

THE TRANSMISSION OF TRAUMA THROUGH  
CARETAKING PATTERNS OF BEHAVIOR  
IN HOLOCAUST FAMILIES: RE-ENACTMENTS IN A  
FACILITATED LONG-TERM SECOND-GENERATION  
GROUP

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ABSTRACT

*In 1980, thirty-five years after the end of World War II, the long-term impact of war-trauma on individuals' lives led to concern about Post-Traumatic Stress Disorder. While the focus here is not on "disorders," it is on interactive patterns of "defensive" caretaking behaviors which contribute to intergenerational transmission of anxiety, silence and losses related to the Holocaust. In this long-term group, defensive caretaking patterns are conceptualized as second-generation behaviors which focus on parental needs thereby avoiding addressing second-generation vulnerabilities. Relevant concepts of Sullivan, Winnicott, Bion and Fairbairn are applied. In an innovative trauma group design, defensive caretaking patterns are illustrated through clinical examples and interventions by the therapist as a "validating object" work to mitigate transmission to still the next generation.*

*Holocaust Silences*

After World War II, Holocaust survivors focused on creating daily routines rather than on the impact genocide had on their emotional well-being (Brown, 1995a). American society, too, wished to bury the painful memories of the war and the mental health field was not yet prepared to struggle with the ways "war traumas" affected individuals' lives. Thirty-five years later, in 1980, things had changed. Survivors were beginning to meet together at reunions which included all who had survived under Nazi rule, not only those who had survived the camps (Bergmann &

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Jucovy, 1982). Books were written about what had truly happened under Hitler (Wiesel, 1978) and about the paralysis that prevented other countries from intervening on behalf of populations in danger of extermination (Wyman, 1984). Moreover, the mental health field was recognizing a new Anxiety Disorder: Post-Traumatic Stress Syndrome (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 1994). Psychological trauma, defined as an overwhelming and life-threatening event which generated "intense fear and helplessness" (*DSM-IV*, 1994, p. 424; Herman, 1992, p. 34), was identified as affecting post-war lives, physiologically (van der Kolk, 1987; Yehuda et al., 1995) as well as psychologically (van der Kolk, 1993).

In this paper, the focus is *not* on "disorders" found in Holocaust survivors or those transmitted to their children, but on the kinds of interpersonal and intergenerational patterns of behavior — *common everyday patterns* through which anxiety and silence are transmitted to the next generation and held in place.

Survivor-parents maintain two kinds of Holocaust silences: conscious and unconscious. In the former, the full story is not told because parents fear they will be retraumatized through remembering, that they will traumatize their children and that they will not be understood if they tell about their experiences. In unconscious silence, denial, splitting, dissociation and/or repression keep the terrorizing events and the repeated psychic assaults outside of awareness and without words. In both forms of silence, the psychic trauma that results from the impact of brutal separations from people whose presence one once took for granted, and the fears for one's own life, are not addressed. These traumas create a "traumatic core" (Gampel 1992, p. 47) which manifests itself behaviorally both as a heightened sensitivity to anxiety and other intense affects, and a diminished capacity to contain and regulate strong affects intrapsychically. These changes permeate the emotional atmosphere in families in ways that have a profound impact on interactions with the next generation.

Although not based on observations of war-traumatized populations, the theoretical frameworks developed by Sullivan (1940), Winnicott (1965), and Bion (1951) contribute relevant concepts which illuminate (1) the impact genocidal terrors and losses have on parents and children vis-à-vis complex patterns of caretaking and (2) the ways in which these particular caretaking patterns both transmit anxiety and reinforce silence as a primary coping mechanism. In the sections that follow I will propose that the heightened anxiety of survivor-parents is transmitted to the next generation initially through "empathic linkage" (Sullivan, 1940), and

that it is sustained by parental silences which offer children no explanations for profound parental upsets and prolonged grief.

In Winnicott's conceptualization of the "facilitative environment," the graduated failures of the "good-enough" mother ("parent" or "surrogate parent" in present-day nomenclature) are thought to be adaptive in that they assure secure attachment, as well as confident, autonomous and open exploration of the world, with minimal fragmentation of the self. In this theory, it is implicit that the "good-enough" mother has received "good-enough" mothering too, having experienced the "normal," manageable difficulties of everyday life, difficulties compatible with her capacity to regulate anxiety both for herself and for her children. Fairbairn (1952), some of whose theories are based on experiences with a war-affected population, elaborates on the intrapsychic processes of ego-splitting (today, we would talk about self-splitting) when significant interpersonal relationships are "too" frustrating for the child to integrate. He theorized that when tensions which arise in the parent/child relationship cannot be regulated, intrapsychic splitting into "good" and "bad" relational parts occurs.

Working contemporaneously with Fairbairn and Winnicott in England after World War II, Bion (1951) introduced the concept of the parent as "container." He emphasized that by accepting and "holding" the child's strong affects, parents prevent the child from being overwhelmed by rage, anxiety, grief and other powerful affective states that are likely to fragment the immature self. The parental container thus creates the conditions necessary for the child to survive strong affective states, and to develop internal structures that effectively modulate and regulate affect. Since many survivor-parents' capacity for "holding" their own heightened affects has been compromised by Holocaust experiences, their capacity to help their children "hold affect" is often circumscribed. When this occurs, children's and parents' needs for containment compete for attention. If children's emotional needs for containment are not met and if in addition, they are faced with the intensity of overpowering parental affects, their tensions heighten and challenge their adaptive capacities. Under such circumstances, many children withdraw their requests for parental care, choosing silence instead. This silence is internalized as an adaptation to the parents' need for help in regulating their own anxiety.

Bar-on (1955, p. 227) refers to the "double walls of silence" where "parents do not tell and children do not ask (speak up)." He adds that even when one opens the window to speak, the others' window is closed. The absence of intergenerational (verbal) communication does not, however,

prevent the transmission of affect. Krystal and Niederland (1971) address how unexplained silences further intensify the affective, fearful power of children's fantasies and dreams that fill in for the untold part of the "Holocaust story."

### *The Rationale for Group Intervention*

The focus on trauma transmission coupled with silence in Holocaust families is not new (Danieli, 1985; Fogelman & Savran, 1979; Kinsler, 1981; Kestenberg, 1982; van der Kolk, 1993). Insofar as intergenerational transmission has occurred within an earlier group setting (i.e., the family of origin), participation in a second-generation group provides opportunities to experience old responses in a new "safe-space" with a "second family" (Yalom, 1985). Here, both attempted "enactments" of the affective underpinnings of attachment patterns, and learned interpersonal patterns of anxiety and affect regulation from early primary relationships can be observed and renegotiated. Group structures and the foci in groups vary, influenced by the different interests and distinctive training and experience of group leaders (Epstein, 1979; Wardi, 1992). Brown's (1995b, 1996) interests center on the role of silence, on anxiety, and on the nature of interpersonal patterns of caretaking, specifically the defensive component of caretaking. She proposes that the defensive component of caretaking, a learned behavioral strategy, acts to maintain anxiety and enforce silence for many in the next generation even though the conscious intention is quite opposite (Brown, 1997).

Brown (1992), herself a child-survivor and a child of survivors was raised within a small community of survivors. She has been observing and exploring intergenerational silences and interactions for many years both personally, while growing up, and professionally, as a workshop leader at Survivor Reunions, a trauma specialist at Trauma Conferences and a facilitator for long-term groups. Her theoretical perspective blends object-relations and learning principles. Group members' narratives of growing up with traumatized parents, and interactions among group members in the long-term second-generation group described below, serve as the data sources in this paper.

### *Goals*

The goals of this paper are: (1) through clinical examples, to define and illustrate the defensive component in caretaking patterns that both prevents second-generation individuals from addressing their anxiety, and enforces silence in parent-child relationships; (2) to present a new concept, that of the second generation's "double loss"; and (3) to describe

the founding of the Intergenerational Healing in Holocaust Families project, and the conceptualization of an innovative group structure, called the "facilitated mixed-model" (FMM) with its twin emphases on anxiety containment and the exploration of feelings around loss.

*Caretaking Patterns of Behavior: Adaptive and Defensive Components*

Typically, caretaking behaviors directed toward others are viewed as laudable. Who would criticize a person for being sensitive to another's needs? If a child rushes home from school so mother will not worry, we think "how kind." If a child comes home from college for mother's birthday, we think "how thoughtful." If a child avoids painful family topics, we think "how understanding." But what if there is an additional motivational source? What if the child must rush home because she is afraid to worry her mother, hurt her father, "cause" pain, and therefore she keeps silent about her own feelings and conflicts, about the reasons for what she is doing. Such inhibitions can hinder the development of intrapsychic mechanisms essential for regulating anxiety and for the development of a separate, secure sense of well-being.

And yet, in many survivor-families, where parental needs to cope with anxiety and children's developmental needs compete, second-generation children perceive and/or fantasize that survivor parents benefit from their caretaking actions. In so doing, children put their own anxiety needs and their requests that parents attend to those needs second. West and Keller (1991) labelled this behavior "parentification," based on Bowlby's (1977) concept of a compulsive care-giving attachment pattern. Main and Hesse (1990) examined this pattern of infant attachment further in relation to parents' unresolved traumatic (non-war) experiences. They reported that the parents' anxious behavior could be frightening to their children. Based on these observations, Main and Solomon (1990) provisionally proposed a "Second-Generation Effect."

The concept of "defensive caretaking" (Brown, 1997) goes beyond the need for what Bowlby describes as "proximity" to parents, and beyond a focus on children "caring for parents" in response to parental needs or fears. Caretaking-behaviors-of-others, the "defensive component of caretaking," is an interaction aimed toward diminishing parental tension by focusing on parents' upsets (caretaking-the-other) in order to *ward off examining the impact on the self of perceived or anticipated parental upset; the fear is that such upset will be overwhelming in ways the child perceives s/he cannot regulate internally alone*. Most often, children do not fully recognize these fears about their own sense of vulnerability, but focus rather on real *and* imagined "fragilities" in their survivor-parents.

These themes were played out in the FMM group, as illustrated by the following exchange illustrating the operation of “defensive caretaking” (names coded):

In one session of the group, Alice stated that she was not getting what she needed and thought she might leave the group. In the following session, Howard told the group he had spoken with Alice between sessions. When the facilitator (EMB) asked him who had called whom, Howard said angrily he had called Alice. EMB asked, “Why did you call?” Surprised and somewhat annoyed, Howard said that he had called because Alice was upset. “And you, were you upset?” EMB asked. “No. I thought it was a nice thing to do.” Everyone agreed it was a “nice” (other-caretaking) thing to do, but EMB persisted and asked Howard what feelings motivated him to call Alice. EMB thought it was important to encourage an upset member to make contact on her own, not because someone was trying to take care of her, but because she had learned to ask for what she might need directly. EMB assumed that it was the person who had called who felt anxious and so she asked Howard, “Did calling make you feel better?” He responded by saying he now felt he had done something wrong. Questioning his behavior had led him to respond to EMB as he responded to his father when his father asked him to account for something he had said or done. EMB said he had done nothing wrong, but he had avoided dealing with his own feelings directly, which hopefully would be more helpful to him in the long run than taking care of Alice now. The exchange ended there. About five sessions later, Howard shared what he had been worrying about when he called Alice. He said he was aware now that he was concerned that if she left the group he would feel abandoned. “Abandonment is a big theme in my life.” In a following group meeting, he reported a dream in which he was slowly and very carefully opening up the “black box” he had spoken of in one of the very first sessions.

Not immediately, but after some sessions, Howard, “the terrified optimist” as he called himself, was able to acknowledge that calling Alice had “protected” him from getting in touch with his concerns around “abandonment.” These had been raised unknowingly, when she said that she might leave the group. The facilitator’s exploration of Howard’s calling Alice functioned to *block the re-enactment* of caretaking-of-other behavior, and *unblocked the motivation* necessary for introspection, thereby allowing Howard to open up the “black box” containing his own anxiety around “being left” (caretaking-of-the-self). Following Howard’s

insight the facilitator then discussed the defensive component of caretaking behaviors didactically with the group. The information provided subsequently became a tool for each group member, helping the members identify defensive caretaking in both in-group and out-of-group interactions.

A second example illustrates how concern for the next generation (“caretaking-others”) can, at times, block the examination of one’s own unresolved childhood sorrows (self-caretaking):

Michael shared that his daughter was still not reading on grade level and had recently been tested in school. It appeared almost as if she “didn’t want to” work on reading. As had been her pattern, Barbara (a school professional) made numerous suggestions.

Howard (to Michael): Is this advice helpful?

Michael: It feels critical.

EMB (to Barbara): Is there something about Michael’s daughter’s reading difficulties that concerns you specifically?

Barbara: Yes (beginning to cry). I had great difficulty starting to read too; I didn’t speak English well and no one seemed to realize it. I felt like I received no help.

EMB: So, you would like to give Michael’s daughter the help you did not receive and ask Michael to pay more attention.

Barbara: In a way yes, but maybe just tell him that it must be very hard for her and for him, too.

In this example, Barbara’s ability to refocus on “caretaking” herself evoked her experience of childhood grief over felt-neglect (the loss of attention), and led her to abandon giving advice to Michael (caretaking-the-other). Instead, she was able to feel increased empathy for Michael and his daughter, a helpful interchange in itself, and one not aimed *only* at the “other.” Initially, she had used “caretaking” to focus exclusively on the other, thereby defending against any examination of her own feelings.

Caretaking-of-others at the expense of caretaking-of-the-self ultimately does not resolve either person’s issues or lead to change. Caretaking-the-other is learned in family-of-origin interactions. It expresses itself through the absence of self-examination over, for example, why one is “afraid” to cross parental boundaries or is hesitant to ask about a parent’s unexplainable outburst or silence. The crucial issue defended against involves examining why one does not ask a particular question or express certain feelings, and why one perceives the motivation for such

silences as a wish not to “hurt” one’s parent(s). In defensive caretaking, second-generation survivors avoid learning about what they anticipate will upset them, if they should ask. In the example involving Howard and Alice, Howard “acts” like a “good guy,” but does not get any lasting relief from his fears of abandonment. Alice is temporarily pleased by Howard’s call, but her frustration around the group process remains as unclear as ever. Very often, without self-examination, caretaking efforts toward others simply repeat themselves, eventually turning into self-devaluing feelings. It is only when attention shifts from the other person to the impact of the other person’s upset on the self and the reason for one’s own upset, is it possible to experience what one truly fears and begin to address those feelings directly. In so doing, one may ultimately experience one’s own strength and autonomy. Since caretaking patterns develop in family-of-origin interactions and are learned patterns of behavior, they can be unlearned despite their dynamic underpinnings. Focusing specifically on trying to understand the complexity of caretaking interactions may trigger larger changes.

Telling parents that they were participating in a second-generation group was not a formal group goal, but quickly became an important issue for each group member. The members carried fearful expectations of their parents’ responses and initially were intimidated by these expectations. Michael was the first to tell his parents about the group. The members’ responses were: “How did you do it?” “Why?” “Why now?” Michael said he felt his “parents were ready.” It seems likely that he too was ready, and telling them provided him with an opportunity to ask questions about the Holocaust he had been wondering about for years. He found his parents receptive and his former fears unfounded. Barbara told her parents considerably later. She expected no response and got none, at first. However, some months later her father began to talk about his Holocaust experiences with her and even went so far as to be videotaped by the Spielberg Foundation saying, “I did it for you because you told me you were interested.” Speaking up in the face of her own anxiety had its rewards. Not only was her father’s response positive, but even more important, she had made her needs known and felt good about doing so.

Experience with parents varies, but the underlying issues are unvarying. In the examples cited, the underlying issues for group members in telling others, particularly their parents, about their participation in this group was a means to an end. Their anxiety about the pain they would cause their parents by talking about the group camouflaged a wish to open the door to Holocaust dialogue. Their anxiety competed with their need to know. They had hesitated about asking certain things before they came

into the group. In the group, they shared anticipated fears of parental upset *as well as* fears about not being able to deal with parental upset. Over time, they recognized that they were fearful about feelings the anticipated parental upset would generate in *them*. These unrecognized, unacknowledged second-generation fears illustrate the dynamics of defensive caretaking as defined here.

Caretaking behaviors are complex containing both adaptive and defensive components, often intertwined in the same action. If both aspects are not understood and worked through, they obscure the complex motivations for caretaking behavior. Fleischman (1997, p. 164) states, "We feel peaceful when our sense of concern is directed outside ourselves toward others, not as a substitute for self-care, but as an extension of it."

*"Double Losses" for Children of Survivors: Concrete and Affective*

Losses cause pain and anxiety that require a grieving process. When people think and talk about Holocaust losses they most often focus on the survivor's losses. The second generation, however, also experiences Holocaust losses despite not having lived through the war. Brown (1995a) describes two sets of second-generation Holocaust losses: concrete, and emotional. Concrete losses involve losses of persons, places, and things, as well as the feelings and fantasies associated with those things. The deaths and disappearance of extended family members involves the loss of persons. Grandparents, aunts, uncles, and/or cousins have disappeared prematurely, and with them, the support and warmth that participation in an extended family brings has also been lost. Losses of place involve the absence of nearby family locales to visit, places where parents grew up and grandparents are buried are simply not accessible. Losses of things include the dearth of meaningful inheritable objects, e.g., family dishes, monogrammed linens, photo albums and the stories that go with each photo.

The impact of concrete losses on the second generation is *different* from the impact these losses have on their parents. For example, the survivor-parent's loss of her mother is the loss of a grandmother for the second generation. The survivor's loss in not being able to visit his/her childhood home, is for the second generation, the loss of the physical setting from which the family came, and a disruption of family roots. The survivor's loss of family photographs (concrete images of lost loved ones) is for the second generation, a loss of *any* image of dead family members, and often, the stories that accompany such pictures. These concrete losses and the intergenerational emotional threads they represent, are direct Holocaust traumata on the second generation. While not

transmitted directly, they often make the second generation uniquely sensitive to their parents' losses.

For many in the second generation, the Holocaust's double loss, the emotional loss, as defined here, is related to how they are affected by their survivor-parents' traumatic core. One change already discussed is the heightened affect transmitted to the second generation through empathic linkage. For example, in the FMM group, one member reported the intense anxiety generated in her mother when she arrived home "five minutes" later than expected from school. "If I was walking home from school and a friend stopped me to talk, I would start to feel very tense in anticipation of my mother's upset over 'where were you.' I knew I wasn't very late but I knew my mother was getting increasingly upset with each passing minute. I would interrupt my friend in order to get home. Now with my children, I get anxious if I see I will arrive home later than they expected. Once I arrived ten minutes later than I thought my son expected of me. I asked him, "Were you worried?" He said, "Not much, maybe a little bit." She herself, could recognize almost immediately upon telling the group this story that the intensity of her upset was related to her experience with her mother and not with her son."

Another change characteristic of the traumatic core is the "variability in emotional availability" (VEA) in many survivor-parents. VEA results from a complex set of conscious and unconscious stimuli which direct parental behaviors with the result that some of the time parents are much more emotionally available to meet their children's needs than at other times. Feelings attached to war memories, anniversary reactions, dimly remembered but excruciating frustrations, stresses of living in a new country and the experience of prolonged mourning often interfere with a parent's reliable presence, i.e., "being there" both as a soothing presence and a container for their children's day-to-day anxieties. The VEA of many survivor-parents is often perceived by the next generation as "distractability," "preoccupation," "short-temper" or "lack of fit." The children experience this often unpredictable variability as frustrating and tension producing. It seems as if, at times, parental behaviors do not correspond to the circumstances of everyday life. For the parents, past experiences often control current reactions. The following examples were reported by FMM group members: (1) "I knew my mother was always more anxious than the mothers of my friends when I wanted to do something away from home"; (2) "My father always told me that they had not had it so bad during the war, but for me being around him was like walking in a minefield"; (3) "My mother wasn't there for me. I had always thought my mother was suffering, but I really knew it when we

went back to Europe and I heard her speak French with friends she had left behind; she became so animated.”

Extremes of under-responsiveness can vary with extremes of over-excitability even when both arise from a common source of parental upset. Examples of under-responsiveness include: “My parents never responded to my report card or asked where I went; in many ways I felt I raised myself”; “When my grandmother died, no one cried.” At the other extreme, some parents exhibit over-excitability about seemingly minor events, e.g., “There was a road repair which held up traffic; my father exploded and began knocking down the orange cones with the car. I was terrified.”

Being there for children and providing a predictable “continuity of being” (Winnicott, 1965) that fits the reality of everyday life requires the non-intrusion of a traumatic past. Frequently, parents who have suffered severe trauma cannot consistently fulfill this requirement. While VEA occurs in non-survivor families, it is *heightened* within all survivor families. Here, the heightened variable availability in survivor parents is newly conceptualized as a loss for members of the second generation. It is the Holocaust’s double loss. Even though not necessarily disabling in everyday life, the double loss requires grieving and healing. For members of the second generation, patterns of defensive caretaking must be addressed for them to deal with the feelings related to the double loss that results from the psychic changes in their parents. In other words, trying to caretake-the-other develops in an effort to restore *indirectly* second-generation loss(es) experienced in the parent-child relationship. In large measure, caretaking involves an attempt to help parents repair themselves so they can then be more responsive and more reliably available to the needs of the children who caretake them. Helping members of the second generation care for themselves can be understood as a strategy aimed at addressing their Holocaust losses *directly*. It prevents their losses from being minimized in the shadow of survivor losses, and recognizes these losses as different and significant.

Noteworthy is that the anxiety raised in children when parents are variably available is not intergenerationally transmitted anxiety, but anxiety generated by the double loss, the loss inherent in parents’ variable emotional availability due to the Holocaust. In this sense it is a new “trauma” related to the psychic changes in their parents which children perceive as a loss to themselves and a loss they fear others will not understand and they cannot regulate on their own.

*Intergenerational Healing in Holocaust Families: A New Trauma Group Structure, the "Facilitated Mixed Model" (FMM)*

The FMM group was developed as part of a project called the Intergenerational Healing in Holocaust Families at the University of Massachusetts (Brown, 1993). Brown initiated the project as a result of her growing awareness that many child survivors raised in silence by their survivor-parents had raised their own children in silence too. In pursuing insights gained while attending International Child Survivor Meetings from 1993 to the present, Brown ran notices in local Amherst-Northampton, Massachusetts newspapers, where she lives, announcing a general meeting for the children of survivors (the "second generation"). Forty-five second-generation survivors expressed interest in the meeting, a very large number for an area with a total population of 32,000. Half the respondents inquired about whether or not they "qualified" as "second generation." As the adult children of survivor-parents many of whom did not claim survivorship, they were unclear about their own Holocaust names and identities. One story will illustrate: "My father, an underground resistance fighter, survived the murder of his entire family (personal communication, 1993), but as he was not in a camp, he did not consider himself a survivor. Can you tell me, do I qualify as second-generation?" Increasingly, all parents who survived under Nazi rule are now recognized as survivors. Their children are called the "second generation."

Twenty second-generation survivors attended the first general meeting. When Brown asked why they had come they shared their parents' Holocaust stories, not their own. Initially, they said nothing about being raised by traumatized parents. At the end of the meeting, Brown was asked about her reasons for calling the meeting. She shared her hope that small groups would form and offered a facilitated mixed-model (FMM) ten-week group. She added that sessions would be taped and releases signed so the coded (to preserve confidentiality) transcripts could be made available to persons studying trauma groups and trauma transmission. There would be a fee for the FMM group. The response was mixed. Some were eager to join such a group: "Ten weeks sound great; things won't get too hot"; others were passionately critical and suspicious: "It would make me feel like an object; like what Hitler did with my parents." Over the first few years, one FMM group and two support groups formed.

Apart from exploring the experience of growing up in survivor families, the one clear goal for the FMM group was to encourage increased self-expression of hidden (silenced) feelings. Brown recognized that this process would develop slowly, given family injunctions

against direct affective expression, especially around pain and anxiety. The mixed-model group structure was designed intuitively to be sensitive to the heightened anxiety experienced by the second generation. Ten-week cycles were offered to reduce the anxiety inherent in an open-ended group structure (Rutan & Stone, 1993, p. 235).

An initial, pre-group interview was scheduled with each person interested in participating. That meeting was structured to explore two main questions: (1) What is your family's Holocaust story? (2) What is your own Holocaust story; i.e., your experience of what it was like to be raised by traumatized parents? Two secondary questions were added: (1) What is your earliest memory? and (2) What fears do you have? In addition to the information elicited, these questions were designed to convey several important messages to the participants: (a) that the second generation has two different stories to tell, the first about their parents' experience and the second about their own; (b) that the second generation's Holocaust identity is separate from their parents and is important; and (c) that the second generation's story needs to be told, heard, and validated.

The FMM group began with seven members and now has five. At present there are two men and three women ranging in age from 40 to 50. All are married except one. Four have children; one has already lost his parents; all have limited extended families because of deaths incurred during the Holocaust. All are Caucasian and middle class. None were born in their parents' countries of origin due to the dispersion that occurs when families are victims of genocide. All but one have been in long-term individual treatment; that individual entered individual treatment during the course of the group.

All the group members were seen for an individual session at the end of the first ten-week cycle, and at the end of every cycle thereafter. These sessions provided a scheduled opportunity to express anxiety that was not articulated in the group, directly to the facilitator. In addition, members were told they could request individual sessions at any time during the cycles. Toward the end of each cycle, the group-as-a-whole discussed whether the group would continue for another cycle, and whether individual members wished to continue. The structure of starting and stopping at the end of ten-week cycles created an in-group need for individual and joint decision-making at the end of each cycle. By definition, decision-making causes anxiety. Who is going to continue/terminate? What will the impact be on the group? When will the group meet again? On what day and at what time? This decision-making process created a "here and now" in-group situation where tensions within and between individuals were aroused. Old and new caretaking

patterns were “played out,” observed, discussed, and re-aligned by all present. For these group members, all of whom had grown up in families decimated in the Holocaust, discussions about ending and separating were particularly evocative. To date, the group has met for 15 cycles, the equivalent of four years. During the first year two members who requested repeated individual sessions left the group.

Building in an individual session at the end of each cycle was a unique but critical parameter both for anxiety containment and anxiety expression. The individual sessions offered a predictable point of contact with the facilitator, thus creating a structure wherein group members would be encouraged to “contain” the anxieties they were reluctant to discuss in the group — heightened by histories of transmitted anxiety, intergenerational loss, and silence — until a specific time when they had the opportunity to express them directly to the facilitator. During these sessions the facilitator discussed the risk that members might use the individual session to bypass group sessions. Members were encouraged to bring material from their individual sessions into the group meetings, which most did almost immediately and all did eventually. Typically, members used the individual sessions to seek support from the facilitator for their anxiety about group issues before addressing these issues in the group; e.g., “X’s lateness upsets me. I was wondering if I should bring it up”; or “We are talking too much about other people and not ourselves. Do others mention this too?”

From the facilitator’s viewpoint, the individual sessions at the end of cycles provided opportunities to reduce member anxieties and to open channels for communication within the group for members who wished to continue for an additional cycle. The facilitator viewed requests for additional individual sessions during a cycle as an indication that a member was experiencing more anxiety than s/he could manage, and was not able to wait for the end-of-cycle session. These requests reflected individual attempts to manage anxiety so as to continue participating constructively in the group.

### *Research*

Relevant scales were not identified in a search of the literature so a series of self-designed paper and pencil materials were created (obtainable from author). These were distributed twice: before and after the first cycle. Participants were asked to complete the forms outside of group sessions. One scale — a bipolar adjective-check list on which self-ratings and ratings for each parent using a seven-point scale were sought — generated objections. Some group members protested vigorously against

rating parents on this scale. Remarks included: "Scales trivialize our (parents') being", "My father would kill me if he knew I was filling this out on him", "What do you mean by the word 'perception'?" No one filled out the parent-scales completely; two people left them completely blank. Participants did rate themselves, however, using the same scales. Understanding that scales such as these have limitations, group members' defensiveness on their parents' behalf was both noteworthy and consistent with the formulation for defensive-caretaking patterns. The scale will be redistributed at a later date and the meaning of being asked to "rate parents" will be discussed further.

### *Reflections on the FMM Group*

The FMM group structure is planned for use with trauma groups. It blends therapy, support and education, but establishes a "frame" similar to that utilized in therapy groups (Yalom, 1985). It differed in that the facilitator revealed more about herself than usual, in part because she and the group members live in a small town and in part, because her published autobiographical writings are readily available. Being a survivor is not a prerequisite for facilitating a FMM group. There are different issues for facilitators who are survivors and for those who are not. During its four years of meeting, the group was invited to participate in a Holocaust program and members agreed to present their individual stories and the story of the group on a panel with the facilitator. Presenting the stories of a long-term group is unique. The presentation was videotaped, with group consent. In addition, the group met outside of formal sessions on two occasions: once to see *Schindler's List* and once to join a member for her son's bris. Otherwise, social activity was discussed and rejected as a group goal.

As conceptualized by the author, the FMM group neither precludes nor competes with individual treatment. Initially, the facilitator thought it would be better not to meet individually with members of the group because of possible conflicts of interest, and the risk of heightening competition between group members. This issue is now open to reconsideration since the two persons who left the group had asked to meet with the facilitator individually on a more regular basis.

The most critical aspects of the facilitator's role in this first FMM group has been to "give permission" to members to express their feelings and have them validated. Feelings of anxiety and lack of safety filled the first cycle. During the group process the following interventions guided the work and are viewed as uniquely applicable to work with the second generation. They grew out of the theoretical ideas presented earlier: (1)

interventions focusing specifically on inquiring about and interrupting patterns of “defensive caretaking” with its inhibiting effect on self-expression, (2) interventions involving psychoeducation that were designed to shift group members’ focus from taking-care-of-others, to examining their own fears, conflicts and vulnerabilities, and (3) the facilitator’s consistent intervention as a “validating object.” Validation is a term that professionals debate. As used here, validation begins as an internal process whereby *feelings* aroused in the *facilitator/listener* by the significant emotional components of a member’s story, become external as the facilitator articulates “the unarticulated”; giving words to the emotional impact the story is having on her. In this way, unacknowledged and unexpressed feelings (anxiety, anger, pain, joy, grief, etc.) are validated because of the impact they make on another. The role of the validating object does not focus on interpreting. It is not understood as a caretaking behavior because it is not focused on reducing anxiety either for the speaker or the listener. Rather, it focuses on creating a framework in which identifying and expressing feelings is valued and supported. Ideally, the validating object models (1) how group members can connect with their own feelings when listening to the emotional content of another’s story; (2) how they can become more self-confident in finding words for their own feelings, thereby breaking silences; and (3) how they can develop the skills necessary to become validating objects for one another.

### *Summary*

Interest in the impact of trauma on individuals’ psyches over time has grown substantially since the 1980s when the mental health field recognized a new Anxiety Disorder: Post-Traumatic Stress Disorder. However, interest in and understanding of the impact that being raised by severely traumatized parents has on children, has grown less rapidly. The “double” losses of the second generation of Holocaust survivors, both concrete and emotional, have received far less attention and validation than they are due. Intergenerational Healing in Holocaust Families was founded to address some still unanswered questions about the impact trauma in survivor-parents has on their children — the second generation. Initially, seven members of the second generation volunteered for a cycle of ten weekly group sessions. For more than four years, five members of that group have participated in repeated ten-week cycles for the purpose of sharing their own stories of the Holocaust — stories of what it was like to be raised by traumatized parents.

The facilitated mixed-model structure used was a newly designed

trauma group format focused to contain the heightened anxiety often transmitted in Holocaust families, and thereby encourage greater affective self-expression in regard to multiple, complex second-generation losses. Emerging from the narratives and observations of group interaction, as well as the author's ongoing exploration of her own Holocaust background, is the thesis that the defensive component of "caretaking" prevents many of the second generation from recognizing and resolving their own significant issues. This thesis informed the facilitator's role in the group. By emphasizing psychoeducational interventions, interrupting enactments of old caretaking patterns, and validating unarticulated affect, the facilitator encouraged new, more insightful interactional patterns in the group members.

The framework for caretaking presented here is not focused on pathology. It does not apply exclusively to Holocaust survivor families, and may have relevance for the second generation in families where parents have undergone other forms of severe trauma and loss. One of the questions that remains is: What is the impact on the third generation if the second generation does not reflect on and speak about their "inherited" silence and losses? The impact trauma has in Holocaust families is viewed not only as a parent-child issue, but also as a generational issue and a group issue. Based on insights derived from the careful study of Holocaust families, intergenerational transmission of trauma is also viewed as an issue that profoundly affects all of contemporary society.

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