

**A CHILD SURVIVOR OF THE HOLOCAUST
COMES OUT OF HIDING:
TWO STORIES OF TRAUMA**

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Abstract

This paper is a personal narrative of the author's Holocaust story, the experience of her war trauma as a very young "child survivor," and aspects of her two therapies and hospitalization experiences, all of which helped to reshape the author's professional endeavors. Within the narrative, she compares experiences in her personal treatments to highlight what main qualities in the therapist's person and stance were both helpful and a hindrance for her, and what elements she, the patient, may have brought to each of these endeavors. Prevailing psychoanalytic culture and the sociopolitical climate of the times are considered as some other variables that affected the treatment.

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I lived inside a wall for a long time
A wall I built unknowingly.
It protected me from others' indifference
And protected me from baring sensitivities carved
deep within the inner reaches of my soul.

The wall was concrete
Roughly textured with a surface of gray grit
Enclosing me, safely
In a self-created isolation

Protected from the outer world
No one paid attention to what lay deep within.
Like a bear in winter, I was asleep and breathing
Unlike a bear, I did not emerge each spring.

Others could not see I lived inside a wall
I could not see . . .
Me . . . clearly
I could not see the wall.

In the decades of the '60s and the '70s, there was little interest in the needs of the Holocaust family and particularly child survivors, and there existed a conspiracy of silence (Danieli, 1985), not only in American society, but also in the analytic community. This was not as true for other minority groups. Women (Friedan, 1963), blacks (Grofman, 2000), Chicanos (Salvador, 2001), American Indians (AIM, www.dickshovel.com/AIMintro.html), gays and lesbians (McDarrah & McDarrah, 1994), and eventually those in the Anti-War Movement, all clamored for recognition and equal rights with some success. With the end of the Vietnam War and the influx of returning veterans, interest in war trauma was stimulated in the general psychiatric community and led to the inclusion of post-traumatic stress disorder in the *Diagnostic and Statistical Manual of Mental Disorders (III)* in 1980. However Holocaust trauma and childhood war trauma, and its impact on children's development, did not yet gain specific attention. Some attributed this lack of attention, in part, to the apparent lack of interest in the needs of the Holocaust family in American society (Wyman, 1984). It is noteworthy that in this country, in the early '70s, there existed no Holocaust Museum in Washington, no movies like *Shoah*, Claude Lanzmann's 1985 epic Holocaust documentary, little media coverage of survivor issues, and no

national day set aside to memorialize those lost in the Shoah (Hebrew name for the Holocaust).

There was also a predominant silence in the Holocaust community itself, except for a very few, who were able to write their stories down in the decade and a half following the war; these included Frankl (1946), Levi (1959), and Wiesel (1958). From the early initial contacts between the psychiatric community and survivors over the issue of assessing reparations (Kestenberg, 1982), there emerged a “survivor syndrome” (Niederland, 1968) considered by some to reflect a limited understanding of the psychological impact of Holocaust war trauma (Krell, 1997). This may have added to the general feeling that no one would understand a survivor’s experience because it was too unimaginable. How could nonsurvivors be asked to relate to the extreme terror of daily threats to life and separations from loved ones most often not to be seen again. Bar-On (1995) pointed out that there was silence, too, in many survivor families, “a double wall of silence,” where children did not ask questions, and most parents did not talk to their children about what had happened.

It was only in the early ’80s, that child survivors were distinguished, as a group from adult survivors and given their name (Moskovitz, personal communication, March 3, 2005). In 1983, Moskovitz published her book, *Love Despite Hate: Child Survivors of the Holocaust and Their Adult Lives*, in which she followed up on 24 child survivors taken to Lingfield, England, from the mainland of Europe during the war. At this time too, Kestenberg and Kestenberg (1982) began to point out that psychoanalysts were failing to explore adequately the unique Holocaust history of the child survivor. Moskovitz (personal communication, March 3, 2005) concurred and added that in the early ’70s, psychoanalysts were continuing their habitual ways of working, exploring such developmental issues as toilet training and oedipal themes, while taking little notice of the impact of wartime disruptions, such as the loss, terror, helplessness, and suffering experienced by survivor children. In addition, she felt that many psychiatrists could not believe the stories and memories they heard and therefore gave the message that they did not wish to listen or understand. The term used most about child survivors were that they were “damaged.” Terms such as their “resilience,” “courage,” “adaptability,” and “endurance” were mentioned rarely.

In the early 1980s, a decade after the author began her first treatment, Milton and Judith Kestenberg cofounded the International Study of the Organized Persecution of Child Survivors of the Holocaust and began semistructured, audio-taped interviewing of these child survivors. Moskovitz on the west coast and Gampel (1992) in Israel joined this effort,

followed by Krell (1985), a child survivor, in Vancouver, Canada, who had begun video-taping the interviews with child survivors. Thus began a concerted focus on listening to child survivor stories in a new way, validating for them the importance of their traumatic memories from the war. Krell for the purpose of a common understanding would delineate “child survivors” further identifying them as having lived under Nazi rule and not older than 16 by the end of the war. This age was chosen to demarcate those children still under the care of adults; those 17 years and older were viewed as fending for themselves and making more of their own decisions. Such a definition, while arbitrary, helps to distinguish the child survivor group from adult survivors and from members of the second generation. The latter includes those children born to survivors, either after the war ended or during the war, but not in countries overtaken by Hitler.

It should be noted that by this time and already in 1979, Dori Laub, a child survivor, and Laurel Vlock began the video-taping of initially, adult survivor testimony, which eventually led to the founding of the Fortunoff Video Archive for Holocaust Testimonies at Yale (Felman & Laub, 1992). Adult survivor memoirs were also being written at that time in greater numbers. Simultaneously, Helen Epstein (1979) would publish her pioneering book, *Children of the Holocaust: Conversations with Sons and Daughters of Survivors*, which helped to draw attention to the second generation. Child survivors were less noticeable, in part because they remained more “hidden” in the general population and were fewer in number. Child survivors would get noticed and increasingly differentiated only when they, themselves, began to organize their own large conferences, the first of which occurred in New York City in 1991 sponsored by the Hidden Child Foundation/Anti-Defamation League and when they began to publish their own child survivor memoirs (Lobel, 1998; Richman, 2002). The memoir of Richman is of particular interest because she reflects on her therapies and the “hiddenness” of her first therapist.

In 1996, Kestenberg and Brenner (himself, a member of the second generation), in their book: *The Last Witness: The Child Survivor of the Holocaust*, hoped to share with mental health professionals some of the issues confronting child survivors from concentration camps as well as those who had been in hiding, concerns that were different from the problems facing adult survivor and second generation groups. Of essential importance was their highlighting that in working with the child survivor her *capacity to mourn her own unique losses needed to be reinstated* and with this, talking would follow. This insight confirmed what the author found as she broke her silence in her second therapy (discussed later in this paper) and began to share and record her own story.

Writing aided her in examining her feelings (Pennebaker & Seagal, 1999) and helped her to break her silence with her children. In the early '90s, she sent some of her essays to Elie Wiesel with the hopes of meeting him, which she did. Wiesel told her to write down her life story saying, "It is the most important thing a survivor can do." The author spent the next year of 1995, writing her memoir, "Through the Concrete Wall: A Child Survivor Comes Out of Hiding," a compilation of poems and prose. However, she was unable to find a publisher. It is noteworthy that in this memoir the author did not include her "failed therapy experience." This was the last secret about which she remained silent, even though some years earlier, she had spoken with Dr. Kestenberg about the importance of trying *to understand failures in treatment . . . from the patient's point of view*, especially where the patient is a therapist . . . and a child survivor.

The Narrative of My Child Survivor History and My First Therapy

My life unfolded in chapters during the years of my silence and after the late '80s. By then, I was in my early fifties, in a long marriage with a family, and expecting my first grandchild. In addition, I had a busy career as a practicing clinical psychologist and was just beginning to write and speak on matters of the Holocaust. I broke my silence because of the fruitful work in my second therapy; my first therapeutic experience crushed my spirit and my self-confidence for some years. During the decade in between the two therapeutic experiences, I tried to make sense of what had gone wrong. I do not know, even now, that what I write here is the "right" interpretation of this time in my life, but I feel it is the right time to write about it and make it public.

Therapists infrequently write about their failed treatment with patients (Reppen & Shulman, 2003); patients write even less frequently of their own failed treatment process; it is understandable. It is a hard thing to do. And therapists speak even more rarely of the details of their own personal therapy experiences (Guntrip, 1975) and hospitalizations (Little, 1990; Rogers, 1995). I do not believe that is because such events do not happen. If my experience is at all typical, it points to how very difficult it is to talk about any kind of "failure" in one's life, especially if it reflects so directly on one's sense of self.

Adding to my difficulty in speaking about this time in my life was that the events occurred in the early '70s when few people talked about being in psychotherapy at all, much less their own failures in therapy. It was a

time when speaking of being in treatment or having been hospitalized led more to a feeling of being stigmatized than the expectation of an empathic response. Furthermore, to speak of a failed therapy means that patients must speak about their own vulnerabilities before and after the event, and what they were not in control of, did not know, and did not foresee. In addition, where a hospitalization is involved, a therapist/patient needs to have reached a point where her sense of public humiliation and shame has subsided. I had to give up the inhibitions aroused by feeling that the therapist must have known more than I, and that the failure occurred “only” because there was something basically wrong with me. It was not until I entered a second therapy, a decade later that these feelings toward myself began to ease, and then, lift.

It should be kept in mind that what is reported here is just one person’s experience. As such, generalizations that can be made from the data are limited; still, aspects of the paper may apply to some individuals’ understanding of parts of their own treatment process.

I began treatment with my first analyst, a psychiatrist, (referred to as BL) in the fall of 1972. I had just moved to a small university town in Western Massachusetts with my husband and three children. My mother wanted to be closer to us, so my parents left New York City and moved directly into our home on the same day we did. I wondered briefly if this was what I wanted, but I did not give voice to my doubts.

I chose to work with BL as he had been highly recommended to me by a number of colleagues at the small, well-known psychoanalytically oriented hospital where I worked. BL was described as well trained, well regarded, and was considered to be a Mensch, a person with an exemplary kind and human heart. I thought this would be a good person for me to work with. I did not yet connect my early Holocaust history of losses, abandonment and physical trauma, and the nature of my relationship with my mother or my father’s long absences from home as reasons for self-exploration. Instead, I focused on wanting to experience a training analysis for the purpose of becoming an analyst myself.

In my first session with BL, he was welcoming and friendly, all of which I gathered from his benevolent smile and quiet air. He offered me a chair and took the armchair opposite me. In some order, I began to tell him about myself and that I knew I wanted to become a psychologist by the age of 13 years. I was hoping to try and understand my mother in this way, not realizing it was me I needed to understand. My mother had had preexisting psychiatric difficulties prior to the war, times of great terror during the war, and a major depression when I was 8 years old. My father, who was very involved with his work and becoming a financial success in America, as he

had been in Europe, left me alone for long periods of time with my ill mother. This responsibility frightened me, both because of her erratic behavior and the fear of losing her . . . again.

While my relationship with my father was affected by his long periods of absences from home and his general lack of involvement with my everyday life, I did feel him to be a loving presence. He had a wonderful smile and sense of *joie de vivre* when he was relaxed and not too tired from his work. At Chanukah, and once, when I ran for elective office in my high school, I remember him joining my activities in a lighthearted and helpful way. At these times, he would tease me—to my delight—though this was often interrupted by my mother's abrupt instruction for him to *horauf* (stop). My father never acted to counter my mother or protect our time together; he avoided conflict with her. I never said, "No" to her either and do not recall ever having an occasion to say, "No" to my father. My paternal grandfather died when my father was 3 and his mother was murdered in Theresienstadt, but he did not talk about these things with me and I knew not to ask him questions. In retrospect, I did not want to cause him (or my mother) more pain; I surmised that they had had enough already. Such feelings are not atypical for children of Holocaust survivors.

When I was about 8 years old, I began violin lessons. My teacher was a concert violinist and a graduate student in clinical psychology. As she taught me where to place my fingers and how to use the bow, she talked with me about human relationships and human interactions. No one in my family—not my father or my mother—had ever talked with me about such personal things. From my conversations with my teacher, I gathered that clinical psychologists were interested in understanding relationships and their dynamics and that from such analyses an understanding of a person would arise. Toward that goal, I majored in psychology in college and directly thereafter went to graduate school, to which my father said, "Have a good time." I smiled, but said nothing. I received my Ph.D. in clinical psychology in 1967 at the age of 29.

The first job of my career, working in a school for disadvantaged children, was cut short when my husband, a physician, was drafted. It was the time of the Vietnam War and our orders were to relocate from New York City to Westover Air Force base in Massachusetts. Once there, I began a part-time position as a research assistant at the small, psychoanalytically oriented psychiatric hospital mentioned earlier. This exposure to things analytical raised my interest in becoming an analyst. Toward this end, I left my research position to take a clinical job, elsewhere. It was at this time that I sought to enter a training analysis with BL.

BL listened attentively to all I said and occasionally nodded. I appreciated that he listened to me and gave me his attention, although his prolonged silences and reserved manner made me feel insecure. I wondered what he was thinking and what he thought of me and what I was saying. Up to now, my knowledge of treatment had come mainly from lectures, seminars, and books, and while I imagined that the experience of treatment would be different, I had not anticipated how unsettled it would make me feel.

I went on to tell BL the outline of what had been told to me of my very early life in Europe during the Holocaust. I had been only 3 when the family immigrated to the United States, and so I hardly remembered anything on my own. Most of what I knew, I had picked up in bits and pieces from my extended family. It was only much later, and through much exploration on my own, that these fragments were put together. I told BL that I was born in Germany on July 13, 1938, and that after my birth, my mother took ill and left me for an unknown period of time. I was cared for by a series of baby nurses all looking to emigrate. Kristallnacht occurred four months later and due to the courage of my father and some good fortune, we were able, finally, to leave Germany (more details on Kristallnacht can be found in Brown, 2006).

We immigrated to France where, after some months, my father was declared a “foreign alien” and was rounded up and sent to a detention camp. I was separated from him for almost a year. In June of 1940, when I was not quite 2 years old, my mother and I were walking on the street of Rue Fulton in Angers, a small city southwest of Paris, with a friend of my mother’s and her young son. It was then that we were caught in one of the very early German bombing raids on France. My mother’s friend was severely wounded and died immediately; her son was unscathed. I was hit in the head and on the right side of my body near my rib cage, which led to a loss of some of my rib cage. As for my mother, her left leg was shattered and, once hospitalized; she had to have it amputated. Meanwhile, I was sewn up and hidden in a Catholic orphanage where nuns in “big white hats” took care of me. No one knew at the time that three pieces of shrapnel remained deep inside my brain.

All that I recalled of these events was the sensation of blood running down my face and a fleeting image of those big white hats. The extent of my psychological trauma from my physical injuries, the abrupt separation from my mother when only a toddler, and the absence of a viable language—German or French—did not surface directly in my therapy. The confusion that I must have felt at the time—the pain, the terror, and the sense of abandonment—lay buried. These traumatic experiences, as well as the total disruption of my family’s life, were never discussed in our

family. The only wound that was acknowledged, though not talked about, was the amputation of my mother's leg. I told BL these facts of the first chapter of my life, dispassionately, and minimized their importance to me. BL listened, but did not respond in any way that I could see or feel. Perhaps had he said something or acted in some way, I might have avoided responding back, but I would have noticed it, just as I registered his nonresponsiveness. I do not recall focusing on my life growing up after the war, a time with its own series of disruptions and repeated separations from my also traumatized parents (Brown, 2006).

During the course of my one year in therapy, I remember focusing on my day-to-day life: my husband, my children, my work, and my hopes of one day becoming an analyst. BL seemed to listen to me carefully and this made me feel my goals were being appreciated. I spoke also of my parents, particularly my mother who was looking to me—demanding of me—for a great deal of support and attention, while I was focused on helping my children resettle and adjusting to a new town myself. BL seemed impressed at how much I was doing and how much I had accomplished by the age of 34. This made me feel my efforts were being noticed, even though I thought, too, that there was much left unsaid about who I was. I did not realize how much I had yet to understand about myself.

On the whole, though, I felt very positive that I could talk with BL, who was someone who paid attention and seemed interested in what I had to say. I think this was accentuated because I had not been listened to as a child. Perhaps this was especially important now because I was in a new town and felt rather isolated and not yet among a network of new friends. Talking to my doctor reduced some tension in me and, while he was very reserved and spoke rarely, he would smile at me, and that felt caring of me. I was aware of wanting to make a good impression on him without truly knowing what would impress him. I began to think about my therapeutic hour, more and more, after it was over. I was unaware that this might mean that I was starting to feel connected to him and that this might make me feel anxious or that feeling connected to him might mobilize things of which I was not aware but unconsciously feared just the same. I think the pattern in my family of hiding true feelings contributed to my transference with BL and led me to exhibit a desire to please or at least impress him, but in no way talk about what I truly felt.

After I had been in treatment for a few months, I remembered referring to something as if “coming out of the clear blue sky,” and I wondered if this thought had something to do with “airplanes in the sky and bombs falling out of nowhere.” I began to wonder about the bombs that had hit my mother and me so long ago, but then I stopped these thoughts from coming, and I

stopped myself from telling these thoughts to BL. I stopped other thoughts, too, thoughts of the sensations of blood running down my face and thoughts about the lines of scarred cross-stitches on my ribs where my body had been hit by shrapnel. "For the longest time I thought that these . . . were rather insignificant, as they . . . fit into no story that I really knew. I would learn, decades later, that this is how very young children remember things, not with words (explicit memory) but through snippets of imagery and sensations (implicit memory) (Brown, 2006, p.61)." Something had happened to me, but I had known not to ask either of my parents questions about the bombing and the injury to me. I did the same with BL. When I did not know or understand the meaning of something, my pattern had always been to keep it to myself. On one hand, I did not want to appear unsure, because I was, and that was scary to me. And I did not want to appear stupid, and not knowing something made me feel a bit that way. Or perhaps it was that in the beginning, and for many years after the war, my parents did not have the energy to be asked questions or to reflect back to me thoughts on my own issues.

In the many ways that I talked with BL, I did not open up with him. I liked him, but in hindsight I would say that something was not working. Some months into the treatment, I was feeling caught between my therapist and my mother. BL and my mother were critical of one another. My mother was threatened and angry at the idea of a competing relationship, while BL, uncharacteristically, criticized my mother's inability to parent me empathically in the past and allow me to become emotionally independent from her now. When my mother criticized BL, I defended him verbally, but wondered about him silently; when he criticized my mother's capacity to parent me empathically, I felt annoyed at him and defensive of my mother. I shared none of these thoughts or feelings. It was only in my second treatment years later that I would appreciate and understand what my first analyst (BL) had meant.

Looking back, I would say that I tried to figure out on my own what to do about my analyst's and my mother's differences and the bond I felt with my mother and the growing connection I felt toward BL. It was like I had a private space within myself, and a public space open to others. The public space is what I shared with him, things about my everyday life, which I might have some questions about; the private space is what I thought about alone, things about which I had feelings and that I did not understand or created conflict for me. That is what I had always done: kept personal things to myself, trying to figure them out alone, through introspection, private readings, and the observations of others. I did this even when I felt in much uncharted territory and very lost, as I was beginning to feel now.

“After all, I was the only child survivor in a family, which left me an only child, with no one to talk to—if, indeed, I would have talked to anyone at all about the war (Brown, 2006, p. 63).”

It was as if somewhere the relationship between my analyst (BL) and me stopped growing. I liked him and felt connected to him, too, but somehow I hesitated in opening up the concrete wall surrounding the core of my innermost feelings. I would learn much later, in my second therapy, that what I was safeguarding was the world of strong feelings, unresolved sorrow, grief, and rage; it was the world of torrents of unwept tears and the myriad of childhood losses. It was the guarded space where a child survivor of a terrible war still harbored the hope that someone, somewhere, would help her feel *safe enough* and *secure enough* to reach out beyond a wall that she, as yet, could not see clearly. BL was not going to be that someone for me; I had a halo around him and protective barriers around myself; I did not recognize either.

As the pressure and confusion mounted behind my sealed lips, I began uncharacteristically to stay in bed as a way, I felt, to decrease outside stimulation and control my rampaging anxiety. Most often I got up when my children returned home from school, but it was an effort. And I did go to my sessions, but I harbored this “magical” idea that if I could stay very still inside, BL would somehow know how to help me, even without my telling him how bad I was feeling, how stuck, how immobilized, and how I felt unable to act to help myself. My independent will seemed to be wiped out. It was as if my mind, one of the strongest parts of my life, had given up. I did not know, and my analyst (BL) did not seem to know either, or at least greatly underestimated, how profoundly I would be affected by my history of trauma and abandonment. Still, I imagined and hoped that in the work with BL, I would pull through. This is what I told my husband, too. But I did not get better; I got worse.

In what would be my next to last session, BL asked me to bring in my husband. He then told us that I needed to be hospitalized, and that I should not come back to see him. He said something to the effect that I had spiraled down to a point where he could no longer be of help to me. He recommended that we use the hospital where my husband had trained. It was then that I asked him what he thought had gone wrong. He said, “I do not know.” I heard the words, but I could not believe them. He was my doctor; others respected him; I thought that he had to have had some understanding of what was going on. I had pinned my magical hopes on him. I had not recognized what was happening to me, not only because I could not comprehend what was going on but also because I thought he knew better; he would help me; he would not abandon me. But in the end that is how I felt.

From one day to the next, my analysis was over and with it much of my self-confidence was shattered.

That day my husband called the hospital in New York City and we drove down for me to be evaluated. The first thing I remember about going through the doors of the hospital was that everything seemed darkened, as if the lights had been turned down. Everything moved slowly, and I did, too. In the meeting with the admissions officer, I tried to appear in control of my thoughts and my rising anxiety, but after what seemed like a few minutes, he said I should be admitted. (I would learn from the hospital record much later that he diagnosed me as depressed with psychotic features.) Someone came to take me where I had to go, and I followed without resistance, though a feeling of great fear of being overwhelmed and helpless to do anything about how I was feeling, arose within me. Still, I did not look back to say good-bye to my husband, once more. I was afraid that if I turned toward him I would collapse and that would make it so much harder for him and for me. I just kept walking . . . afraid.

Initially, I shared a room with an older woman. That night this woman woke me up, stared at me with her crazed and bulging eyes, and scared me half to death. My insides caved in and I screamed. The next morning I was in a room by myself. It was a large room with a bathroom. I was happy about that. Then I faded out and floated away, probably due to the medicine I had been given. I floated in and out for some time and then I became aware of a man sitting in a chair at the foot of my bed. It looked like he was resting there. I was resting. Neither of us said anything. I could see him breathing, as he sat there; I could hear myself breathing, as I lay there. It was quiet, even peaceful. Slowly I would come to know him as my doctor, and slowly, I would be reassured by his presence. I remembered another thing, too: every night a light shone through the partially opened door of the bathroom. It was comforting and I would note it every night, and I would wonder who had known enough to turn it on for me and I could tell, as I was thinking, that my brain was waking up.

And then I remember a visit from my husband, though how much time elapsed in between I do not know. There was Norman, bending over me with his beautiful, beautiful smile, the smile that I had known since I was a teenager, when we had first met in summer camp. A feeling of warm happiness spread over me and it was as if the blood in my veins began to flow again where only water had been moments before, and I could breathe, the way you breathe after a heavy weight is lifted from your chest, amazed that you are free to inhale so easily. And then Norman moved his head downward to kiss me. I tried to raise myself, to meet his kiss halfway, but I could not; Norman did not seem to mind, though. He just bent over me even

more, and then we kissed. In that moment, it was just the two of us. All the empty spaces inside of me disappeared, and I began to feel like myself again. We talked together about the children mostly, and then he left. I felt happy and sad; happy to have seen Norman and hear about my children, sad about all that had happened.

In a later visit, Norman told me that the children would visit me next time with him, not in the hospital, but in the park outside. I was happy and scared—overjoyed at the thought of seeing them, scared at the thought that they would find me different. I knew I was not fully recovered yet, and I felt very bad and very guilty about having had to leave them at all. I had been left too often as a child to ever want to do this to my own children.

The day of the visit was a grayish fall day, cold. As I entered the park, I could see the three of them swinging on swings. When they saw me they came running, and slowly I realized that no matter what had happened to me and no matter that I was away from them, I was still their mother. This was the most significant thing I remember of the visit, not what they said, but the way they acted toward me . . . so happy to see me and so loving. Shortly after that day in the park, my hospital stay ended. It had been three weeks, though at first it felt like my entire life.

In the hospital, with a different psychiatrist (referred to as MA) and with medication, I improved relatively quickly. His treatment of me seemed to be focused on creating a positive and supportive relationship, with the goal of helping me manage and reconstitute my life. MA met also with Norman and it was in these sessions that he explained to Norman that my parents were not to visit me in the hospital, and that we should strongly consider their moving out of our house. I did not know any of this at the time.

Before I was discharged, MA spoke to me about keeping in regular phone contact with him for a few months. He did not recommend entering a treatment again and said that given my horrific early history, the outcome of my treatment with my first analyst (BL), and how well I had functioned prior to my entrance into therapy, it was ill advised. In a final session, we met together with Norman and my parents. At our meeting, my mother did not look well; she looked angry. My father was quiet and thoughtful. My doctor said some words about giving myself time to adjust to being home and then we left for Massachusetts.

Once home, my readjustment went smoothly, and after some weeks, I found myself eager to resume a part-time job. Slowly, I became more aware of my mother's anger toward me, and the burden of our living in the same house. In the safety of a session, I had felt protected; once home again, her behavior began to unsettle me and I came to the decision that we would

have to ask my parents to move out. Acknowledging this was a big step for me and made me consider that despite the failure of my first therapy, it had left me feeling somewhat stronger, though not confident enough to tell my parents of my decision myself. I asked Norman to tell them. He chose to speak with my father alone. Though my father must have had a range of feelings at the news, what he said was, "If it is good for Eva we will do it."

The events of 1973 remained extremely painful and sad for me. I felt very alone with my feelings for a long time. This was one area I did not even talk about immediately with my husband. The chain of events had been so totally unexpected for him, for me. I also could not find the words to explain to my young children, 10, 8, and 6 at the time, why I had "abandoned" them.

For ten years, I did not seek to reenter therapy and I avoided speaking with anyone about what had happened to me. Instead, I looked to my own clinical work to find some of the answers about what had happened in my analysis. I asked myself the questions I had heard from my professors at Cornell and Columbia: What is it that "works" in therapy so that it is healing for the patient, and if it is, how is this goal reached? And if the therapeutic action is minimal, what is "not occurring?" How much interpretation by the therapist is helpful and when does it raise anxieties that interfere with patient flow and the building of the therapist-patient relationship? Moreover, how does one build an empathic bridge toward the patient, so that trust will grow and she will feel encouraged to take the risk of sharing with another, her most vulnerable self?

I began searching the writings of well-known practitioners to see if I could find some further understanding of what had happened to me in my first treatment and some comfort as well. Freud (1940) entertained the possibility that trauma in childhood, due to excessively frightening external events, had yet to be fully grasped, and Ferenczi (1928) questioned whether it was always the patient's resistance that caused failures in treatment or whether it might be related to the analyst's unwillingness to adapt his approach to the patient's psychotherapeutic needs. This felt consoling to me, as if this made me less to blame, though it made me blame my therapist more for a while.

I reread a great deal of the work of Harry Stack Sullivan, the mentor of Otto Will, for whom I had worked. I was taken by Sullivan's words: "We are all much more simply human than otherwise (1940, p. 16)." For me, with my long-held feeling of being different, Sullivan's words felt embracing and accepting. His text seemed to include me with my assumed and real dissimilarities from others and reflected an approach to patient care that I held.

I reread Hannah Green's (1964) *I Never Promised You a Rose Garden* and made notes of the patient's perceptions of Fromm-Reichmann's interactions with her and then I reread Fromm-Reichmann's (1960) view of her work to see whether there was a match between the two. Both books identified as important the role of the therapist's hopefulness for the patient and her desire to have the patient work with her as a team. This seemed relevant to me because I think BL, my first therapist, lost hope in his work with me and this affected some of my own hopefulness for myself. I would learn in my second therapy that the felt experience of teamwork between my therapist and me helped to rekindle some of that lost hope for me. In addition, Bowlby's (1979) observations of 2-year-olds and the disruptive impact on them of overlong separations from parenting figures, though in a nursery-school setting, helped me see myself at 2 in a more realistic and compassionate way.

Eventually, I became a member of a long-term, peer-supervision group, which helped to reduce my isolation from others in the professional community and gave me some insight into different therapists' styles and training, in terms of how "active" or "reserved" some were. Yet despite the fact that I, too, became a very well-respected psychotherapist, questions remained. Why had my initial foray into treatment ended as it did? I asked myself how it was related to my first therapist's stance of reserve and sense of distance from me. I began to wonder too how it was related to my disrupted childhood and interrupted language development, and my own unmet dependency needs from childhood.

The Narrative of My Second Therapy

In 1983, I entered therapy again, though this time not for intellectual reasons. Instead, I began therapy because I was worried about the stress I was feeling, related to my father's long, terminal illness and the effect this was having on the dynamic with my mother, as she tried to limit my visits with him. (My parents were now living in Florida.) One might ask why I would try a course of therapy again after my earlier experience in treatment. I asked it of myself. I think it helped that I was a much more experienced and well-read clinician and had seen that therapy could be helpful. Also, I had truly experienced that things could go from bad to worse. I was starting to feel overwhelmed and I was afraid I would feel more so, as I had at the end of my first therapy and then in the hospital. I remembered that time as one of great fear and panic, a period that reminded me of my early life in Europe when I was small and not yet 2 years old, and not yet fully verbal in either French or German. That was the time when I had been wounded, abruptly

separated from/abandoned by my mother, and left in a place where everyone and everything was unfamiliar to me . . . a time that I could not remember, but a time that had to have overwhelmed me and made me feel helpless.

I consider myself fortunate for the psychotherapeutic relationship that did develop with my second therapist (GR), who was also a psychiatrist. Thinking back, I would emphasize that central to my developing a sense of trust and safety with GR was my focus on trying to get to “know” him as a “real” person through cues I could pick up not only from his words, but from his actions, his nonverbal behavior. All the information that I gathered contributed, eventually, to my feeling secure enough to begin to ask GR questions about himself. This is the heart of what I want to emphasize in this paper: my second therapist was “less hidden” and more interactive with me, which added to my feeling of greater safety in the situation. GR “moved around.” I could “see” how he listened to me, not only patiently and quietly, but with a compassion and kindness that was communicated through his responses. If I said something that touched him, his facial expression would show it and I could tell that he was listening and that he cared. Significantly, our nonverbal exchanges became much more pronounced than a simple nod of the head or a leaning forward to show that he was attending. One such example occurred one day when he sprang out of his chair and closed a shade to the left of where I sat. It allowed me to stop squinting from the sunlight streaming in the window. His quick action startled me, but it also made me feel that he was paying attention and cared and could act on his feelings. Another example was when I began making some adjustments to GR’s physical space; I guess I was feeling more comfortable in the office and so, I began altering things physically that seemed to bother me. I began by closing a cabinet door. Another time, I got up and moved his desk chair, out of my direct line of vision. After I was seated, GR arose from where he was sitting and lifted up this chair and “slammed” it down, though not changing its location. I wondered, silently, why he had done this, but said nothing. He was silent about this exchange, too, but then, I thought, that chair represents him; he is showing me that he is strong and it made me feel that he had a stronger sense of himself than I had and good boundaries. I brought this up at the point of termination, and he thought I was right. He also said that I would become stronger after I had stopped seeing him and could solidify my own sense of self.

A final example, occurred a bit later in the work, as I tried to set limits on our exchanges in order to try and control the intensity of my emerging feelings. In such exchanges, I began by making a hand motion to push him away indicating that I wanted him to stop pushing me. In my everyday relationships and when strong or conflicting feelings arose, I would often

withdraw into silence or even leave a relationship. I did not want to leave therapy, though. As GR listened to me, I began to couple my hand motion with the words "Do not push me." I tried to sound threatening. He listened to all these kinds of communications and this gave me a feeling that I was understood. Eventually he responded and said, "I have to push you a little," then he would smile at me, to encourage me to try things his way and move forward. With time, I began to think yes, I can try this with him. I believe it was through the understanding of these kinds of initially nonverbal communications with him that allowed the building blocks of trust to form within me.

In addition to these examples, GR encouraged me to work with him as part of an integral member of a team. He did not want me to assume that he knew more of my experience than I did. He encouraged me to explain things further when they were not clear to him and eventually, he convinced me that I knew more than I had initially shared or than he could imagine of my early life. He would offer his point of view, but he labeled it as just his perspective and one that I might consider and see if it fit with my self-knowledge. He did not want me to simply rely on him or let myself be solely dependent on his words. He would regularly point this out whenever I minimized my own contributions to our teamwork. This gave me practice in countering my own dependency leanings. With time, his respect for my input eroded the enormous loss of self-respect that I had felt after my first therapy experience and convinced me that I could contribute something of value.^{1 2}

I observed, too, that GR began to alert me when I appeared unaware of my own anxiety. It took me some time to listen to him, but eventually I realized that he was using his own (anxiety) reactions to inform me of what I was ignoring in myself. I asked him once, "Am I making you anxious?" He replied, "Yes." His honesty was enormously helpful to me. It validated what I was sensing in him and directed me to pay attention to such feelings in myself. Years prior, Kestenberg (personal communication, 1992) had suggested to me that she thought the function of "signal anxiety" in child survivors had been impaired. I wondered if this was what she meant.

¹ In this light, Moskowitz (1985) agrees that child survivors need to be encouraged to share what they know about themselves: their vulnerability, hidden terrors, resilience, strength and courage.

² And I concur with Krell (2001) that child survivors need to be aided in overcoming their fear that their experiences and feelings of intense sorrow and rage will not be understood by others. How best to appreciate and validate the child survivor's feelings remain the challenge for the therapist.

In my usual pattern, I studied and read about things I did not understand, though every so often I would share some thoughts or questions with GR. I read some of Kohut's work and saw a similarity to GR's approach. I asked him once, "Are you a Kohutian?" and he said, "Yes" and smiled; I smiled, too. Out of these direct interactions with GR and the changes I felt within, my trust in GR began to grow along with a sense of sufficient safety so that the concrete wall surrounding my inner self began to open. It was as if an entranceway began to form in the wall, a doorway through which I could see GR standing . . . quietly, as if waiting for me to invite him into my inner world (of feeling and experience) when I felt ready enough to share my grief and my tears with him. It was then that I thought I would never stop crying. He reassured me that I did not have to. I asked GR once if it was difficult to hear my story when I finally told it to him. He said, "No, it was a pleasure. The difficult part was being with you beforehand."

These progressively positive steps did not mean that the road was always smooth. Earlier in the work there was another hospitalization for which the precipitating event is no longer clear to me, though I remember becoming extremely fearful. GR strongly recommended medication, which I refused to take, afraid of the stigma, influenced by my past training, and driven by the need "to do this on my own." My experience of this second hospitalization was very different from my first. For one, GR interceded sooner when he saw that I was having difficulty and therefore medication was mandated (in the hospital) more quickly. In two to three days, I felt like myself again. Secondly, there was never a question that GR would no longer meet with me, so I was still held in the relationship. There was a time, too, when I was conflicted over what I imagined were our differences over my studies for my adult bat mitzvah (Brown, 2004) and I left treatment. I was not on medication then by mutual agreement. After a few weeks I returned as I was beginning to feel unsteady, medication was resumed with which I concurred and we proceeded. Still, I asked myself why had my second hospitalization occurred and why was I someone who needed long-term medication? GR's hypothesis was that when I had difficulty dealing with my angry feelings toward him, or others, I feared the other person would disappear. He felt that even he at times underestimated this fear. In addition, there were always the factors of the unknown contributions of the variables of my brain injury, which came up from time to time, and the physiological alterations understood to follow early trauma (Van der Kolk, 1994; Yehuda, 1998; Schore, 2003).

As my relationship with GR progressed and I got more in touch with what my childhood had been like, I became increasingly interested in

filling in the gaps of my history. I began by traveling to the graveyards of the grandparents I never knew in Nuremberg, Germany, in the concentration camp of Theresienstadt, Czechoslovakia, and at the Mount of Olives in Jerusalem. And I returned to the place of the bombing in Angers, France, and arranged to meet a woman who had befriended my mother and me during the war (Brown, 1998a). With each endeavor, I met very kind people interested in helping me learn more about the facts of my history and showing me that they appreciated the painful circumstances under which I had lived. As I learned things, GR encouraged me to share them with others "outside of the office." He told me that he did not want or need the 100 percent loyalty required by my mother.

When I was invited to speak at my first survivor meeting (Brown, 1993), I went over the objections of my mother. I chose to speak about breaking silences with the next generations. After speaking, a young woman approached me and informed me that I was a child survivor and should consider contacting Dr. Judith Kestenberg to discuss her project of interviewing child survivors of the Holocaust. The term "child survivor" fit who I felt myself to be. In 1992 I went to New York and had an interview with Dr. Helene Bass-Wichelhaus. She identified for me that the sensation of blood running down my face and the vague image of those big white hats were real memories. She also shared that failures in treatment for Holocaust survivors were not uncommon. After our meeting she suggested I contact the Boston Child Survivor Group.

At my first Boston child survivor meeting, I asked those present whether anyone had been able to tell their story to their children. Only one person raised her hand. When I returned home, I put an ad in the local paper inviting members of the second generation to my home. Out of this meeting, three groups were formed: two leaderless ones and a third, which would become a long-term second-generation therapy group. In the latter group, the members, through their interactions with one another and me, began educating me about what it was like for them to be raised in a Holocaust family. I learned that children of Holocaust survivors, as differentiated from "child survivors," have their own unique story of Holocaust losses and silences (Brown, 1995). I conceptualized what I would call their "double losses" (Brown, 1998b), losses that also needed to be mourned. These included not only the concrete losses of persons, places, and things but also the double loss identified as the one attached to the emotional changes in their parents as a result of surviving the Holocaust. Gampel (1992, p. 47) refers to these changes as the "traumatic core of survivors," which I suggest can lead to a variability in emotional availability in survivor parents that often raises anxieties in their children

(Brown, 1998b). I have proposed the concept of “defensive caretaking” (p. 271) in which the second generation, as a rule, acts to protect their parents from imagined and real anxiety, *not* as implied in the term “parentification,” but as a defense against “opening the box” of their own anxieties (Brown, 1998b). This anxiety is different from their parents’ angst and, hence, is not to be considered intergenerationally transmitted. It should be kept in mind, too, that the prewar adjustment of survivor parents will also color post war equilibrium.

The story of the second-generation is my story, too, as I am both a child survivor and a child of survivors. I was affected by the devastating impact the Holocaust had on my parents and also experienced double losses. For most child survivors, the first set of losses includes the unique loss of a childhood, a broken Holocaust family tree, and the loss of a primary language. Like with the second generation, the child survivor loses parents familiar with the mores of their new country and extended family members murdered in the war. For the child survivor the second set of losses relates to the emotional impact on them in being raised by traumatized parents, parents who are different than they were before the war, a difference child survivors can often remember (Bass-Wichelhaus, personal communication, 1992, Gampel, 1992). However, while child survivors sense that they were affected by the changes in their parents, they often do not recognize their full impact on them, and do not, initially, have the words to express what they feel. In sum, the child survivor, as different from the second generation, experiences losses connected with being a survivor, as well as, the double loss associated with being a member of the second generation . . . if their parents survived. That said, I think most important for me, finding my own child survivor story made me appreciate that every generation of children on the Holocaust family tree has its own unique perspective on what it observes, what it feels, and what it experiences as personally significant about the Shoah.

When I have shared these ideas of breaking Holocaust silences and uncovering the losses they conceal at professional conferences for therapists (Brown, 1995), I have been struck that the response of many of the participants focuses on the silences in their own families. They share that they are from the second generation of households replete with the silence of other traumas: physical and sexual abuse, the impact of having dads who returned silent from Vietnam, the early death of a parent, divorce. . . . The participants could relate to the message that in a family with traumatic experiences *every* generation has a silent story and for many it is their own story.

... And I can see, the concrete wall is not unique to me
 Finding it in myself
 Lets me see deep in others
 Where lies this universal property
 I close my eyes and hear the echo of its crashing walls
 I see the opening into broader spheres
 I see the possibilities of what can be
 If all confront together—its restrictions.

—“Through the Concrete Wall” (segment of unpublished poem, 1995)

The Importance of the Real Relationship in Creating a Sense of Safety in Treatment

It is my position that the goal of treatment is to create conditions that will validate the child survivor’s own experience and encourage her to break out of her perceived “safety in silence.” The early phase of treatment should be marked by the awareness of the therapist that the patient is already in a heightened state of vulnerability and defensiveness. Therefore, it helps to focus on trying to observe and understand how the child survivor co-creates and inhabits the therapeutic relationship, which will illuminate how she has dealt with unprotected situations of her past. How does she get to feel comfortable in the environment of the office setting and how does she get to “know” the therapist within this setting and in a way that will provide her with a sense of safety gained through feeling understood?

Winnicott (1971) and Fairbairn (1958), though not working with child survivors, pointed to the significance for the patient that the therapist be not only a transference figure, but also a “*real*” person.³ My paper highlights the importance of the latter. Bacal (2006) shares, that in his search for specific factors contributing to the “optimal responsiveness of the therapist,” he once asked Winnicott, one of his supervisors, how to begin treatment. Winnicott answered, “If she, the child, holds out her hand, take it” (p. 144). This suggests that when a patient moves toward the therapist in this way, the therapist *needs to respond*, not necessarily in a verbal manner.

³ Frank (2007), in a recently published and informative article, questions the usefulness of the term “real” relationship, originating as it did from a one-person psychology and an objectivist epistemology. He suggests instead the use of the term “personal” relationship to capture more accurately a two-person, perspectivist approach, and to emphasize the intimacy and authentic affective engagement that characterize relational psychoanalysis at its best. His exposition merits continued consideration and discussion.

It is noteworthy, that Winnicott only takes the hand of the child *after* she extends it to him. This allows the child not to feel intruded upon, but responded to in a positive way. These kinds of nonverbal actions by the therapist in response to behaviors of the patient will help to engage her in the relationship and will eventually contribute toward her feeling “understood.” In other words, as the therapist becomes less “hidden” from the patient in nonverbal interactive ways, and more of a known, “real” entity, the therapeutic setting will feel safer for her.

Another aspect of working with a child survivor is that the story she first tells of her parents’ trials is one that focuses on the *facts* and not on the *feelings* of how this history impacted on her. Still, this parental story is important, and a first step toward the retrieval of her own personal narrative and eventually her own feelings.

The challenge for the therapist is to support and respond to her patient in a way that legitimizes the child survivor’s own story, which will often then come out not in words, but in *tears*. As has been pointed out, this is the goal of the work: to progressively help build a sense of safety and growing trust that will enable the child survivor to navigate through her wall of silence, so that her process of mourning can begin.

In my experience, post-traumatic life can resume a sense of normalcy, though it can never be the same. The many experiences of loss and trauma in my childhood during and after the Holocaust cannot be forgotten. They provide a backdrop for all that comes thereafter. A failed therapy leading to a psychiatric hospitalization cannot be lost to memory, either. Still, these two monumental periods of time in my life have been put into a perspective, tempered by what has followed . . . the ongoing process of their repair.

My second therapy, my professional work and my personal writings have helped me consolidate how I understand my life and my journey. In retrospect, entering therapy again gave me a second chance of working through aspects of my life experience that remained hidden during my first analysis.

Thus it turned out that, rather than my failed therapy being the end of my therapy story, it became just one chapter in my efforts to truly acknowledge, deeply wrestle with, transform, and integrate many of the post-traumatic residues and feelings surrounding my Holocaust child survivor past. For me, the process of healing from massive childhood psychic trauma beyond therapy is an ongoing lifetime endeavor. It is facilitated by increasingly vital connections with others, by deepening my own conscious awareness and insights gained through the experience of meditative practice, self-reflection, and wide readings, and by the trust placed in me by patients, over the years, traveling on their own path toward healing.

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