Affect regulation in extreme traumatization – fragmented narratives of Holocaust survivors hospitalized in psychiatric institutions

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In this paper, we examine the rôle of affect regulation in the stammering, nearly spasmodic attempts of chronically hospitalized Holocaust survivors to know and to communicate trauma. An extended study of 26 videotaped interviews, completed in Israel in 2002 and in 2003 provided a corpus from which the conceptual model for understanding trauma-related affects, the “affect propeller,” could be used and further developed. This model was initially based on videotaped interviews with 40 Holocaust survivors and 12 survivors from the Rwandan genocide 1994. An overall impression of the narratives studied was that extended memory gaps, lack of visible affect, the warding-off of questions, and the avoidance of certain themes seem to be remarkably more common than in non-hospitalized Holocaust survivors. Two categories of trauma-related affects were identified as reflecting this difference: affect imploding and affect encasement.

Key words: extreme traumatization — affect regulation — genocide — affect propeller

In previous studies on severe genocidal trauma, both authors of this study have repeatedly observed that survivors experienced difficulties in attempting to relate their traumatic experiences. This pattern of disorganization in survivors’ narratives led to the present study that seeks to examine a subgroup of survivors of the Holocaust who practically gave up their efforts to communicate, and who spent most of their lives as psychiatric patients hospitalized in Israel.

All Holocaust survivors (i.e., Jews who came to live in occupied countries under Nazi rule during the German Reich and suffered from the Nazi persecution of European Jews, be it living in hiding, in ghettos, performing forced labor, or being deported to concentration or death camps), were targeted for extinction. All of the participants in this interview study are such survivors, who lost large parts of their families during the war.

We suggest that the verbal content of their interviews alone falls short in capturing the depth of information that is contained in them. How something was said and accompanied by a facial expression became just as important for understanding the victim’s trauma experience as what was said. Therefore, a web of memory fragments and affects became the foundation for a number of hypotheses concerning affect regulation. These hypotheses form the basis of a developing theory concerning the psychological processes that Kaplan calls trauma linking, generational linking, and the dynamics between them. The concept of linking implies an associative connection between affective states and major narrative elements (Kaplan, 2006).

Trauma linking means that traumatic experiences are easily evoked associatively in the interview as well as by events in everyday life. Survivors appear to live with a “vertical split” in the self. The past and the present
exist in different compartments, between which there is no associative connection.

*Generational linking* is used to indicate that subjects have their attention directed towards significant persons and objects in the past as well as in the present. This strengthens and allows for feelings of living in a context. Such feelings can also be seen as an aspect of reconciliation. Trauma linking and generational linking phenomena may be helpful in orienting oneself in the analytic work with traumatized individuals. Either linking phenomena may be dominant. By picking up on underlying themes associated with generational linking phenomena, and highlighting them – even when their presence is subtle, and not forceful – the analyst demonstrates his predilection for creativity and life continuity. This is quite different from supportive therapy, in which defenses are stressed and self-exploration is not a priority. It is through the analyst’s containing activity, that the capacity for generational linking increases (Kaplan, 2008).

Trauma and generational linking processes belong to the theoretical model of the “affect propeller” (Fig. 1), based on research on children in genocide: the Holocaust and the 1994 genocide in Rwanda (Kaplan, 2006, 2008).

The shape of a propeller is used to emphasize the dynamic process within each individual. The blades of the propeller represent different categories: affect invading, affect isolating, affect activating and affect symbolizing. The blades may cover each other or lie separately, similarly to how emotions fluctuate. An overall conclusion from this earlier work is that past traumatic experiences are recovered not as memories in the usual sense of the word, but as affects invading the present. Thus, the “affect propeller” has proved to be a useful analytic tool for the conceptualization of the interplay between affective states. In previous work (Kaplan, 2006), an aspect of trauma linking was observed, *affect evacuating*, a defensive strategy that marks a form of coping with the desire for revenge. In this study, we will discuss yet another aspect of trauma linking, which we understand to be the opposite of affect evacuating as a defense against overwhelming affects. This form of coping is *encapsulation*.

Hopper (1991) describes the process of utilizing encapsulation as a defense against the fear of annihilation, “[for] the most traumatized, an encapsulation may remain devoid of imagery, intact but stunted. However, for the less severely traumatized … sensations of initial anguish may become associated with words, images, thoughts … feelings and fantasies” (p. 610). Schore (2003a, b, 2009) notes that the defensive phenomenon of dissociation is inextricably linked to trauma. He elaborates on the failures in integration that lead to dissociation and to a subsequent inhibition of the capacity to cope with stressors. Schore’s hypothesis complements Krystal’s (1988) observation that psychic trauma in childhood results in an arrest of affective development, whereas trauma in adulthood leads to a regression in affective development.

The importance of secure attachment with respect to affect regulation highlights that “the concept of affect regulation has become increasingly central” (Fonagy et al., 2004, p. 90), as the absence of congruent and mentalized affect mirroring between infant and caregiver may lead to deficits in affect regulation processes. Schore has described how, “in self-defense the child severely restricts overt expression of the attachment need and significantly reduces the output of the emotion-processing, limbic-centered, attachment system” (Schore, 2009, p. 114). According to Allen et al. (1999), cited by Schore (2009), this hypo-metabolic brain state, caused by inconsistent early relationships, creates “dissociative encoding failures” in the autobiographical memory of the developing self. Separation from early attachment figures creates significant problems in symbolization processes during extreme traumatization.

An infant has two psychobiological response pat-
terns to trauma: hyper-arousal and dissociation (Perry, 1995; cited by Shore, 2009). These responses may correspond, in exaggerated forms, to the subcategories presented in this paper as affect-imploding and affect-encasement, respectively. A 1993 survey of approximately 5,000 long-term psychiatric inpatients in Israel identified a sub-population of about 900 holocaust survivors; a survey conducted in 1999 found that this number had decreased to 725, of whom 80% had been hospitalized for more than 2 years. These patients were not treated as unique individuals, and their potential trauma-related illnesses were neglected in diagnosis and in decades-long treatment.

Common features regarding the patients’ memories of the Holocaust experience were detected in this study, such as the high prevalence of “erasure” themes; for example, claiming to have “forgotten it all”, doubting that it “ever happened” or insisting on an unyielding ambiguity as to “what precisely happened?”, or even claiming that their traumatic experiences were neither extraordinary nor unique and therefore did not merit being spoken of. It appeared as though the trauma had been registered, but kept frozen in a different area of the mind.

During these encounters, the interviewer had to be active and lead the way by offering himself or herself as an authentic new object – totally present and engaged for the moment, in the mutual endeavor to come to know the interviewed persons. In many instances, survivors did not give a coherent story, but instead, only fragments – often very affect-laden – and the interviewer had to serve as a holding container that allowed such fragments to come together. The interviewers helped construct a narrative for the survivors, and repeated it back to them. The survivors listened very attentively, vehemently agreeing or disagreeing with what was being said, and thereby correcting it. In this manner, they participated in the construction of their life narrative as it was taking place (Strous et al., 2005).

Without even examining the narrative content of the testimonies, we noted a glaring difference between the verbal and syntactic composition of a transcribed page taken from the non-hospitalized survivor compared to that of a hospitalized survivor. The transcribed page taken from the former’s testimony was filled with the survivor’s own words and organized in full sentences and paragraphs. By comparison, a page transcribed from the latter tended to be a verbal shadow of the former: sparsely worded, limited to brief utterances and statements, punctuated by frequent comments and questions posed by the interviewer.

In this paper, we begin by examining the rôle that affect regulation plays in the stammering, nearly spasmodic attempts of a chronically hospitalized Holocaust survivor to relate a traumatic narrative. Additionally, our research attempts to determine how video testimonies of interviewed chronically hospitalized survivors may contribute to the theory of extreme traumatization.

METHODS

Phase I: 26 out of the 200 inpatients housed in specialized wards for Holocaust survivors within two psychiatric hospitals in Israel – Beer Yaakov and Lev Hasharon – agreed to give their video testimonies. Exclusion criteria were: severe cognitive impairment, mutism, and unwillingness for interpersonal communication, or severe psychotic disorganization that precluded a coherent testimony. We sought the patients with the highest and most stable functioning, and whose clinical course was least likely to change during the course of the study. Most were diagnosed as schizophrenic. Of the 25 participants, 15 were male and 11 were female. Their mean age was 72.2 years.

The patients had all been hospitalized for more than 10 years in various public and private institutions, some continuously so since the early 1950s, shortly after their arrival in Israel. They had all received the customary anti-psychotic treatment that was in vogue at the time, including insulin shock, ECT, and psychotropic medication.

The interviews were conducted in an office of a therapist within the hospital. The “liaison person” was the patient’s primary clinician, who was responsible for obtaining informed consent and was frequently present during the interview. The interview itself was always conducted by two interviewers, one of whom was Dr. Laub, a psychoanalyst with extensive clinical experience in the treatment of trauma and a child survivor of the Holocaust himself. The other interviewer present for about half of the patient interviews was Dr. Irit Felsen. She is a clinical psychologist, with rich experience in the field of trauma and testimony, and is also the daughter of two Holocaust survivors. In cases when Dr. Felsen was absent, hospital staff rotated in as the second interviewer.

The vast majority of the interviews were taken in Hebrew. Isolated interviews were taken in Yiddish and in German. A translator was used only once, for a
There was no formal or standardized interview structure. Rather, the researchers applied their previous clinical experience of partaking in the witness’s suffering, and patiently “listening to and hearing the silence,” in order to guide the taking of Holocaust testimonies from these survivors (Felman & Laub, 1992). The purpose of the interview was to come to know the survivor as a person – his or her memories concerning his early life and family, his social context and community, his holocaust persecution experience and the after-effects that led to his lengthy hospitalization, and his experience of multiple treatment interventions and their effects. The survivor was encouraged to speak as freely as possible while following a chronological timeline of events.

As mentioned, previous studies had shown that an intense and active listening presence was crucial for the testimony to take place. Survivors rarely asked to interrupt their testimony, even when confronted with extremely painful memories that emerged. Therefore, the researchers saw no ethical conflict involved in urging the study participants to remember potentially negative and affect-laden memories.

Phase II: 8 of the 26 video testimonies were forwarded to Dr. Kaplan, along with their respective transcriptions and translations into English, to be analyzed and conceptualized according to the approach provided by the “grounded theory method” (Glaser, 1978) and the “affect propeller” (Kaplan, 2006), respectively.

RESULTS

Categories of trauma-related affects in hospitalized survivors

Two categories of trauma-related affective states emerged: affect imploding and affect encasement. These categories appeared to have dissociating functions, although they were found to be experiential extremes on the spectrum of trauma-linking processes. They appear as sub-categories of affect invading and affect isolating, respectively.

Affect invading: the affect as the link to the trauma

The concept of affect invading is drawn from results of previous studies (Kaplan, 2006, 2008) and is defined as an invasive sensory experience that has been triggered by emotions evoked during the interview. These emotions are responsible for the fragmentation found within the patient’s narrative: there were observable sudden changes in the voice, and the interviewees often openly expressed feelings by either crying or laughing in a panic-stricken way. The affect as link to the traumatic experiences does not imply a lack of words, but manifests itself rather through a partial sentence fragmentation and through the affect’s predominance over content. Therefore, the affect appears in this context as a sensory perception that is able to intrude, as if the trauma were happening in the present.

Attempts to approach the trauma in one’s mind are experienced as “unthinkable”; memory voids therefore replace the traumatic memory. In some cases, even despite the great extent that these voids remain contained and sealed off, the personality is usually maintained intact. Extreme forms of overwhelming invasion of affects are discussed further below.

Affect imploding

Within the affect invading category, a subcategory of trauma linking emerges that we call affect imploding, which may be characterized as the emergence and impact of strongly affect-laden memory fragments. The individual does not manage to make a functioning vertical split. He or she cannot deal with extreme experience, and feels threatened by anxiety to be “blown into pieces” at the margins of his or her contact with, or linking to, the trauma; he or she feels fragmented. The individual’s defense against this threat is to deny the meaning of current or earlier traumata or becoming psychotic. Affect fragments that undergo a process similar to dream revision constitute the center of his or her traumatic experience. The fragments are strung together through rationalizations so that they make sense. What we are dealing with are word equivalences and with a pseudo-rationality. This phenomenon is most salient within the narratives of the chronically hospitalized survivors. What one sees in these interviews are the ruins of someone who has experienced himself or herself as fragmented. He or she cannot answer questions during the interview, such as: “did you become sad then?” or “what did you think then?” or “what do you think now about what you are telling me?”

Affect isolating: encapsulated links to the trauma

Affect isolating (Kaplan, 2006, 2008), which is characterized by distanced narration, was the manner in which most of the interviewees started their interview. Affect isolation may seem to be a completely locked position, but can at the same time mean that the sur-
vivor remains in control of the trauma, thus gaining space for living his or her life. The ultimate fate of affects that remain totally and chronically encapsulated may be their conversion into somatic symptoms. In such instances, it is no longer the affect but rather the body that tells the story of encapsulated affects. Affect isolating narratives are at other times provided as dreams, which could be seen as attempts at symbolization. However, this is often a case of “stiff” symbols, which seem to help the survivor maintain distance. The dream that leads to a deepening of associative processes was uncommon in our material.

**Affect encasement**
Within affect isolating, we may define a subcategory, an extreme of trauma linking: affect encasement. The experience here may be described as “dislodging something from stone.” The affect-encasing individual reacts with especially strong defensiveness – a massive disassociation with minimal contact with the trauma. It is as if the traumatic experiences and later, more normal experiences are kept apart by an immensely strong concrete wall.

**Affect imploding and affect encasement** are phenomena that in seemingly contrasting ways bring about linking to the trauma. However, imploding and encasement often appear together and may be functionally related. There are sometimes quick oscillations between these positions during an interview. Both, further, interrupt thought that leads to “erased memories” that cannot be told because they have never reached consciousness (Laub, 2005). This deficit in symbolization is demonstrated by an astonishing muteness in the interviewee.

We want to emphasize that we are not illustrating personality profiles characterized by a certain kind of affect but rather the prominence of the aforementioned affective states that we have found in comparing the interviews of hospitalized and non-hospitalized survivors. The “erasive” positions predominate in the chronically hospitalized group, although, among these interviewees, too, there are fluctuations and shifts to other less extreme affective positions.

The following section is comprised of excerpts from interviews that allow for a close observation of the affect-regulating processes with special attention paid to the trauma-linking that appear as de-linking processes.

**Affect imploding: codes and examples**

(a) “Nonexistent” experience
The history is hardly existent, only fragments seem to remain without affects or details that are possible to recover.

_Yaakov_ (with whom the dialogue is largely in Russian)
Q: Was mother alone?
Q: She didn’t have any brothers or parents?
Q: What happened to the brothers and sisters?
A: Translator: He says that the brothers died too, the parents died too.
Q: His?
A: Translator: Hers, hers.
Q: The Germans killed them?
A: Translator: He says that they died.
Q: Did they live in Rovno as well?
A: Rovno, Rovno, Rovno
Q: And the Germans killed them in Rovno?
A: Translator: Near Kiev.
Q: What is it? What does he say?
A: Near Kiev.
Q: Does he remember whether they were killed together?
A: Translator: He wasn’t told. He doesn’t remember.
Q: How old was he when that happened?
A: Translator: Seven years old.

(b) Repetition
Repetitions of questions and answers are a common defense against affect invading. Such repetitions were very common in the interviews with hospitalized survivors. The interviewee may say the same things, utter the same expressions or retell the same event two to three times during an interview.

_Avner_ kept retelling how his father was unable to go to his wife’s funeral (the patient’s mother) 12 km away because of a heavy snowstorm, and _Leah_ was repeatedly talking about living and working in two different places. It is as if the events they are talking about happens over and over again in the present, but proceed only to a certain point and then get stuck without moving forward. Variations of repetition sequences in the present include: “I do not understand the question” or simply, “what?” This seems to be an unconscious way of avoiding the traumatic memory through losing one’s focus on the subject.

(c) Time collapse
A collapse between the experiences of now and then is clearly emphasized.
**Avner**

A: I was a soloist at school
Q: A soloist at school, so when was the voice lost?
A: Right now, here

Although it is very tempting to interpret this answer as a rich metaphor, it is its very concreteness that in our opinion is closer to the survivor’s immediate experience. It requires interpretation from the listeners to elucidate the metaphorical layer. The survivor's unconscious creativity is indeed the source of the metaphor, in an attempt to master the trauma; such metaphor, however, allows for only a momentary glimpse into the multilayered complexity of the full traumatic experience. The hospitalized survivor feels totally incapable, cognitively and emotionally, of bringing the traumatic experience to consciousness. He or she has to obscure it immediately, and flee. Therefore, when asked to elaborate on the metaphor, the only thing the survivor can do is to repeat it, and thus continue to flee from it in terror because of the threat its affective richness (terror, loss) poses. What remains is a hollowed metaphor, an empty shell, akin to a concrete thing.

**Ruth**

Q: Nightmares?
A: No, I had no dreams. Oh, I had no dreams (laughs).
Q: You didn’t have dreams at all?
A: I didn’t have special dreams.
Q: But, were there dreams? Are there dreams?
A: No [laughs], I have nothing to dream of. My mother is not alive and one does not dream of what has happened. I have no dreams. I don’t know about my mother.
Q: When mom is not alive…
A: If mom is not alive, there is no choice, one has to keep on going as it is. I have no address to ask where is she. That’s the thing, I don’t know what to think in relation to mom, what about mom.
Q: But do you sometimes ask yourself what happened to her?
A: I don’t have such questions (laughs). I can’t answer, so who has such questions?

In the above example, it is very tempting to connect the loss of the mother with the loss of the capacity to dream. And while the narrator may have unconsciously linked the two themes, they remain two discreet fragments that are walled off, separate and concrete. Their coalescence has to be avoided at all cost because of the emotional threat they pose. Such steps could result in the creation of a deeper and more complete level of experience of the totality of the loss and of the terror experienced. Indeed it is a synthesis that may threaten psychological survival.

**(e) Cutting off**

A common phenomenon is a sudden cutting off of the conversations, as if they had become too overwhelming. There seems to be a need to “lock the door” that has been opened. Sometimes, the narrating ends abruptly with the interviewee expressing statements such as “I cannot any more” or “That’s it” or “Enough” or “I can’t remember!”

**Avner**

Q: Do you think that whatever you went through in the war contributed to it?
A: Of course.
Q: If you wish, can you say how, perhaps?
A: I didn’t work. So I didn’t have. And the brother and sister could not help me, that is all.
Q: But how does the war, your experiences in the war, how did it contribute to the fact that it didn’t work, that it didn’t function, that there was despair?
A: Enough, enough [Stands up and leaves].

**Affect encasement: codes and examples**

The second category of the trauma linking phenomena is a complete obliteration of all feelings and a complete separation from dialogue with both oneself and one’s listener. The interviewee avoids connections between current pain and traumatic experiences, and avoids the questions. Additionally, the interviewee often twists the subject in an overly concrete way.

**(a) Giving minimalistic answers**

The avoidance of experiencing overwhelming affective states also manifests itself when the interviewee talks about the traumatic experience, while simultaneously undoing it by minimizing and tightly controlling it. Simple answers are given such as “there is nothing special to tell about…” or “it was alright” and no additional information is offered. It is as though the interviewee finds relief in giving permission to him/
herself for not having to think or reflect about personal history.

_Gideon_

A: My father disappeared. There is nothing to describe – a regular man.

Q: Your father disappeared. Do you remember your father?

A: Yes.

Q: Describe him a little.

A: There is nothing to describe, a regular man.

Q: Are you similar to him?

A: I don’t know.

Q: Do you think so?

A: I don’t know. I have no idea.

Q: Did you see pictures of him?

A: Excuse me?

Q: Did you see pictures of him?

A: Yes.

Q: Describe to us a picture of him; do you see a picture in front of you?

A: A picture of a man.

Q: Religious? A smiling face?

A: A regular picture.

Q: Do you look at those pictures?

A: No.

Q: Were there times that you did?

A: No.

Q: Never?

A: No.

Q: Who gave them to you? You were so young when it all started.

A: I, I found pictures after the war.

Q: Among relatives?

A: Yes, when I was a little boy.

Q: So there is a memory of your father, or is it just from the pictures?

A: As usual, nothing special.

Q: But are there memories of your father?

A: No.

Q: As a child then, did you get any feeling of what happens, people disappearing?

A: I took it as a fact, as a fact I took.

Q: As a fact. What are your first memories?

A: Nothing in particular.

(b) **Avoidance**

Avoidance could take the form of a “shut down” in the thinking process. The interviewee answers as if the question led nowhere. The process may go much deeper than a mere denial of feelings – it most likely demonstrates a collapse in thinking at the moment the trauma is enacted in the room. There is only a ‘nothing’ present. There is no longer a subjectivity present that would allow for personal feelings.

_Ruth_

Q: No thoughts of family?

A: Yes, but I don’t have, I don’t have any special things to tell. I have nothing to tell.

_Avner_

Q: How did you feel when mom died?

A: Nothing, I was with dad, with the brothers. We were (it was) not normal to feel feelings

Q: It is very important

A: No feelings, no attention

Q: No mourning, no pain

A: Nothing

(c) **Normalizing**

Healthy normalizing includes optimism for the future. But rather, in these interviews, normalizing indicates a lacking capacity to reflect about possible consequences, both during the traumatic event and in the interview situation. The interviewee remains noticeably unaffected by the questions that are raised. While this might be a way of groping for safety in a threatening situation, the “normality” of not experiencing and expressing feelings may be a shield against vulnerability.

All the examples that state that it was normal during the persecution not to feel anything at a separation or death of a parent, because of shock and the speed at which the events took place, constitute an unstated rule that one should not have or show feelings or vulnerability to either perpetrators or oneself. In maintaining this attitude, the interviewee continues his or her efforts in the service of survival. Normalizing, however, includes aspects of warding off, denial, and ignorance, as in the following example.

_Gideon_

Q: Who knew that you were a Jewish child?

A: The nuns.

Q: The children didn’t know?

A: No.

[…] Q: But, did you sometimes consider yourself Christian just as they were?

A: I didn’t think I was Christian, I didn’t think I was Jewish either.

Q: So what, who did you think you were?

A: A human being.

We suggest that what appears to be a transcendent statement, “not a Christian nor a Jew, a human being,”
is really an empty phrase or metaphor replacing an inassimilable experience.

Normalizing may involve explaining away traumatic events or at least stating that traumatic events were “facts” and “nothing to talk about” and include a refusal to acknowledge any concern or worry about the event.

**Gideon**

Q: As a child then, did you get any feeling of what happens, people disappearing?
A: I took it as a fact, as a fact I took.

**Ruth**

It wasn’t felt in our town but in our surroundings there was nothing special to be told.

*later on, she says*

Oh, there were, we had hair, but there were individuals who had their hair shaved as well, but it was nothing special.

*(d) Rationalization*

There is also a rationalization, which presents as an attempt to explain how things were and to give a reasonable description of the situation. Questions about feelings are answered with a concrete piece of information pertaining to surroundings, and thereby feelings are encased.

**Ruth**

We didn’t know how to worry, we had no thoughts of the family. They were taken by force and put to work, and each of us was in its place. How did the war end? I don’t know.

*later on she says*

If mom is not alive, there is no choice; one has to keep on going as it is.

**Border areas between imploding and encasement**

There are border areas between affect imploding and fragmentation and affect encasement. In some cases, there can be a swift oscillation between extreme positions, as bodily sensations are expressed at the very moment of telling.

**Avner**

Q: But before that there was hunger, freezing. Dad couldn’t walk in a snowstorm. Didn’t you freeze?
A: I have signs
Q: Signs of?
A: Ice burn
Q: The toes were frozen. Do you remember the cold?
A: Of course I remember. But it didn’t bother, didn’t bother
Q: Didn’t affect. What do you remember?
A: I used to shiver
Q: What do you remember of the cold?
A: Of the cold, there was snow and ice of course. But what do I remember, what is there to remember?

**Affect activating and affect symbolizing**

Through the repetitive exploring interventions by the interviewer within a safe context, some individuals seem to be able to transform affect encasement with dissociation into a more normal form of affect isolating and defensive distancing. A narration of an event or a dream takes shape and is given a content that makes the encased experiences visible. The shape of the narrative may include what we called stiff symbols or, in certain cases, dynamic symbols. Affect activating becomes possible through the interviewer’s interventions and encouragements to open oneself up to detailed narratives and the possibility of allowing feelings to show.

*(a) Turning points – efforts of affect symbolizing*

The authentic dialogue may be seen as a key moment – a turning point – in the interview. Feelings are clearly expressed. As utilizing symbolic meaning is usually not allowed in the discourse; it is the interviewer’s responsibility to look for possible deeper meanings in the survivor’s statements. Yet, the survivor hesitates to emotionally go further. The interview stops in such moments of affective attunement by the interviewee saying: “Let’s finish, maybe.”

**Shoshana**

Q: Yes, but what were the dreams of your mother, for instance, tell us …
A: I used to see her.
Q: Did you speak, were you a little girl when you were with her?
A: No, she was already a 58-year-old woman.
Q: In the dream.
A: No, she was really 58, but she was killed.
Q: How old was she in the dream?
A: Maybe fifty years old.
Q: And you were already a grown up. What did you do in the dream?
A: I saw her. She hugged me.
Q: You hugged her. Did you miss her in the dream?
A: [Cries].
Q: It is very difficult. I understand that those are terrible dreams, Shoshana.
A: [Cries for 20 seconds]. Let’s finish maybe.

Affect activating includes reflections about the interview and a degree of coherence in the narratives, even when relating the traumatic events. Feelings are expressed in self-reflective ways, as memories of physical and mental states at the moment of the traumatic occurrence, as painful memories of parents dating back to the time before the war, or as feelings experienced in the immediacy of the interview. The survivor takes the risk of being emotionally touched when admitting feelings of pain and daring to express anxiety in the present. The interviewee may at these moments feel freer in relation to the past – one could say that the trauma is no longer split off, but rather exists more or less integrated with the interviewee’s present life.

(b) From warding off to expressing feelings
Another kind of turning point occurs when the survivor shifts position from refusing to tell to being willing to disclose his feelings. There is sometimes terror shown at the very moment of telling: Shoshana “… yes. I had no fear of course, I was ready, but I feared tremendously.”

(c) Remembered feelings put into the present context
Sarah
A: I went. Grandpa took me every Sabbath. He got the Torah and sort of a balcony, a stand in the synagogue and he got the Torah. And he prayed and I stood next to him. Oh, I don’t want to talk because it will not do any good before going to bed. I just wanted to fix a painting from yesterday …

(d) Patient’s reflections on remembering
Examples of the interviewees’ comments on remembering in the interviews are: “One forgets to remember!”; “I don’t remember that. I was still young.”; “I don’t know anything because of the war.”

Extremely traumatic content was sometimes followed by contemplative comments, as follows:

Avner
Q: The memory of dad and mom and the fact that they are not living, and of the sister, how did this follow you?
A: Nothing
Q: Nothing. Never. It didn’t leave pain, did it leave fear, nostalgia?
A: (Nods) Nothing. Memories

Q: Memories. What are the memories?
A: What I talked about.
Q: Yes, but what feeling does the memory leave?
A: The end of man is to die.
Q: The end of man is to die, is that what you said?
A: Of course.
Q: We must accept it.
A: Of course.
Q: Do you cry at night sometimes?
A: (Nods). It wasn’t. It wasn’t the loss of luxury.

Sometimes the wish to forget the experience is expressed in direct ways.

Ben
Q: But by being here, did you help yourself too or …?
A: Yes, I try to delete the unnecessary tapes.
Q: For example, what unnecessary things?
A: Tapes, tapes, delete memories, delete memories.
Q: Delete memories.
A: Yes.
Q: Are they easier to delete when bringing them out?
A: With time. The first years are hard, and then it becomes easier.
Q: Only the first years. I understand, I understand.
A: That’s it.
Q: I ask whether you think that you have helped yourself by speaking.
A: I would delete it myself already. It is not the first time I talk about it.

DISCUSSION

In listening to the hospitalized survivor’s video testimonies and to one’s own counter-transference responses to it, what is conveyed is by no means emptiness. On the contrary, the psychic space seems overcrowded with inchoate, tumultuous masses threatening to break through into consciousness by paralyzing ego functions and eliciting psychotic experiences.

These survivors have strikingly little capacity for an inner reflective space that allows for ambiguity, doubt, ambivalence and associative resonances; a space wherein secondary process functions such as reality testing, judgment, remembrance and in which mourning, can operate and defense mechanisms such as repression, projection and disavowal can contribute to an enhanced emotional mastery of the experience. In the absence of such space, a blockage forms, and a paralysis occurs wherein the massive affect fragments that fill the survivor’s whole psychic space are neither associatively worked through nor integrated.
into a coherent, whole experience. The authors were aware that this group of patients whose mean age exceeded 72, and who have been institutionalized for many years and treated with a variety of somatic therapies (pharmacotherapy, ECT, and insulin shock, etc.) could be suffering from various degrees of cognitive impairment. Our findings in the study do not indicate however, that such impairment played a major rôle. What we know from studies with aging Holocaust survivors, is that those who suffer from PTSD show poorer learning-memory performance than those who do not (see Yehuda et al. 2006). It was our clinical experience, that helped us understand however, that what we witnessed while interviewing our subjects and analyzing the video recordings were effects of the traumatic memories and not cognitive deficits.

What is missing in many of the narratives is a narrating agency, an experiencing subject, who within his or her self organizes a sequential flow of events, a specific time frame that has a beginning, a middle, an end, and a finite, designated place. The affect fragments, though overbearingly present and incessantly colliding, remain at a standstill; the survivors cannot gain control of them through the creation of a coherent and progressing narrative; they can at best evade them. We have called this fragmented condition affect imploding. It should be stressed that this state can also momentarily be observed in non-hospitalized survivors, for example, as blank memory spaces. In the non-hospitalized survivors, however, affect imploding is contained to a degree that allows for adequate psychic space to be freed for both memory and life to evolve relatively unimpeded.

The traumatic state of fragmentation we described becomes more intelligible if we recognize the loss of the object, the “thou”, the counterpart, the external and internal other it entails. Not only does facing the relentless executioner destroy the internalized good object, but, also, incurring such loss has a cumulative effect. The trauma merges with pre-traumatic experiences of parental conflict, abrupt separation from parents, the speed at which blows followed one another, having no one to listen to their pain and terror, and related traumatization. All of these factors prevented the discovery and the recreation of the lasting good object in the survivors interviewed in this study. Since there was never a way to recover an internal dialogue with the good object, no attempt to tell one’s story to oneself could occur either.

Failed attempts at narrativization may also be observed in survivors who lead regular lives – those who built families and careers, and actively participated in the lives of their communities. The narrative eclipses of non-hospitalized survivors are limited and occurred when an interviewed person came close to recounting extremely traumatic and affect-laden experiences, but where these lapses in narrativization were brief and self-contained. Such survivors, different from those we have reported in this study, would convey a sense of paralysis and speechlessness and then regain their composure within a short time and resume an internally driven narrative flow.

There is sometimes a more or-less explicit concession from the survivor that it is not “normal” to be aware of feelings during extreme traumatization. Being observant of one’s own feelings would have been counter-productive to emotional and physical survival. Additionally, the absence, or loss of an internalized holding figure during the traumatization, potentiates the psychic defense of “closing off,” and the subsequent defensive and non-reflective position of “no problem” and “no worry” that denies the traumatic experience itself. Thus, feelings became immovable stones within the survivor’s psychic space to be treated as irrelevant. Yet, while providing a measure of protection, the creation of such massive internal walls renders the survivor unable of moving beyond them: this is the phenomenon we have referred to as affect encaement. Whenever there is effort at verbalizing, there is simultaneously an avoidance to do so, perhaps because of the pain of realizing not only the totality of the traumatization, but also the length of time spent in the hospital without tending to it. All of the aforementioned models are integral to understanding the phenomena of “erased memories.” (Laub & Auerhan, 1993).

Scharff (1998) employs Oliner’s reference to Green’s ideas of the organization of psychic experience in formulating that experiences of extreme traumatization, without the benefit of psychic processing, create psychic presentations, as opposed to representations. Presentations of overwhelming affects and memories may, through psychic processing, be internally transformed into representations imbued with personal meaning, and thus achieve relative psychic cohesion. Through trauma studies, however, analysts have come to understand that unprocessed presentations can be carried in the mind as information completely devoid of meaning or connection to the individual’s personal history – becoming nothing more than a heavy stone that calcifies around unbearable feelings of lonesomeness and a sense of void.

During the testimonial process, the interviewer herself was not spared from experiencing a lack of feelings and an erasure of memories that she is empathically trying to imagine. The analyst who works with traumatized survivors of the kind we have described must accept the duality of memories that is implied in these
separate processes, and realize that it is the deadening of meaning, which is the result of the actual trauma (Scharff, 1998), that prevents such psychic processing.

In attempting to use Schore’s paradigm (2003a, b) of pervasive effects of childhood traumatization in order to understand the findings in our study, the question arises as to how much we can extrapolate from childhood to adult traumatization when, after all, only very few of our interviewees had been small children during the Holocaust period.

In considering the effect of childhood traumatization, we must admit that there are some indications that a number of the interviewees had grown up in families that had experienced conflict. Going beyond the family, we also need to take into consideration the effect the strain caused by a growing and increasingly brutalized societal antisemitism had on these children prior to their deportation. Finally, the damaging absence of crucially important caregivers and the subsequent impossibility for interactive repair that leaves infants “to endure intense negative states for long periods of time” (Schore, 2009, p.111), must be taken into consideration.

The central question we need to address is therefore whether our interviewee sample was composed of such young traumatized children who failed to develop the resilience necessary to deal with later massive life traumatization, or whether such traumatization in young adulthood led to the affective regression postulated by Krystal (1988). This presents a difficult methodological problem; an in-depth analysis of the videotexts in our study may, however, allow us to do just that.

CONCLUSIONS

The first viewing of the videotapes indicated a quite different kind of narrative structure as compared to interviews conducted with non-hospitalized survivors. The distinguishing feature of hospitalized survivor testimony is the persistent de-contextualization of their overpowering affect fragments, rendering them unable to be contained in a narrative frame. Whereas, in normal testimonies, fragments of intense affects are key nodal points that simultaneously convey meaning sufficient to drive the narrative and navigate internally created impasses, in this group, the flow of the narrative simply halts. Processes of symbolization and inter-subjectively communicative free association are virtually non-existent. It is only in examining counter-transference that the interviewer can attempt to restore such processes through experiencing the terror himself, near annihilation, and paralysis. It is only through careful scrutiny of clinical phenomena that the uncontrollable affects can be traced through body language, cryptic utterances and above all through the defensive strategies the survivor adopts.

The interviewees did not appear psychotic during these interviews, yet due to the disruptive and inhibitory presence of overwhelming and unintegrated traumatata, responsibility fell to the researchers to infer trauma histories that led to their hospitalizations. Such historical information was gleaned from the content of the survivors’ narratives, the manner in which their life histories were presented through language, their body movements, and from their relationship with the interviewers while attempting to relate their stories.

The pre- and post-traumatic phases in life seemed of particular importance. The traumatic experience itself did not have to be unique or excessive as compared to that of other survivors. The internal representation and formulation of the experience both during and after the actual experience (however coherent a story the survivors were able to tell themselves) were strikingly different from those of other survivors.

A marked individual vulnerability, secondary to pre-war family collapse, might have predated the trauma of the Holocaust and contributed to their emotional decompensation during the war. Additional psychic strain may have contributed to a fragile attachment bond in patients coming from dysfunctional families. One must therefore ask oneself whether the interviewees could already have been psychically sensitized prior to the Holocaust trauma or whether the rise of anti-Semitism could have exacerbated existing vulnerabilities found in survivors’ family histories.

An overall impression of the narrative from this group is that extended memory gaps, lack of visible affects, the warding off of questions, and avoidance of certain themes, seem to be remarkably more common than in the group of non-hospitalized Holocaust survivors. It would seem that there were never any psychic representations of memory images or even affect experiences, resulting in such experiences to be stored instead as bodily memories. Thus, these trauma experiences have never reached consciousness, having been, according to the affect propeller model, relegated to one of the following new categories of coping with affect: (a) affect imploding or (b) affect encasement.

It should be noted that other traumatized populations seem to retain the ability to use various affective categories flexibly. By contrast, in the hospitalized survivor cohort we have studied, access to useable affective categories is drastically narrowed.
ACKNOWLEDGEMENTS

Both authors want to thank Julie McNamara for her dedicated work and David Titelman for his help in editing the revised version of this paper. We also thank the Ax:son Johnson Foundation, the Institute for Social and Policy Studies, Yale University, and the Conference on Jewish Material Claims Against Germany, Inc., for grants during different phases of this work. Special credit is given to the following clinicians and researchers who participated in this project: Rael D. Strous, MD; Mordechai Weiss, MD; Irit Felsen, PhD; Boris Finkel, MD; Yuval Melamed, MD; Avraham Bleich, MD; Moshe Kotler, MD; Miriam Rieck, PhD, and to the people who have been interviewed. We have used pseudonyms to protect identity.

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