,

Robin E. Moss

M.S.W. Intern

APPENDIX B

POSTCARD

____ Yes, I have worked with children of Holocaust survivors.

I estimate (# of clients) ____ in the last 6 months

____ in the last year

____ during my practice

____ No, I have not worked with children of Holocaust survivors to my knowledge.

The best times to reach me re: arrangements for an interview are: (Please include days and times)

Phone No. at which I can be contacted:

Remarks:

APPENDIX C

INTERVIEW GUIDE

INTRODUCTION

As I indicated in the letter, I'm interested in exploring the areas of treatment of children of Holocaust survivors. I would like (later, I'll welcome any questions) to begin with some background questions.

General Information:

How long have you been working as a social worker?

How long have you been working for this agency?

Have you ever worked for another Jewish Agency before?

Explanation:

Before we begin, I'd like to clarify what I mean by the terms "Holocaust survivor" and "child of survivor." By "survivor," I mean someone who has lived through the concentration camp or work camp experience, lived in hiding, participated in a partisan or other resistance group, or masqueraded as a non-Jew during the Holocaust. By "child of survivor," I refer to a child of one or both survivor parents who either was born after the Holocaust or has not him or herself been subject to persecution or maltreatment during the Holocaust.

Treatment Process:

I understand you've had some experience working with children of Holocaust survivors. Could you tell me about it?

Include: How did you come to know that a client was a child of survivors?

At what point in treatment did the factor become known?

Who first brought it up--if it was--for discussion?

In what context was it discussed?

What were the presenting problems?

What were other emerging issues of therapeutic significance?

Describe generally the course of treatment.

How important or influential a factor was their being a child of survivors with regard to the identifying problem and emerging issues?

Were there any situations when the significance of the events in their parents' lives were or could have been discussed?

How did you feel you handled the case?

(For workers with more than one or two child of survivor clients):

Were there any ways your work changed from first starting to work with this client population in later cases?

Is there any thing you'd do differently if you had the chance now?

Countertransference:

Did you find you had any difficulties of the kind often referred to as "countertransference?"

How do you feel about working with children of Holocaust survivors?

Did you find any ways it's different working with this client population?

Can you think of any ways that the knowledge that a client was a child of survivors affected your perceptions of, or reactions to, the client?

Did you find your role as facilitator of a child of survivors' separation more difficult given the awareness of the parents' Holocaust experiences?

Can you think of any ways your own experience may have affected the way you have dealt with these cases?

Where were you born? Your parents?

May I ask if any of your relatives were directly affected by the Holocaust?

(If Yes) I would imagine this had some impact on you and how you perceived these clients. Am I correct? In what way?

Extent of Reading--Interest in Training Program:

Have you done any reading about children of survivors?

(If So) How much?

If your agency were to run a training session or seminar about this client population, would you be interested?

What would you like to see included?

Do you think other workers in your agency would be interested?

Do you have any questions of me?

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