Panel

A Reconsideration of Explicit Memory: Its Role in Enactments, Repetition and Working Through

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Ilany Kogan

2, Mohaliver st.

Rehovot

Israel
Remembrance of historical reality in the analyses of Holocaust survivors’ offspring

INTRODUCTION

The debate involving the place of memory in psychoanalysis was explored in depth by Bohleber (2007). In this paper I wish to show the importance of explicit or declarative memory in the analyses of Holocaust survivors’ offspring by focusing on the phenomenon of enactment. Though I greatly appreciate the place of implicit or procedural memory in analysis, I believe that especially in cases of sons and daughters of Holocaust survivors, explicit memory, which is involved with the retrieval of information about the traumatic past of parents, has great therapeutic value. In these cases, the conscious elaboration of preconscious relationship representations generated by implicit memory and by the analyst’s attention to the transference is not sufficient. Explicit memory facilitates the reconstruction and elaboration of traumatic events from the parents’ lives, thus leading to the awareness of the reality of the trauma – an awareness that becomes part of the patient’s flow of life.

Over the last twenty years I have dealt with the subject of the intergenerational transmission of the Holocaust trauma and its impact on the lives of Holocaust survivors’ offspring, approaching it from different angles. For children of survivors, there was never a time when they were not aware of the Holocaust, whether articulated or unconscious. The remembrance of the Holocaust is constructed out of materials or stories – those spoken aloud, told and retold, as well as those silently borne across a bridge of generations (Axelrod et al., 1978; Barocas & Barocas, 1973; Kestenberg, 1972a; 1972b; Klein, 1971; Laufer, 1973; Lipkowitz, 1973; Rakoff, 1966; Sonnenberg, 1974; Laub & Auerhahn, 1993; Auerhahn & Laub, 1998; Brenner, 2002). This remembrance marks those who carry it as secret bearers (Micheels, 1985). Children who become burdened by memories that are not their own (Auerhahn & Prelinger, 1983; Fresco, 1984) often echo the dramas existing in their parents’ inner worlds by enacting them in their own life (Krell, 1979; Phillips, 1978; Laub & Auerhahn, 1984; Kogan, 1995; 1998). In this way, shared fantasies of
parents and children are concretized by the children, in the sense that they are grafted upon the environment and woven into current reality rather than verbalized.

These often violent enactments involve an intermingling of death wishes with exposure to potentially dangerous situations (Kogan, 2002; 2007). In many cases, they are caused by persecutory anxieties which grow into delusional fantasies of paranoid proportions, anxieties that include a lack of differentiation between self and others, past and present, inner and outer reality.

At the core of the compulsion to enact the parents’ traumatic experiences in their own lives is a kind of identification with the damaged parent, which is termed primitive identification (Freyberg, 1980; Grubrich-Simitis, 1984; Kogan, 1995; 1996; 1998). This identification leads to a loss of the child’s separate sense of self and to an inability to differentiate between the self and the damaged parent. I find this phenomenon similar to the identification which takes place in pathological mourning. Freud (1917) described this identification as a process whereby the person in mourning attempts to possess the object by becoming the object itself, rather than bearing a resemblance to it. This occurs when the mourner renounces the object, while at the same time preserving it in a cannibalistic manner (Grinberg & Grinberg, 1974; Green, 1986). It is this type of identification that is at the core of the offspring’s inability to achieve self-differentiation and build a life of his or her own.

The coexistence of the offspring’s global identification on the one hand, and the denial or repression of the parents’ trauma on the other – a coexistence present in many of these cases – creates a gap in the child’s emotional understanding, a gap I have labeled a ‘psychic hole’ (Kogan, 1995). The ‘psychic hole’ can be seen as a state in which conscious ignorance of the Holocaust (the hole) is one side of the coin, while unconscious knowledge of it is the other.

Enactment in their own lives of themes which belonged to the parents’ traumatic past precludes symbolization of the past and thus prohibits memory via symbolization or representation (internal images). The past is endlessly re-spun and no resolution of the trauma is possible. I now want to show by means of the following clinical vignette how explicit memory pertaining to traumatic events from the parents’ past fills the ‘psychic hole’ and enables the elaboration and integration of the trauma in the offspring’s life.
CLINICAL VIGNETTE

Kay was the stepdaughter of a Holocaust survivor who had been castrated by Mengele’s doctors. Kay communicated with me (in the first phase of treatment) through infantile drawings. One of her pictures, bearing the title "Electricity," depicted a man with a wiry flower emerging from his head. Only at a later stage in analysis, when Kay was able to communicate with me verbally, were we able to understand her unconscious fantasy: the flower of death symbolized her stepfather’s traumatic experience of having to avoid death by spending an entire cold night standing naked between the electric wires of the concentration camp.

Kay was referred to treatment after attempting to jump from the eighth floor of a building. In analysis, we were able to understand her attraction to death caused by jumping off high places as an attempt to enact the torment associated with her stepfather's survival and close encounters with death. For her stepfather, falling would have meant touching the wires, electrocution and a horrible death. When Kay went up to the eighth floor, intending to throw herself out of the window, she was convinced that she would survive. Her delusional, paranoid fantasies of magically and omnipotently conquering death were endangering her life.

The following episode illustrates Kay’s compelling need to enact the reparation of her stepfather’s castration upon her own body. After my summer holiday, she informed me that she had undergone breast surgery during my absence. She stressed the fact that she had chosen to do it when I was away because she did not want to cancel her sessions after I returned home. Elaborating, she explained to me that the operation was the fulfillment of a wish she had had since she was young – to enlarge her breasts with silicone implants.

Kay added that she had visited a doctor who examined her breasts, after which he described them as ‘empty’ rather than small. He indicated that an operation was possible but was not without risks. She was warned of the possibility of her body rejecting the silicone, a condition accompanied by tissue inflammation, fever, and pain, and one that would necessitate further operations. She was told that she might never be able to breastfeed a child. Despite being terrified of these prospects, Kay nevertheless decided to go ahead with the operation. She was referred to a shop where she was measured for implants, and selected them from a catalogue, choosing a medium size, which she felt would make her look much more like a ‘whole’ woman.
Kay came to analysis on the appointed date, two weeks after her operation. She entered the room walking upright and, pulling her blouse against her breasts, asked if I could see any change. Only afterwards, when lying on the couch, did she tell me the whole story. She was overjoyed and stressed her satisfaction with her ability to conquer her fears.

In my countertransference feelings, I felt a heavy weight burdening my heart. This made me aware that Kay was not in touch with her sadness, which was conveyed to me by massive projective identification. Attempting to understand what had compelled her perform this deed during my absence, I pointed out to Kay that she had begun feeling that her breasts were ‘empty’ only when I was not around, when she wasn’t getting the feeding and support from our regular sessions. Kay laughed a short laugh and then confirmed my hypothesis in an angry voice, “I don’t need you; I don’t need anybody. I want to depend only on myself.”

I showed Kay that her need to "fill" her breasts stemmed from her anger and frustration at feeling abandoned by me. Gradually, she became aware of these feelings and accepted them. Working through these feelings in the transference led her to reveal her fantasies of flirting with death on the operating table. She had undergone the operation in order to repair her femininity, but thought she might die as a result. Of course, she now felt that she had once again overcome a terrible danger.

Kay associated her victory over possible death on the operating table with a story from her stepfather’s life. After the war, he had met one of the few other men who had survived castration in the Mengele experiments. The man told Kay’s stepfather about a Jewish doctor in Paris who performed restorative surgery – i.e., implantation of testicles – on these victims free of charge. Her stepfather decided to go to Paris and have the operation. It was successful and he was able to resume sexual relations with women, though he remained infertile.

Kay and I then attempted to find out what was filling her ‘psychic hole’, the unconscious fantasies that compelled Kay to enact her stepfather’s life story on her own body. I pointed out to Kay that she might have been trying to implant her femininity into her breasts in the same way that her stepfather had had his manhood implanted into his empty testicle sacs.

A pregnant silence filled the room as Kay absorbed my words. Then, understanding the meaning of her choice to undergo surgery, she was overwhelmed by a powerful surge of emotion. It took us a long time to work through the feelings of
fear, depression and pain which subsequently replaced her euphoria. Furthermore, we tried to elaborate on the complex needs she had expressed through her surgery. Consciously, she was trying to attain a better, repaired sexuality. Unconsciously, she was attempting to endanger herself in a concrete way, to come as close as possible to an imagined death in order to omnipotently overcome it.

Kay did not know many details of her stepfather’s experiences during the Holocaust, because he kept them mostly to himself. The atmosphere at home was one of silence, which concealed a past full of terror and violence. Her stepfather had been writing his memoirs of the Holocaust for the last twenty years, but Kay had never had the courage to ask to see them. In analysis, after working through her fear of discovering what had really happened to him, and encouraged by my supportive attitude, she decided the time had come to do so. To her great surprise and excitement, her stepfather sent her his complete autobiography, which he had dedicated to his adopted children. Kay read it avidly, and brought it to me so that I too could read it. I did so, feeling that I had to participate in this action; thus I ‘actualized’ (Sandler & Sandler, 1978) her wish to make me her partner in ‘the search for the self through family secrets’ (Gampel, 1982).

The elaboration of this episode enabled us to begin an exploration of the way Kay had communicated with me during the first part of treatment, and the way she had lived her life until then, using her body to express unconscious fantasies pertaining to bodily sensations, anxieties and emotions that were experienced by her stepfather during the Holocaust.

We could now understand her constant preoccupation with her body – physical fitness, weight, and muscle tone – as part of her survival complex. It was based on her unconscious fantasy that “I feel my body, therefore I exist.”

All through her treatment, Kay complained at length about her defective sense of smell. Only now could we make the connection to her stepfather’s story about the awful stench emanating from people dying in their excrement and vomit, not being able to “make it” to the public latrine. Thus, impairment of the olfactory sense became a survival mechanism for him. Kay’s constant state of hunger, as well as her suffering from cold and her inability to find suitably warm clothing, were primary aspects of her stepfather’s wartime experiences as well.

Kay had a fear of incontinence (which she expressed by running often to the toilet during sessions). In this regard, she brought up a story of woe and humiliation from her stepfather’s memoirs: “Father stood for hours at roll call, peeing in his
pants, knowing that any movement could incur the death punishment.” Urine was the substance used by her stepfather to treat a wound on his leg caused by a brutal kick from a German soldier.

During this phase of analysis, in which she recounted these stories, Kay felt that she was treating the wounds in her soul with bits of information from her repressed consciousness, things which she had known but had forgotten over the years.

**DISCUSSION**

For many years, the historical reality of the Holocaust was completely ignored or denied by psychoanalysts who refused to acknowledge the impact of parents' traumatic memories on their offspring's lives. Only several decades after the end of World War II did investigators begin to acknowledge the inevitability of transmitting pathology from survivors to their children (Sigal, 1971; Rakoff, 1966, 1969; Trossman, 1968; Kestenberg, 1972a; 1972b).

Even in contemporary psychoanalysis, we can find approaches which give only secondary consideration to the impact of memories connected to the traumatic Holocaust past. An example of this can be found in some of the reviews of my paper “On being a dead, beloved child” (Kogan, 2003), in which I described the impact on my patient of growing up as a replacement child of two Holocaust survivor parents, each of whom lost a child during the Holocaust.

In his eloquent discussion of the case, Ferro (2003) dealt with the issue of the weight that should be given to the atrocities of the past. He maintained that the memories of the parents' traumatic history which surfaced in analysis may be regarded as a metaphor to the “narrative scenery of analysis” (p. 777). Ferro did not see these atrocities only under the rubric of reality, but also as deep emotional experiences of the patient. He claimed that the prioritization of the historical reality over the narrative reality makes it more difficult for the analyst to unravel emotional threads, thus postponing the recognition of these emotions for only later in work. In Ferro's view, the narrative has greater psychoanalytic value than the mere historical truth. This approach reminds us of that of Fonagy (1999), who considers patients' memories as inaccurate, therefore of almost negligible importance, and significant only in the sense that they reflect early object relations in the transference.
In his discussion of the same case, Brenner (2003) attaches less importance to the historical reality of the Holocaust than to the analytic exploration of childhood conflicts. He states that “sexual and aggressive wishes of childhood become and remain throughout life a source of conflict for everyone” (p. 772), and the historical reality is significant only when it has an influence on these conflicts.

By contrast, I myself firmly believe that in the case of Holocaust survivors’ offspring, it is mandatory to recognize the importance of traumatic memories linked to the historical reality of the patients’ damaged parents and work them through.

The vignette from the above described case demonstrates the impact of the traces of autobiographical memory on the patient’s life. While I have great respect for the importance of the reactivation of early object relationships in the transference (the fact that the patient conceivably had to fill her breasts when I was away and thus unable to feed her), as well as for the analytic exploration of childhood conflicts (which would include the exploration of the patient’s oral dependency needs and her struggle against them), these would not have been sufficient in this case. I feel that helping the patient to understand her enactment – the actualization of her father’s trauma upon her own body – was vital in this case.

Based on my rich experience with Holocaust survivors’ offspring, I believe that the most effective way of transforming the compulsion to enact into a cognitive mode is by helping these individuals find the historical trauma in their parents’ lives and bind\(^1\) it in a meaningful context, thus consigning it to the past of the parents. In these cases, cognition and emotions had been severed by the parents’ repression of the trauma, leaving traces of the repression in the child. Finding the parents’ ‘unknown’ story and lifting this repression, followed by a process of working through,

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\(^1\) The concept of ‘binding’ was first described in Freud’s (1920) theory of why certain events have a traumatic effect upon the mind, and how the personality takes account of and adapts to the resulting changed internal conditions. The concept appears in connection with his famous meta-psychological explanation (1920, p. 31) of trauma as an “extensive breach made in the protective shield against stimuli,” which occurs only when the mental apparatus is not prepared for anxiety, i.e., the parts of the system which are to receive the excessive stimulation are not properly hypercathetced and therefore “the inflowing amount of excitation could not be bound.” It is hard to be sure what precisely Freud meant by “binding,” since he used the term at different stages of his work in different ways (Laplanche et al., 1973). However, by 1920, it had taken on the general meaning of a defensive operation that restricts free-flowing “excitation.” Once the catastrophic breach in the protective shield has taken place, and mental functioning is in turmoil and disarray, the problem is one of “mastering the amounts of stimulus which have broken in and of binding them in the psychical sense, so that they can then be disposed of.”

In the recent literature (Garland, 1991, 2002), ‘binding’ is described as a process by which the ego creates links between the free-flowing excitation and functions of the mind. In this way the ego attempts to recreate structures of some permanence in which ego functioning is possible.
transforms the possible enactment into an “affective understanding’ (Freud, 1915). This kind of understanding links thoughts and feelings, thus greatly decreasing the need to repeatedly enact the parents’ stories in the children’s current lives.

The quest for information – the purpose of which is to enable the patient to give up these enactments – is a difficult experience for the survivor’s offspring. It is my view that in the initial stages of analysis, only a supportive, nurturing environment, which includes a holding relationship (one that decreases the patient’s tremendous anxiety) and holding interpretations (those that help the patient mobilize his/her forces to find the meaning of the trauma in the parents’ lives) can strengthen the patient’s mental organization to the point that the flow of fragmenting, potentially life-threatening re-enactments is halted (Kogan, 1995; 1996; 1998; 2002; 2007).

The quest for information also serves the purpose of differentiation and the creation of a new and separate self. On this level, it might be accompanied by torment and anxiety. Consciously, the child is afraid that his questions about the past will force the parent to relive painful, traumatic memories that may threaten his psychic survival. Unconsciously, the child experiences the wish to know his parent’s history as a step toward differentiation and relieving the burden of the past, which he feels may be potentially destructive for the parent. This search is usually facilitated by the holding atmosphere in analysis and by the patient adopting the analyst as an ally in his quest.

Treatment often does not end here, and there is much psychic work to be done in further stages of analysis. It is only after the initial phase of holding, in which the patient’s self is strengthened, that interpretations of his or her unconscious life become not only acceptable but also necessary. During these later phases, it is possible to work through the missing pieces of the parent’s history, which is often connected to the child’s feelings of shame and guilt.

In some cases, the parent’s story does not emerge easily, but has to be actively sought. The therapist’s supportive attitude facilitates the patient’s discovery of that part of the parent’s history that will fill the ‘hole’ by means of the acquisition of concrete details from the parent’s past. Kay’s request to read her stepfather’s memoirs in order to learn – among other things – about his castration by the Nazi doctors, was enabled by my support.

In conclusion, the construction of an unbroken narrative based on explicit memory – one that fills the gaps in the child’s knowledge, that makes it permissible to mention the unmentionable, that interweaves the awareness of the realities and
horrors of the Holocaust with the present – enables survivors' offspring to gradually gain some comfort from the split-off knowledge, which has been accompanied by unacknowledged affects and fears. Explicit memory facilitates the reconstruction of the traumatic events and narratives that formed the starting point of the child’s wound, so that the split-off and diffusely re-enacted memory fragments from a persecutory world are elucidated. The reconstruction of the historical trauma based on explicit memory leads to the interpretation of fragmentary, defensive re-enactments. This process facilitates the work of mourning which continues during the latter phases of analysis and eventually frees the offspring from the burden of the past and enables him to achieve a stronger, better integrated self.

REFERENCES


