The transgenerational transmission of holocaust trauma

Peter Fonagy PhD FBA

To cite this article: Peter Fonagy PhD FBA (1999) The transgenerational transmission of holocaust trauma, Attachment & Human Development, 1:1, 92-114, DOI: 10.1080/14616739900134041

To link to this article: http://dx.doi.org/10.1080/14616739900134041

Published online: 02 Jun 2006.
The transgenerational transmission of holocaust trauma
Lessons learned from the analysis of an adolescent with obsessive-compulsive disorder

PETER FONAGY

ABSTRACT This paper outlines an attachment-theory based model of transgenerational trauma inspired by the successful psychoanalytic treatment of a severely disturbed adolescent with obsessive-compulsive disorder who was the first child of the first daughter of a holocaust survivor. It is proposed that the transmission of specific traumatic ideas across generations may be mediated by a vulnerability to dissociative states established in the infant by frightened or frightening caregiving, which, in its turn, is trauma-related. Disorganized attachment behaviour in infancy may indicate an absence of self-organization, or a dissociative core self. This leaves the child susceptible to the internalization of sets of trauma-related ideation from the attachment figure, which remain unintegrated in the self-structure and cannot be reflected on or thought about. The disturbing effect of these ideas may be relatively easily addressed by a psychotherapeutic treatment approach that emphasizes the importance of mentalization and the role of playful engagement with feelings and beliefs rather than a classical insight-oriented, interpretive approach.

KEYWORDS: Holocaust - trauma - transgenerational transmission - disorganized attachment - self development

SOME RELEVANT PSYCHOANALYTIC CONTRIBUTIONS

Freud, in *Totem and taboo*, made a remarkable assertion. He wrote: ‘We may safely assume that no generation is able to conceal any of its more important mental processes from its successor’ (S. Freud, 1913, p. 159). A number of
outstanding psychoanalytic clinicians, writing almost two decades ago, made major contributions applying Freud’s radical insight, to cases of children of victims of the Holocaust. Three key contributions are selected as they make a compelling case for traumatic reactions in the children of survivors, mediated by the impact of Holocaust trauma on the early emotional environment provided by the survivors for their offspring.

Judith S. Kestenberg’s innovative investigation of the effect of the Holocaust on the second generation led to her description of the trans-generational transposition of trauma (Kestenberg, 1982). Kestenberg’s patient, Rachel, appeared to live in the reality of her father’s past, withdrawing from all social contacts, hiding like her father, who had escaped by concealing himself outside the concentration camp. She is noted to have developed an insusceptibility to bodily and affective signals, retreating into a narcissistic grandiosity that could withstand and survive torture and persecution. Kestenberg recognizes that what is at work in second-generation victims is not covered by the concept of identification; that it is tantamount to the patient’s immersion in another reality and integrally involves the patient’s body. The mechanism of ‘transposition’, according to Kestenberg, resurrects the murdered objects whom the caregiver (the survivor) cannot adequately mourn. The objects are re-created in the mind of the second-generation survivor at the cost of extinguishing the psychic centre of her or his own life. Of course Kestenberg’s observations overlap with those of Heidi Faimberg (1987) concerning the ‘telescoping’ of generations that is readily observed in victims of trauma.

Ilse Grubrich-Simitis (1984, 1981) further advanced our understanding. She focused on the impact of the extermination camp conditions on the ego’s capacity to use metaphor, and the related capacity to structure past, present and future time. She pointed out that ego impairment of this kind may evoke a ‘timeless concretism’ in psychic functioning (1984, p. 303) which manifests in the second generation. The immense anxieties of the traumatized victims, for which no intra-psychic defence is adequate, find expression in their effect upon the primary object relationships of the second generation. Building on the work of Masud Khan (1963), Grubrich-Simitis cogently links the mother’s inability to promote her infant’s early ego needs, to a vulnerability in the infant to later trauma. James Herzog (1982) evocatively described the psychological environment created by such traumatized parents as ‘a world beyond metaphor’ (p. 114). In her 1984 paper, Grubrich-Simitis writes, considerably ahead of the revival of the intersubjective tradition in psychoanalysis, that a phase of ‘joint acceptance of the Holocaust reality’ (p. 317) must be experienced by patient and analyst if the ultimate harmlessness of fantasies is to be accepted by the patient.

The third contribution from the early 1980s is that of Howard B. Levine (1982). In agreement with Judith Kestenberg, Levine recognized that children of survivors appropriately experience themselves as the target of persecution since the eliminationist anti-Semitism of Nazi ideology included them as the yet unborn carriers of Jewish genes. Levine points to the ways in which
holocaust trauma undermines parenting capacity in the survivor: depression, poor control of affect, including guilt and aggression, unrealistic parental expectations, overprotectiveness, the undermining of individuation, and so on. Levine’s formulation of the ‘child of survivors complex’ is that the syndrome is neither exclusive to such children, nor necessarily present in all of them, but is, none the less, likely to manifest in problems of the separation-individuation process and the management of aggression. Children of survivors are poorly equipped to deal with the knowledge of the parental holocaust experience, and may find themselves identifying with parental character traits produced by that experience. Levine also stresses that what he describes may be generic to all extreme trauma, including severe sexual abuse, violence, etc.

While all these suggestions are immensely illuminating, they do not fully explain the problems of third-generation victims particularly at the level of psychoanalytic mechanisms. These are children of individuals onto whom trauma was transposed, who created murdered internal objects on the basis of their interactions with survivors, who were brought up in a ‘world beyond metaphor’ but who themselves had no direct experience of trauma. Of course, we may simply assert the transgenerational continuity of these processes, but this would implicitly equate the actual trauma of the first generation of survivors with the manifestations of those experiences in the second and the third generations. In this paper it is suggested that additional constructs are needed to explain how transmitted trauma may impact on parent-infant (primary object) relationships, and in this context attachment theory may be of particular value.

ATTACHMENT THEORY

Attachment theory has been the black sheep of the psychoanalytic family. John Bowlby’s early writings on the resolution of trauma and loss (Bowlby, 1960) were the subject of severe criticisms from Anna Freud, René Spitz and Max Schur as well as others who considered it mechanistic, non-dynamic and based on thorough misunderstandings of psychoanalytic theory (A. Freud, 1960; Schur, 1960; Spitz, 1960). Opposition to his views provided one small area of common ground for the followers of Anna Freud and Melanie Klein (Grosskruth, 1986), and for decades Bowlby was a relatively isolated figure in psychoanalysis.

Attachment theory is, however, experiencing something of a psychoanalytic renaissance (e.g. Lichtenberg, 1995). This is perhaps due to the increasing ecumenicalism of psychoanalysis (e.g. Pine, 1990) or the general acceptance of an object relations perspective in the basic psychoanalytic model (Sandler & Sandler, 1998). According to attachment theory, the primary function of early object relationships is to provide the infant with a sense of security in environments that induce fear (Bowlby, 1969, 1973). Bowlby assumed that on the basis of the interactions between the infant and
a caregiver, self–other representations develop (he termed these internal working models) which reflect the child's cumulative experience of sensitivity on the part of that caregiver. This aspect of infant–caregiver relationships is present in most psychoanalytic formulations and clearly overlaps with some current uses of Bion's containment concept (Bion, 1962), Winnicott's holding environment (Winnicott, 1965), Kohut's suggestions concerning self-objects (Kohut, 1971), and Sandler's concept of safety (Sandler, 1960). The child's confidence in the caregiver's capacity to appreciate his or her state of distress and to act upon this understanding is reflected in the security of the bond between infant and mother (Ainsworth, Blehar, Waters, & Wall, 1978).

Research using Mary Main's Adult Attachment Interview (AAI) may have also contributed to the increasing acceptance of attachment theory ideas. The AAI represents an attempt to assess current mental representations by adults of their childhood attachment experiences (Main, Kaplan, & Cassidy, 1985). Several studies, including one by our team in London, have demonstrated that in as many as 80% of cases, infant attachment classification can be predicted on the basis of adult attachment classification made before the birth of the child (Fonagy, Steele, & Steele, 1991; Steele, Steele, & Fonagy, 1996). Parents with an insecure (incoherent) view of their childhood attachment experiences are highly likely to build an anxious attachment relationship with their infants (van IJzendoorn, 1995).

ATTACHMENT AND DISSOCIATION

The relevance of attachment theory to the present context is clearer in the light of trans-generational studies which have shown that caregivers with unresolved experiences of mourning and trauma appear to cause disorganization in their infants' attachment relationships. The interview reveals such 'lack of resolution' through apparently minor cognitive irregularities when either loss or trauma is discussed (slips of the tongue, confusions of past and present, confusions of identity, momentary lapses of reasoning, prolonged pauses or unexpected intrusions of the trauma into other contexts, etc.) (Main & Goldwyn, in preparation). Caregivers showing this pattern have infants who tend to manifest bizarre or 'disorganized' behaviour when reuniting with their caregiver following a brief period of separation – behaviours such as head-banging, freezing, hitting, hiding, or collapsing. It is important to note that it is not trauma per se, but its lack of resolution, its unmetabolized character, that appears to be associated with disorganized infant attachment. Disorganized infant behaviour upon reunion may accompany avoidant, resistant, or even secure attachment, just as lack of resolution of trauma can be found in dismissing, enmeshed (preoccupied/entangled), or secure-autonomous interviews. Remarkably, disorganized attachment behaviour in infancy manifests as rigid, controlling behaviour in middle childhood and
sometimes quite severe psychological disturbance in adolescence (Lyons-Ruth, 1996). There is considerable evidence that infants manifesting some degree of disorganization in infancy can become controlling, bossy children with their attachment figures even if their attachment classification was originally disorganized-secure (Cassidy & Marvin, 1992). Parents of such children report experiences of feeling controlled by their child (George & Solomon, 1996) and of seeing their children as replicas of themselves (Solomon & George, 1996). Consistent with this pattern of externalization, is the precocious caregiving behaviour manifested by many such children (West & George, in press).

Why should unresolved trauma in one generation be associated with disorganized attachment behaviour in the next? One persuasive theory, recently confirmed by direct observation (Schuengel, 1997), suggests that lack of resolution of trauma may be associated with parental fear in response to infant distress (Main & Hesse, 1990). Schuengel (1997) videotaped natural interactions between mothers and infants who manifested disorganized behaviour in the Strange Situation. Videotapes of the interactions were independently coded. The patterns indicated that significantly more frightened, frightening, or dissociated reactions were found in the behaviour of mothers whose infants manifested disorganized behaviour. It is assumed that the child perceives the parent as either frightened or frightening. As the parent's reaction is unpredictable, the strategy of neither avoidance nor resistance is sufficient to allow the child to cope with these episodes. The child's working model governing the infant-caregiver relationship is incoherent and consequently the infant's behaviour in the Strange Situation is disorganized.

Psychoanalytic observations may help us in elaboration of this process. Acute trauma, such as even temporary separation in infancy, brings forth three biological responses: fight; flight; and dissociation. These reactions are rarely prolonged in infancy if the child's emotional environment is sufficiently attuned and responsive. In the absence of responsiveness, the infant's flight or fight reaction may manifest as a behavioural defence of infancy as observed by Selma Fraiberg (1982). The infant may display a flight reaction and withdraw from the caregiver (Ainsworth's avoidant pattern) or manifest a rudimentary attempt to fight her (the resistant pattern). Whereas the former may be an adaptive pattern when faced with an intrusive caregiver, the latter might be helpful to the infant whose caregiver is only sporadically responsive (Belsky, Rosenberger, & Crnic, 1995). Neither of these strategies is available to the infant confronted by a caregiver who is overall responsive, yet at times absent – is frightened or frightening in response to the child's need for comfort. The infant's emotional expression perhaps triggers a temporary failure on the part of the caretaker to perceive the child as a person in its own right. The child comes to experience its own arousal as a danger signal for loss of emotional contact, accompanied by an intensification of the need for comforting. The child's best strategy may then be dissociation, the splitting of consciousness, absenting himself or herself mentally from a situation from
which he or she cannot escape (Liotti, 1995). Internal working models, based upon such interactions, may then contain a construction of a self-representation that is threatening, even devilish, alternatively helpless or out of control, disintegrating, or defensively grandiose and all-powerful.

The behaviour of the infant in this situation gives clear indication of multiple, incoherently integrated structures, highly reminiscent of dissociative adult patients. Like dissociative adult patients such infants often show disorientation and look glazed, as if in a trance, express intense affects but are unable to relate their behaviour to current events. This lack of integration is clear in dissociated adult patients who may ask for attention, then reject offers of help, then voice a sense of feeling dangerous, go on to accuse the therapist of having damaged them, then voice the hope that they are loved, and so on – all sometimes within a matter of minutes. Of course, such reactions mostly follow trauma in later childhood or adolescence (Allen, 1995; Terr, 1994; van der Kolk, 1994). What is being claimed here is that dissociative response to trauma in adolescence or adulthood is *primed* by the presence of a dissociative core in the self-representation. In other words, disorganized attachment creates a predisposition to a dissociative response.

These ideas may help us understand ‘the children of survivors syndrome’. Let us assume that some survivors of the Holocaust, often manifesting no overt symptomatology, find the experience of child-rearing at times an intolerable challenge. At moments interactions with their infants may have triggered memories accompanied by unbearable psychic pain from which they could find refuge only in states of dissociation. These may have been momentary experiences in a personality otherwise well defended and apparently intact. Such moments of dissociation might, however, have been sufficient to create disorganization in their infant’s attachment behaviour. It is important to recall that disorganized attachment may frequently accompany otherwise secure internal working models. Other survivors, including those with profound post-traumatic disorganisation of character, may have led their child to be avoidant or resistant as well as disorganized. It is not mere insecurity of attachment that constitutes the ‘child of survivor’ syndrome. It is the disorganization that contains within it the seed for a dissociative response to later trauma, through its impact on the child’s experience of internal reality. More specifically, self-states and associated mental representations that appear to trigger a frightened or frightening reaction from the caregiver will be marked in the child’s mind as dangerous, and sensitize the child to specific ideas associated with this reaction. The disorganization of early attachment creates a potential for the child to experience these representations as part of concrete reality rather than psychic reality. This risk persists for the child of the child of the survivor, whether manifest psychopathology was evident in the parent or not, and may account for the apparent ‘transmission’ of specific memories and related affect across three generations.
CASE PRESENTATION

Glen started his analysis in a profoundly dissociated state. For the most part, he was mentally absent and totally inaccessible. Although he was 15, he had the appearance of a 10-year-old. He sat in a chair withdrawn, staring vacantly, there and yet not there, huddled in his tent-like coat far too big for him. Sometimes he hid his face in his hands, occasionally he looked at me through a gap he made between his fingers. Frequently, he totally failed to respond to what I said, or would respond after a long interval, ignoring other things I had said in between. I had a sense of immense hostility, of uncontained confusion verging on madness, and yet this did not seem to be what he was expressing. There were sessions when he was able to talk and at these times the infantile nature of his mental functioning was revealed in a stark and disturbing way.

His clinical diagnosis would have been obsessive-compulsive disorder (OCD). The diagnostic profile described Glen as ‘almost pre-psychotic’ and painted a picture not usually considered suitable for psychoanalytic treatment. Such labels, however, cannot adequately convey the word and thought magic which had totally overtaken his life. His life was completely organized around rituals from the moment he got up and had to tidy his room, in a particular order, sometimes repeatedly if he felt he might have got the order wrong, all through the school day, and to the moment he got into bed when he had to place his pillows at certain angles to the room, to the sunset and to his body. On the surface, he wished to avoid ‘bad luck’ but underneath was a dread of intrusive ideas, concretized as alien beings, spiders, and bacteria. He was terrorized by the delusional (almost hallucinatory) idea that the creature from the film *Alien* lived in the fireplace or in the garden.

His dissociative state was not restricted to the clinical setting: his referral was prompted by his parents observing him walking through the house in a kimono holding a candle, failing to respond to his parents’ anxious inquiries as to what on earth he thought he was doing.

There appeared to be little in Glen’s background that would easily justify his state of mind. His father was probably an authoritarian man who certainly lacked empathy but who was also rather concerned about his son. His mother also seemed to be a caring person but she tended to be depressed; she denied the pervasive nature of Glen’s disturbance and described her relationship with Glen’s father as deeply troubled. I knew that she had been in treatment with a colleague of mine following an earlier referral of the child to the Anna Freud Centre.

It was difficult to know how best to formulate Glen’s difficulties; he seemed relatively bright and in some ways even talented, but totally isolated, and embattled in a constant struggle against a regressive pull in order to contain intense destructive fantasies. His symptoms had worsened rapidly before his referral for treatment and he and his parents were clearly terrified that he was going mad.
Once treatment began, I was quickly at a total loss about how to help Glen. Nothing seemed to work. I attempted to do interpretative work with little success. Not one of a wide variety of interpretations had any apparent effect and it was clear that I was not getting through to him. I became angry with him and found it quite hard to resist the temptation to give up on him. I blamed others, the diagnostic team for not screening him adequately, his parents for not recognizing his difficulties, but above all him for remaining inaccessible and making me so helpless. After a year of treatment the frustration was almost intolerable and seeking consultation seemed the only solution.\(^2\)

The consultation helped in making me aware of the presence of trauma somewhere in Glen’s history. Second, the consultant recognized my anxiety about driving Glen mad which undoubtedly made me interpret more than was helpful. Third, the consultant supported me in my work with his paranoia, which turned out to require a radical change of approach. I abandoned some of my formal interpretative style with him; I became livelier, almost trying to cajole him out of his suspicious stance. I started making jokes and humoured him about his feelings of anger with me, his wish to kill me so I would stop bothering him ‘once and for all’. I imitated his behaviour, showing him rather than telling him how he appeared to me. I chatted to him about my messy room and how I thought he disliked it but did not want to say so in case I might be offended. On a wet morning we talked about him being cross about getting wet, just so he could come and be bored by me for 50 minutes. On one occasion, when he mentioned a teacher of his who was bald and inadvertently glanced at me, I said how pleased he must feel that he had hair and I didn’t, and how ridiculous he thought I looked.

This change of strategy began to bear fruit. Slowly he became visibly more relaxed, his posture changed, he took his coat off. He also opened up verbally and told me about important anxieties, particularly surrounding work. He shared with me, in a manner implying his wish for me to help, his worries about his homework, his wish to be appreciated by his teachers and the dread that he might disappoint them. I suggested that he must have been frightened all along about not coming up to my expectations, that he might feel just terrible were I to be disapproving, and were he to care even momentarily about what I thought and felt about him.

Glen started looking at me, and there were fewer periods of long silence. He began to talk about the thoughts and feelings he had had when he had been withdrawn. He had imagined that he was throwing knives into my body or just missing me, loving the feeling of control and torture. He gave me room to interpret that his worry about my power over him could be related to his wish to control and frighten me; that he wished to destroy people because he was so afraid of them. He was increasingly grateful for my interpretations and some days almost seemed pleased to see me. By the end of that year, a therapeutic alliance had developed where I was seen as both useful and, on the whole, non-malevolent.
Over the next couple of years he made increasingly good use of the analysis and improved symptomatically in ways that both he and his parents clearly noticed. For example, the rituals almost completely ceased and no longer preoccupied him. His obsessional work patterns gave way to a far more relaxed but by no means disorganized attitude. The most remarkable change was at the level of his relationship with me. Even at moments of great anger and resentment, of which there were a fair few, I mostly felt in the presence of a young person rather than an alien being. Only in retrospect did I become aware of how dehumanized I had felt with Glen in the first period of his treatment.

There were several key points. The first was our recognition of the significance of his early period at school when he was regarded as a slow learner and offered remedial teaching. He had found the experience humiliating, not least because of the exceptionally high performance of his older brother and his 'friends' thinly disguised mocking attitude. He was terrified that I wanted to exploit him: 'You don't want to help me, you just want to research my problems.' In the transference, I was the father/analyst ready to exploit and humiliate him. Reversing the transference, empathizing with the wish to humiliate me, seemed to help.

Although I did not notice this at the time, the material we were working with had a special character. A choice had to be made between success and catastrophic failure. The world was for geniuses and retards, millionaires and beggars, masters and slaves. But where one ended up seemed arbitrary.

Importantly, I now think, our understanding of Glen's problems took a leap forward when some feelings concerning the Holocaust indirectly entered the material. This was initiated by a school visit to the film *Schindler's List* which he was seriously considering not going to. He was greatly disturbed by the film. Over a number of sessions he was once again silent. The dissociated, dreamlike states returned with somewhat of a vengeance. I told him that I knew from our past work together that he was suffering but I could not help him because he dared not let me. He accused me of being a torturer. I was surprised but I said (somewhat insensitively) that I wondered if he was not confusing me with a part of himself. He got angry. 'You understand nothing! You are not Jewish!' I reflected that perhaps at the moment it felt safer for me not to understand and not to be Jewish because that protected me from the torturer part of him. He cried but between his sobs he explained that he did not understand, but felt that if people were as inhumane as the Nazis then really they should not be considered human. I said: 'I think you are telling me that I don't understand what it feels like when you have thoughts which make you feel inhuman.' He eventually disclosed, as I had suspected, that he had fantasized being the Camp Commandant in the film who was using Jewish workers for target practice. This quickly led to the elaboration of these fantasies and a shameful disclosure that he constantly fantasized about attacking people and killing them in painful ways.
It took us some time, but eventually we talked at some length about his fantasy of torturing me. He described the various ways he had thought of causing me pain, particularly enjoying the idea of my begging for mercy. Interestingly this was linked to his neurotic concern about his father's tendency to shut himself off in his study, particularly after playful teasing by his family. He feared his father might commit suicide and dreaded both being blamed and the horrible feelings of self-blame. Historical material emerged about his experience of his father's vulnerability and the fragility of his parents' marriage. Eventually it transpired that his concern was far greater about his mother's depression than his father's. It seemed that his mother terrified him by retiring to bed, sometimes as early as 6.00 p.m., leaving the children to look after themselves. His fears about my fragility suddenly made more sense to both of us and he told me how reassured he had been when he realized 'that you can take a joke'. His sadism out in the open, he became increasingly relaxed in the sessions, would sit slouched in the chair, would play games at my expense, mock my room, mimic my habits, comment on my baldness and my tendency to wear the same clothes all the time. In the transference I seemed to become a pre-depressed mother and he was visibly enjoying the experience of the revival of this relationship. Other clinicians working at the Centre noted the change in him: unbeknown to me, he was walking down the stairs whistling.

About two years into the treatment he began to trust me with his sexual secrets. He masturbated to pictures of naked women. He felt deeply ashamed about this and wondered if I would refuse to see him after he disclosed his practices. His aggression deeply permeated his sexuality. The excitement of guns, pain in others and sexual pleasure appeared to be confused in his mind. My acceptance of these fantasies led to an immense sense of relief and he started thinking about asking girls out, although, initially at least, he had little success.

Glen's analysis was completed in three and a half years. During this time anxieties about performance in exams, masturbation and other aspects of sexuality emerged as would be developmentally expected. His adaptation improved remarkably. His obsessional rituals either stopped or they no longer bothered him. His exam performance was well above average and he was offered places in a number of universities. He continued in psychotherapy for a further year, and I continue to receive bulletins of his progress.
remarkable improvement in psychoanalytic treatment. It should be pointed out that some of this information comes from my awareness of therapeutic work with Glen’s mother who was also treated at the Anna Freud Centre many years before Glen by one of the most senior members of the clinic.

Glen was one of three third-generation holocaust survivors I have treated at the Anna Freud Centre and the model I shall outline fits all of them. Glen’s mother was the daughter of a concentration camp survivor who came to England after the war. Both her mother’s parents had been destroyed and only her mother and a younger brother had survived from a large family. Glen’s grandmother almost never talked with her daughter about her camp experiences, although she mentioned the horrific episode of being separated from her own parents who were not selected for ‘work’ on their arrival in the camp. Glen’s mother suspected that her mother, an attractive woman, had been sexually exploited in the camps and that her mother’s shame and humiliation about this had led to the family’s ‘conspiracy of silence’.

Glen’s birth coincided with the death of her father, a kindly man, considerably older than her mother. Her mother became psychotic after the loss, and she had felt very torn between offering support to her mother and looking after her new-born child. She recalled staring at the baby and wondering if it was worthwhile ‘to bring another human being into a world with so much suffering’.

Glen’s mother’s development and pathology fit well with what we know about those in the ‘persistent shadow of the holocaust’ (Moses, 1993), the fate of second-generation survivors. Of special interest here is the possible impact of such transgenerational trauma upon her own parenting capacity. In the final part of this paper I would like to suggest an attachment-theory formulation of transgenerational vulnerabilities associated with severe trauma, using Glen as an illustration. A key construct underpinning our thinking on this subject (Fonagy et al., 1995) is that of mentalization or reflective function. This is the generic human capacity to understand behaviour, not simply in terms of observable outcomes or physical constraints, but by postulating thoughts, feelings, desires and beliefs, taking what Dennett (1987) called the ‘intentional stance’. We have shown that high reflective capacity in the caregiver, in narratives of childhood attachment relationships, predicts attachment security in infants, particularly if the caregiver reports a significant history of trauma or deprivation (Fonagy, Steele, Moran, Steele, & Higgitt, 1991; Fonagy, Steele, Higgitt, & Target, 1994). It also predicts the child’s capacity to interpret the behaviour of others, in terms of beliefs and desires in middle childhood (Fonagy, 1997; Fonagy, Redfern, & Charman, 1997). An understanding of mental states does not spontaneously emerge from the observation of internal experience. Rather, the infant’s observation of the self becomes meaningful in the context of the caregiver’s reactions to his or her expressions of intentionality. The internalization at the core of the child’s self is a perception of the caregiver’s perception of him or her as an intentional being (see Figure 1).
Figure 1 The birth of the psychological self. The infant ‘discovers’ his or her intentional state or subjectivity within the mind of the attachment figure who through a process of inference creates a representation of the child’s mind and behaves in relation to the child in accordance with this representation. The infant perceives and internalizes the caregiver’s representation to form the core of his or her mentalizing or psychological self.

Winnicott (1967, p. 33) warned us that failing to find his or her current state mirrored, the child is likely to internalize the mother’s actual state as part of his or her own self-structure. The child incorporates into his or her nascent self-structure a representation of the other (Fonagy & Target, 1995). When confronted with a frightened or frightening caregiver, the infant takes in as part of himself or herself the mother’s feeling of rage, hatred, or fear, and her image of the infant as frightening or unmanageable (see Figure 2). This painful image must then be externalized for the child to achieve a bearable and coherent self-representation. The disorganized attachment behaviour of the infant, and its sequelae, bossy and controlling interactions with the parent, may be understood as a rudimentary attempt to blot out the unacceptable aspects of the self-representation. Later attempts at manipulating the behaviour of the other permit the externalization of parts of the self and limit further intrusion into the self-representation (see Figure 3). A potential for dissociation is created by this lack of integration of the self, and is used to prevent further encroachment. Glen began the analysis in a dissociated state, with an overwhelming need to control his environment. My initial, regrettable reaction to Glen’s distress, one of angry irritation, was a revival in the transference of the externalization of his perception of his mother’s reactions to him in infancy, which constituted the unbearable parts of his self-representation.

Dissociation is a converse of reflective function, or mentalization. The term ‘dissociation’ refers to a disjunction between related mental contents (Ross, Norton, & Fraser, 1989), which would normally be integrated into a singular subjectivity by mentalization. The individual has awareness of the stimulus but is unable to become aware of that awareness. Although the individual
has feelings and thoughts, he or she cannot represent these as feelings and thoughts. Without the ability to reflect, the normal meaning of experience is lost. Experiences of the self exist in limbo, separate from other aspects of mental function.

Glen had experienced no major trauma, yet the dissociative defence, which normally only extreme stress can create de novo, was, I believe, socially

Figure 2 The birth of 'the alien' self. In infant-caregiver couples where the attachment figure is in a state of momentary dissociation when faced with the infant's distress no representation of the infant's mental state is present. The child is then unable to find himself or herself as an intentional being in the caregiver's mind and internalizes the absence of a representation into the self as well as the actual other which is alien to the self-representational structure.

Figure 3 A model of disorganization of attachment beyond infancy. The individual whose self-structure is at least in part dissociated, experiences the self as incoherent. In order to create a coherent self-structure, he or she must manipulate the behaviour of a physically proximal other to achieve the illusion that the alien part of the self is actually outside rather than inside. The self can then be experienced as coherent.
transmitted to him in infancy. From an attachment theory perspective then, it could be argued that Glen's attachment was on the whole dismissive but also over-controlling, as might be expected as the developmental sequel of disorganized attachment in infancy. We may speculate that as a consequence of the disorganization of his attachment system, there was a vulnerable breach in his self-structure created by his lack of contact with his experience of himself. Hence his dramatic reaction to what were ultimately neurotic conflicts. We believe that the kind of catastrophic reaction that occurred, collapse of his personality, came about through a dysfunction in his self-representation due to what were described as the profound psychological absences of his mother in his infancy, the sequelae of her own infancy and unresolved traumata.

The dissociated core of the self is an absence, rather than genuine psychic content. It reflects a breach in the boundaries of the self, creating an openness in the self to colonization by the mental states of the attachment figure. As Kestenberg (1982) demonstrated, this is not a process of identification as it is not a modification of the self-representation to match the established representation of the other. The dissociative core permits the direct transmission of unconscious traumatic fantasy from mother or father to child. Glen's material contained many ideas from the Holocaust; he appeared to experience these as his own, notwithstanding the distance of two generations. We have noted the profound impact of the film Schindler's List on his fantasies, as well as his paranoid anxieties of persecution. Perhaps even more relevant, his thinking was permeated by specific images which we can trace to his grandmother's experiences, as probably imagined by his mother. In this category I would include: his cruel work regime, used to obliterate psychic reality; his terror of being mocked or humiliated by those he considered his friends; his preoccupation with baldness which was perhaps more than a transference manifestation to a bald analyst as of course his grandmother's head had been shaved; the arbitrary choices between life and death, success and failure may link to the fate of his great-grandparents. He would often say, with complete conviction, that what would happen to him in the day was going to be determined by some random event, such as marks on the Coke can which he would get from the school vending machine. Similarly, his hatred of crowds and his distaste for photography can be traced to fantasies about the extermination camp his mother took to her analysis. Both he and his mother showed a frightened rejection of sexuality, and an assumption that sex meant exploitation and sadism. Many themes that recurred in Glen's analysis were also present in his mother's analysis, and could be linked to holocaust experiences.

As part of her therapy, Glen's mother expressly linked these and other concerns to her own mother's experience - her fear of being photographed, of losing her hair, of being tortured with knives, the terror associated with the thought of being mocked and humiliated by people she knew well, an almost total work inhibition, a terror of exploitation. The match of psychic material between Glen and his mother felt in excess of what could be accounted for
by coincidence. Of course in Glen’s mother these images figured in a very
different neurotic constellation; they were not focused on castration and
homosexual concerns, as were Glen’s. Nor was she as clearly preoccupied
with violent sadism. In our view, once these structures are introjected into
the self, they become part of developmentally expectable neurotic constella-
tions, the vicissitudes of sexual and destructive conflicts. This may account
for a severe presentation that nevertheless appears to respond rapidly to
analysis and, after a rocky start, yields good outcome.

THE MECHANISM OF TRANSMISSION AND
THE MECHANISM OF CHANGE

The images of horror that are transposed into the self do not re-emerge in the
minds of a subsequent generation by a process of magic or even a latter-day
Lamarckian model of evolution (as Freud probably conceived). I believe that
the specificity derives simply from the selectiveness of moments of non-
responsiveness on the part of the caregiver. For example, during our explor-
ation of Glen’s fantasies of throwing knives at me, he told me of his terror of
knives, which during his period of severe obsessionality he had had to keep
locked away. He also had to check, repeatedly, that no knives had been left
out at night, as someone could get up, accidentally knock a knife off the table,
step on it with bare feet and cause serious injury. He mentioned, almost in
passing, that his mother had not let him touch knives until he was at least 9
or 10 and on the one occasion when at the age of 6 he had picked up a knife,
she had screamed and fainted. This had caused him to drop the knife and cut
himself. Specific images of the child’s mind as generated in the caregiver’s con-
struction of the child’s mental states could trigger associations on the part of
the caregiver, and generate dissociative episodes; the representational bound-
ary between self and other in the child’s mind becomes permeable, and the
child’s model of the caregiver’s mental state enters the dissociative core self.
Grubrich-Simitis (1984) made a critical observation concerning second-
generation survivors:

The patients frequently regard what they have to say as thing-like. They
appear not to regard it as something imagined or remembered, as some-
thing having sign character. The open-ended quality of fantasy life is
missing. Instead the expressions have a peculiarly fixed and unalterable
quality, which may at first sight strike one as psychotic. (p. 302)

Grubrich-Simitis links this to ‘the realisation of a psychotic universe’ in the
extermination camp, which brings about a breakdown of inner reality. I
believe this formulation, somewhat modified, may be extended to the third
generation. Glen’s mind, as we have seen, provided a kind of wax mould for
his mother’s representations of traumatic experiences. And once these
representations had been created they acquired a reality and a force indistinguishable from that of externally perceived events. His near-delusional beliefs, which many including myself erroneously considered pre-psychotic, while recognized by him as ideas, were just as powerful as events in the physical world. Developmentally, in these areas at least, he functioned at the level of a 2-year-old, experiencing his mind as if it were a recording device with an exact correspondence between internal states and external reality. We have used the term psychic equivalence (Fonagy & Target, 1996; Target & Fonagy, 1996) to denote this mode of mental functioning which Grubrich-Simitis refers to as ‘concrete’ (as opposed to metaphoric).

The pervasiveness of the concrete, psychic equivalence mode of subjectivity would be hard to over-estimate in the initial phase of Glen’s analysis. It is also important to note that what emerged as an effective technique was a deliberately, and perhaps provocatively, playful stance to confront this dead structure. Although warmth and humour and many other non-specific features clearly were part of this approach, perhaps most significant was the demand on Glen’s ego. The analyst made real that which Glen was determined to dissociate, in a desperate attempt to deny its immediacy. Glen’s analyst forced Glen to play with the ideas of humiliation, torture, annihilation and exploitation. Glen’s tendency had been to regress to a mode of mental functioning where ideas can have no implication for the world outside (the pretend mode of the normal 2-year-old child). Gradually, and through close contact with the analyst’s mind, which could hold together Glen’s terrifying perspective of equivalence and his desperate need to dissociate internal states from reality, an integration of the equivalence and pretend modes gave rise to a psychic reality in which feelings and ideas were known as internal and yet in close relationship with what was outside. Klauber (1987) wrote that ‘transference not only helps the patient to discriminate but also to imagine’ (p. 44). Klauber was probably addressing the same phenomenon that Grubrich-Simitis described and that we have attempted to place within a developmental perspective. Glen could not possibly express his aggressive thoughts until he could learn to imagine, or, more specifically, until he could understand that what he was doing was imagining. The change in therapeutic style recommended by the consultant to the case was of course powerfully advocated by Bowlby (1988) himself as well as other clinicians in the attachment-theory tradition (Hopkins, 1984).

The model of therapeutic change which seems most relevant to Glen’s improvement is the ideas of Thomas Ogden on potential space (Ogden, 1985, 1986, 1989). The therapist’s task appears to be analogous to that of the parent who creates a ‘frame’ for pretend play (e.g. Mayes & Cohen, 1993; Vygotsky, 1967) – except that in this case it is thoughts and feelings that can become once again accessible through the creation of a transitional area. Within the dissociative state, ideas are unmentalized representations, or more accurately the dissociative state of separation between internal and external reality may be conceived of as a defence against the experienced
equivalence between what is internal and what is external. Glen’s analysis and perhaps that of other dissociating traumatized patients was about working with precursors of mentalized ideas. The task could be conceived as one of elaborating Glen’s concrete models into intentional ones. The analyst’s task was one of integrating or bridging Glen’s pretend or dissociated mode of functioning where little of importance felt real with moments when words and ideas could carry unbelievable potency and destructiveness. With highly traumatized patients, this can indeed seem like an awesome task. With Glen, the process appeared to be relatively straightforward. The analyst worked by entering Glen’s pretend world and trying to make it real while at the same time avoiding entanglement, which arises out of the equation of thoughts and reality.

An essential component of this process is the attachment relationship that is established between patient and therapist. Importantly, attachment, as has been suggested, is closely linked to interpersonal understanding (Fonagy et al., 1995). The therapist’s understanding of the patient’s latent (non-conscious) intentionality re-creates certain structural aspects of the infant-caregiver relationship. It revives a situation where the patient attempts to find ‘his mental state’ in the words and gestures of the therapist, much as infants who are not yet self-aware search for their intentionality in the actions of the mother (Fonagy, Steele, Steele et al., 1991). The establishment of an attachment relationship, I believe, is a precondition for the kind of rehabilitative change that is required by dissociative traumatized patients. It should not surprise us then that individuals with secure attachment classifications, whose minds are presumably more open to accommodate mental states in the other, tend to make better therapists (Dozier, Cue, & Barnett, 1994).

QUALIFICATIONS AND CONCLUSIONS

Perhaps at this stage some qualifications are in order. It should be acknowledged that the argument whereby the dissociated state of the mother creates a vulnerability for a similar state in the child, which in its turn could create an exceptional receptivity to specific interpersonal representations entailed in the traumatic experiences of a prior generation, is not only highly speculative but can be supported only by rather scanty clinical data. For example, Glen’s pathology may well have been the consequence of disturbances in his relationship experiences within his own generation. An adequate account of his pathology might be given in terms of his problematic relationship with his father and his therapeutic experiences with an alternative male figure, which might have acted as a kind of corrective emotional experience (Alexander & French, 1946). Where the more traditional account of Glen’s neurosis appears to fall short of satisfying at least the present writer, is in the striking co-occurrence of a very severe presentation, the apparent absence of major environmental deprivations and the relatively rapid response to a
somewhat modified psychotherapeutic approach to his treatment. Of course it is always possible to argue that trauma and deprivation were present in Glen’s own childhood, but this remained hidden from the analyst and other clinicians. Alternatively, a psychosocial account may be entirely replaced with an explanation in terms of genetic vulnerability. At least in the present writer’s experience, neither of these scenarios is consistent with a rapid response to psychoanalytic psychotherapeutic intervention. The evidence for this elaborate theory of Glen’s disturbance is admittedly somewhat preliminary, the clinical puzzle he presented was, however, sufficiently intriguing to justify a certain amount of speculation. From a research perspective, much needs to be learned about the caregiving behaviour of second-generation victims of major trauma. While the impact of trauma on caregiving is relatively well established (e.g. Liotti, 1992, 1995; Schuengel, 1997), we do not know enough about the caregiving that the second generation of victims are offered. Yet, it is clear that stability of attachment classification may often be maintained across three generations (Benoit & Parker, 1994). Ongoing studies in Israel and Germany by Avi Sagi and the Grossmans exploring the impact of the Holocaust on the second and third generations may indeed provide exactly such useful data.

Why did holocaust experiences have such a uniquely traumatizing impact, not only (we can assume) on every immediate victim but also on generations to follow? Perhaps the answer lies in some of the mechanisms that understanding the third generation has helped us identify. Every infant experiences occasional failures of parental attunement (Tronick, 1989). Even the best parents will sometimes fail to reflect the infant’s intentionality in moments of distress, and will then briefly undermine his or her feeling of being human, with a subjectivity, thoughts and feelings that are normally turned into a meaningful psychic reality with the help of the caregiver. Each person is instead, at moments, treated as inhuman, leaving a dissociative area in the self, however small and normally inactive. It is this infantile experience that is activated by the conditions of the Holocaust. The Holocaust involved a society that appeared to be (and to remain) civilized, turning on a group within it and stripping them of all humanity, dignity and safety. People who could have been expected to treat their compatriots as fellow human beings with intentionality, suddenly began to treat the Jews with hatred and a systematic brutality previously unimaginable even between enemy peoples or between humans and animals. The same people continued to behave in a normal way in other relationships.

It is in this duality that perhaps the cruellest aspect of the trauma lies. Mindless persecution destroys our deepest-rooted and most cherished expectations about human behaviour, that it is regulated by a mutual recognition of mental states. The genocide occurred within countries, rather than through external attack, the victims were tortured and degraded by fellow members of a community, people like the victims. Just as child abuse is particularly damaging when perpetrated by a family member, so we may expect
persecution to be annihilating when it is carried out by people whom we might otherwise trust to reaffirm our intentionality. Yet when those people ignore our cries, pay no heed to our evident suffering, we know that this can be achieved only by abolishing a picture of us as psychological beings. Our residual dependence on the social other to reaffirm our psychic reality causes the regression to a psychic equivalence mode of thought and the dissociative/pretend mode of thinking which developmentally represents its counterweight. This regression widens the breach in the boundaries of the self left behind by momentary experiences of inescapable, though probably inadvertent, attacks on intentionality within all infant-caregiver relationships. Individuals with relatively minor disorganization within their attachment system we expect to withstand trauma more effectively but it is unlikely that anyone is immune. Once opened, this gap takes perhaps many generations to heal, and through it pass images of horror, including confusions of identity between victim and torturer, guilt and shame, paranoia and helplessness. Yet once inherited, they acquire meaning in terms of the individual's current psychic reality, and need to be dealt with in the here and now, not the there and then. The third-generation survivor may, however, require unusual care from the analyst to ensure that the intentionality of the patient is fostered specifically in the domains where the intactness of the patient's subjectivity has been so deeply compromised.

ACKNOWLEDGEMENT

This paper is based on a plenary presentation to the Conference of the ICP, Los Angeles, 6 June 1998. The author would like to acknowledge his indebtedness to the editor and to two exceptionally thoughtful reviewers who have helped considerably in the preparation of the paper for publication.

NOTE ON THE CONTRIBUTOR

Peter Fonagy, PhD, FBA, is Freud Memorial Professor of Psychoanalysis at University College London, Director of Research at the Anna Freud Centre, and Director at the Child and Family Center and Clinical Protocols and Outcomes Center, Menninger.

Address for correspondence: Sub-Department of Clinical Health Psychology, University College London, Gower Street, London WC1E 6BT, UK. Email: p.fonagy@ucl.ac.uk
FONAGY: TRANSGENERATIONAL HOLOCAUST TRAUMA

NOTES

1. The psychoanalytic literature on the Holocaust is vast and a comprehensive review is beyond the scope of this paper and this author’s competence. The interested reader is referred to reviews by Jucovy (1992) or Moses (1993).

2. The consultant was the late Marion Burgner, whose enormous help with this case I am pleased to acknowledge.

REFERENCES


