Trauma Therapists in Israel

A Qualitative Study into Personal, Familial and Societal Sources of *A Priori* Countertransference

Yvonne Tauber

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ISBN 978-965-91302-0-7

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Printed by Gildeprint, Enschede

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Traumatherapeuten in Israël:
Een kwalitatieve studie naar persoonlijke, familie-, en maatschappelijke achtergronden die van invloed zijn op *a priori* tegenoverdracht

(met een samenvatting in het Nederlands)

PROEFSCHRIFT

ter verkrijging van
de graad van doctor aan de Universiteit voor Humanistiek te Utrecht
op gezag van de Rector, prof. dr. H.A. Alma,
involge het besluit van het College van Hoogleraren
in het openbaar te verdedigen op maandag 27 oktober 2008
des ochtends te 10.30 uur

door

Yvonne Tauber

geboren op 6 Januari 1950
te Amsterdam, Nederland

Promotores
Prof. Dr. H. Kunneman, Universiteit voor Humanistiek Utrecht
Prof. Dr. Chr. Brinkgreve, Universiteit Utrecht

Co-promotores
Prof. Dr. O. van der Hart, Universiteit Utrecht
Dr. D. Brom, The Israel Center for the Treatment of Psychotrauma, Jerusalem

Beoordelingscommissie
Prof. Dr. H.A. Alma, Universiteit voor Humanistiek te Utrecht
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Prof. Dr. A. Smaling, Universiteit voor Humanistiek Utrecht
Dr. W.J. Gomperts, Universiteit van Amsterdam

Rudy Tauber
George Tauber
Harry Tauber
Hans Tauber
and my grandparents who were all killed in Auschwitz
you are remembered

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ACKNOWLEDGEMENTS

It is a privilege to have so many people to thank for the many different ways in which they have supported me along the path towards the final version of this dissertation. My *promotores* have all, in their unique ways, encouraged, criticized, stimulated and supported me. I am grateful to Harry Kunneman for his generosity of spirit in guiding me through the last and crucial phase, for his breadth of interest and knowledge, enthusiasm and sensitive support. I want to thank Christien Brinkgreve for her genuine interest, both professionally and personally, for her critical thinking, her open-mindedness, the loan of her wonderful hide-away in the dunes for some quiet writing, and especially, for her unwavering commitment to protect the academic expression of my true voice and professional convictions. My thanks to Onno van der Hart for his immediate and positive response to my ideas for this dissertation, his encouragement of the organic development of the sequence of the studies, for nurturing the work during the earlier stages and for the flow of articles and books he made available to me at just the right times. To Danny Brom I owe particular thanks for first suggesting I develop my ideas into a doctoral dissertation and contact Onno van der Hart, and for our stimulating and at times, quite heated, discussions that helped me articulate my ideas more sharply. I also want to thank Onno and Christien for their unfailing, heartfelt concern for both Danny's and my physical and emotional wellbeing at times when life in Israel was at its most precarious.

There are many more people for me to thank, but first and foremost I want to express my immense gratitude and appreciation for the therapists who allowed me to interview them and learn from them. Their openness, integrity, commitment to their clients, courage and wisdom, have remained a source of inspiration. Not all are still with us. You are sorely missed.

I also remain indebted to Haim Dasberg, Karen Shachar and Eli Witztum for sharing their personal experiences regarding the development of awareness, in Israel, of their respective fields of expertise, Holocaust, sexual and combat trauma; to Yolanda Gampel without whose generous investment of time and support during the writing of *In the other Chair*, I might not have started this dissertation; to Yitzhak Mendelsohn for sharing so much of his knowledge of interpersonal traumatization and reconciliation; to Babette Rothchild for her reading of the manuscript and helpful comments; to Kathy Steele for reading sections of the manuscript, her encouragement and interest; to Sheri Oz for her support throughout the process of this doctorate, and for proofreading much of the manuscript; to Elisheva van der Hal and Yitzhak Mendelsohn for their reading and rereading of the different versions of the manuscript and valuable comments; to

Eva Elbaum and Elisheva van der Hal for their help with the Dutch summary; to Avraham van der Hal for taking on the onerous task of preparing the final manuscript for printing, and demonstrating such gracious patience with me along the way; and to Shlomo Avayou, for teaching me about some of the historical developments leading up to the formation of Sephardic and Ashkenazy Jewry. I also want to thank Haim Elbaz, MD and Ronald Ban, MD for teaching me important lessons about healing relationships, co-operation, empathy and respect.

Conversations with colleagues and friends on topics related to this dissertation have been of great help. And on a personal note, I thank my dear friends for enabling me to withdraw for sometimes long bouts of writing while leaving me confident in the knowledge that they would be there at any time to share conversations, meals, concerts and films.

Because of the subject matter and research methods I have chosen, I have had to deal with highly emotive, at times traumatic, material. I therefore want to particularly acknowledge Eva Eshkol, Yitzhak Mendelsohn, Marcia Shaharabani and Elisheva van der Hal who held me in a solid embrace of warmth, friendship, humor and caring. They have, each in their own way, been true companions in all the ups and downs of this work.

I can only hope that all my friends, colleagues and relatives, in Israel and abroad, who invariably expressed interest in how I was getting along and how the work was progressing, know how meaningful their support has been.

CHAPTER 1

Introduction

The encounter between a person seeking relief from psychological pain and difficulties and the trained professional to whom he or she turns to for help is rich in semi-conscious or unconscious emotions as well as preconceived ideas and values held by both parties in the dyad. It would be reasonable to assume that these emotions and thoughts impact upon the therapeutic process and hence need to be brought into awareness, understood and monitored. Whereas the professional literature is, of course, replete with explorations of the inner world of the client, that of the therapist has not received nearly as much attention but might nonetheless significantly impact the therapeutic process.

In this dissertation, it is the individual therapist's personal contribution to the dyad, specifically with traumatized clients, rather than the theoretical approach and technical interventions, that is of interest; the extra-professional luggage as it were that the therapist brings along to the sessions. The term I have coined for this phenomenon is *a priori countertransference* (Tauber, 1998), as these thoughts and feelings are not evoked by way of direct interactions with the client, but arise even before the actual encounter with the potential client.

It took some steps in my professional development before I was able to conceptualize *a priori* countertransference. During my graduate studies in the early eighties in San Francisco, almost every professor would start a new course with a quick check of hands to see who was currently in therapy, and then encourage those who were not, to start as soon as possible. The message seemed to be that the study of clinical psychology demanded more than intellectual effort. I had come to the U.S. to go to graduate school but once there, I had strong emotional reactions to being in the country that, had its borders been open to Jews just before, and during the Second World War, might have saved the lives of my relatives and of many others. At the same time, I was acutely and gratefully aware that had it not been for the American and other allied soldiers, my parents would not have been liberated in time and I would not have been born.

Therefore, I looked for a therapist who had some professional and perhaps, personal, understanding of Holocaust survivors and their offspring. The first two therapists with whom I met were highly recommended, but I sensed a tendency to over-identification and too much, what I have called, anticipatory empathy, which warned me off both of them after the first session. The third therapist told me she herself was a child of survivors without going into further details, and seemed appropriately interested. The therapy was excellent, but rudely interrupted when a letter, informing me that my mother was terminally ill, summoned me home to Israel.

At that time, I had no theory yet about the impact of the person of the therapist on the course of therapy, just intuition and personal experiences ranging from good to dreadful. A visiting psychiatrist at the counseling service at the

Hebrew University in Jerusalem stands out positively in my memory. I saw him for psychotherapy when I was a young student in distress after terminating my engagement to be married. He determined the length of each session as he deemed appropriate at the time, ranging anywhere from a few minutes to well over an hour, always remaining respectful, supportive and professional. Within the few months that he was there, he firmly steered me back towards recovery and growth. An example of a dreadful experience was in London in the mid-seventies, with an ex-junkie, ex-drug dealer who, without formal training, led encounter groups.

A theory about the impact of the person of the therapist started to take shape for me in 1987, in Jerusalem, when I joined an organization that was just being set up to provide psycho-social aid to Holocaust survivors and their offspring. We had no clients yet when I noticed I had significant somatic, cognitive and emotional responses. I first wondered whether those were still aftershocks from some of the recent changes in my life, but when I checked with colleagues, they too became aware of reactions they thought were connected to the work we were about to start. That was when I thought of the concept of "*a priori* countertransference." Together with a small group of colleagues I set out on a journey of self-exploration in order to learn what in our backgrounds of being Holocaust survivors and children of survivors might trigger such responses and what these might have to teach us (Tauber, 1998). One of the more shocking discoveries was that, without exception, we had all gone through at least one course of otherwise adequate psychotherapy, without, in any way, addressing the Holocaust and its consequences on our lives.

Over the following ten, fifteen years, my clinical practice expanded to include survivors of other interpersonal traumatic events, such as terrorist attacks and sexual assault. It was not rare to find myself in the position of being the "first one" clients told of their sexual abuse experiences. Most striking was to hear this from a child survivor who had been in therapy for years with several well known therapists who had specialized in working with Holocaust survivors. She had never been asked directly, however, or felt empowered to speak of the intense betrayal she experienced when she was sexually abused as a small child after the Holocaust.

Fluctuations in Awareness of Trauma

Extensive reading in the literature opened my eyes to societal--and professional--blindness to traumatic events and their consequences, followed by periods of awareness, which in turn were followed by oblivion and blindness again. The first major theoretician of the impact of traumatic events was Freud's contemporary Janet, but despite his "large body of work and his profound

influence both on his contemporaries and on the next generation of psychiatrists, his legacy was slowly forgotten" (Van der Kolk et al., 1996, p. 55). Freud initially accepted Janet's understanding of trauma and traumatic memory but came to mostly reject the reality of childhood sexual trauma in favor of a fantasized seduction (Van der Kolk & Van der Hart, 1991). This led psychoanalysis to disregard so many patients' horrendous experiences, including incest (Van der Kolk and Van der Hart, 1991). In the later part of the twentieth century, Janet's body of work was gradually reintroduced (e.g. Ellenberger, 1970; Van der Hart & Friedman, 1989; Van der Kolk & Van der Hart, 1989).

Awareness of trauma increased significantly during and just after the World Wars (Herman, 1992; Van der Kolk et al., 1996). The waning of awareness occurred in the more peaceful post-war years. This might have meant, for instance, that a veteran who turned for help for psychological complaints in the 1950's would not have been recognized as potentially suffering from traumatic war experiences. Studies in Israel have shown similar, rapid cycles and the increasing understanding of the impact of war traumas on society as a whole. (Bleich, 1992; Solomon, 1995a; Witztum & Cohen, 1994; Witztum & Kotler, 2000; Witztum, Levy, & Solomon, 1996).

Holocaust survivors remained clinically invisible for decades (Tauber, 1998, 2003, Chapter 3), unless they were mentally ill and needed psychiatric intervention. In those cases, their Holocaust experiences might still not have been addressed. Such invisibility has also been true for sexual abuse survivors, even to this day.

Mental health professionals have not really been alert to incest and other forms of sexual assault until the late seventies. In her groundbreaking book on incest, Herman (1981) referred to Henderson's chapter (1975) in a basic psychiatry textbook that taught that there was about one case in a million of any form of incest. It took the women's movement in the seventies for professionals and society at large to begin to understand just how widespread posttraumatic disorders were in non-military populations, especially among women and children (Herman, 1992). Blake, Albano, and Keane (1992) noted that unlike a steadily growing body of literature regarding war-related trauma in the 1980's, surges and drops in publications on sexual trauma in that same decade might be influenced by "social and political events outside the scientific community." (p. 481) Brenner (1999) warned therapists that increasingly widespread acknowledgement of trauma might evoke counterproductive responses because of the implied demand of societal responsibility, and suggested they proceed with caution.

Still, there have always been individual therapists who enabled their clients to speak of these horrors and/or who were sensitive to allusions and encouraged elaborations. The question then arises, what made it possible for these therapists to

behave differently from their colleagues and the contemporary accepted norms. One may wonder whether their personal, familial histories, certain circumstances in their upbringing or merely special empathic abilities enabled them to truly listen to their clients -- questions that will be explored in this dissertation. Perhaps a partial answer can be found in the work of Van der Kolk and colleagues (1996) who noted that the latest revival of interest in trauma was due to work by individuals, including therapists and researchers, who themselves endured combat, sexual or other traumas. Weisaeth (2000), too, remarked on this phenomenon in Europe.

Choice of Holocaust and Sexual Traumatization

Out of concern that despite our best intentions to be of help to our clients, trauma therapists might unwittingly abandon them to their suffering, and out of a strong desire to learn how to become better able to hear our clients, I wanted to further explore the concept of *a priori* countertransference. I chose to stay in the realm of interpersonal traumatization, as opposed to traumatization as a result of natural disasters. Interpersonal traumatization might evoke a sense of personal threat, of personal vulnerability and especially, a sense of responsibility which a therapist might not be aware of nor wish to confront. In my understanding, all members of a society share a degree of civic responsibility for what happens to others by virtue of our ability to vote, protest or take other action. For instance, if a child in Israel experiences incest but no one "knows" about this, I share responsibility for the fact that neither this child's teachers, neighbors or the family doctor have sufficient awareness and social support to intervene, just as I share responsibility for the fact that this child may not have felt encouraged to ask anyone for help.

I wanted to broaden my scope and learn from therapists who did not necessarily share a similar traumatic history with their clients, and who specialized in working with Holocaust survivors, their offspring and/or victims of sexual abuse. I chose these specializations as the Holocaust, the attempted genocide of the Jewish people, is generally considered to be one of the most extreme, varied and lengthy sources of mass traumatization with elements of sudden social exclusion, humiliation, persecution, incarceration, physical and sexual abuse, and, of course, murder. And it was a very public, well organized multi-nation undertaking with many active participants, the perpetrators, but also passive participants, the bystanders, and the victims.

Crimes of sexual assault, on the other hand, and one of the most secretive and devastating forms of traumatization, incest, tend to occur out of the public eye, and easily remain outside public awareness. This does in no way negate an element

of social responsibility, however, in terms of social condemnation of the perpetrators, support for the victims and creating an atmosphere of openness that would encourage victims and bystanders to seek help. Additional reasons for choosing these specializations are both my professional and personal involvement in these areas, as a child of Holocaust survivors and as a woman who, like so many women, has been the target of different forms of sexual inappropriateness.

In-session and *a priori* Countertransference

Therapist responses to specific clients in the therapy setting that I refer to as *in session* countertransference have been studied in the literature on counter-transference over the past century. Ever since Freud's (1910) understanding, as cited by Jacobs (2002), that the analyst's unresolved issues might interfere with analytical work, conceptualization and appreciation of counter-transference have gone through different waves of intensity (Pearlman & Saakvitne, 1995).

Forms of Countertransference

Drawing on the work of Louise de Urtubey, Duparc (2002) summarized the existing attitudes in psychoanalytic thinking by suggesting four approaches to countertransference: The first is the "classical theory in which the counter-transference is viewed with suspicion…. to be controlled or minimized by a rigid setting of neutrality and silence intended to limit the expression of affects on the part of the analyst" (p. 121).

The second approach to countertransference is the totalist theory, first proposed by Heimann (1950), according to which the analyst actually uses the emotions and responses evoked by the patient's transferences in order to increase understanding of that patient. Duparc (2002) points out, however, that when the analyst makes interpretations, "he or she does so as if everything came from the patient" (p. 122).

Duparc referred to the third type of countertransference as "corrective to the excesses of the first two positions…the analyst's self-analysis as an essential factor in the analytic process….the analyst is evidently seen by such theories as able to identify in the countertransference with the dependent child" (2002, p. 122).

The fourth kind of countertransference seems to the preferred one in France and Latin America, where it "is not seen as troublesome, or total, or as something to be subjected primarily to self-analysis, but serves for understanding the analytic situation….The analyst…must remain the guardian of the setting" (Duparc, 2002, p. 123). In fact, Duparc (2002) mentioned that there recently had been increased focus on the setting "to embrace extra-analytical spaces or

therapeutic ideologies molded by the social field in which psychoanalysis is practiced" (p. 125). Thus, at least in some parts of the world, there seems to be a movement towards acknowledging societal influences on clinical practice.

Over the last decades of the twentieth century, there has been a significant increase of interest in the issue of countertransference (Jacobs, 2002). I find it intriguing that this occurred at approximately the same time that the traumatic impact of war, domestic abuse and rape became more generally accepted. In fact, it seems to me that therapist willingness to examine their own personal responses to their clients and the materials clients raise, runs a course historically parallel to that of societal recognition of the impact of trauma.

Countertransference and Trauma

Therapists who choose to work with traumatized clients may face unique countertransferential challenges (e.g. Benatar, 2000; Catheral & Lane, 1992; Danieli 1981, 1994a; Davies & Frawley, 1994; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994a). "Often, the same issues that cause victims to become fixated on the trauma (numbing, dissociation, fascination, revulsion, rescuing, and blaming) obstruct therapists in their attempts to undo the effects of that trauma" (Van der Kolk, 1994, p. vii). The fact that many trauma survivors are also adept at hiding their particular emotional scars, compound the therapists' difficulties. As Hoffman (2004) points out, people do not necessarily look traumatized: "It is only in the family, or among intimates, that the intimate symptoms of psychic injury are evident-and there they are usually understood as modes of behavior, or features of personality, rather than as symptoms of disturbance" (p. 37). Or, in the words of another gifted author (Fuller, 2004):

> Those of us who grow in war are like clay pots fired in an oven that is overhot. Confusingly shaped like the rest of humanity, we nevertheless contain fatal cracks that we spend the rest of our lives itching to fill (p. 250).

Perhaps the most significant and encompassing work published to date on countertransference in work with traumatized clients is Dalenberg's *Counter-transference and the Treatment of Trauma* (2000). She includes the full range of therapist responses to clients in clinical work in her definition of "traumatic counter-transference." While Dalenberg focuses on *in session* countertransference, she does give significant emphasis to the individual therapist's style and attitudes that come into play in trauma therapy. Lindy (1996) sounds a note of warning about possible responses which will be challenged in this dissertation:

> Patience is quite incompatible with the intense feelings of helplessness, rage, rescue, and sadness that these patients evoke. Victims invite their therapists to violate some of the most basic tenets of psychotherapy, which are to suspend value judgments, to avoid moralizing, and to eschew therapist activism (p. 535).

A Priori Countertransference

The various conceptualizations of countertransference and impact of the individual therapist on the therapeutic process are highly relevant and of interest. There have also been sporadic references pertinent to *a priori* in the literature. Pearlman and Saakvite (1995), for example, discuss the impact of "the therapist's own gender identity conflicts, socialization, beliefs, and politics" on their handling of gender issues concerning their clients (p. 191). In a British study, Lewis, Croft-Jeffreys, and David (1990) discovered that "the 'race' of a patient influences clinical predictions and attitudes of practicing psychiatrists" (p. 413). A recent study by Chino, Heck, Nakayama, and Ambady (2006) found that biracial subjects, who had just thought intently about one of their parents, were more likely to perceive faces of people of that parent's race in a visual search of black and white faces. The implications of this observation on therapist *a priori* countertransference seem clear and merit discussion.

There have also been cautions in the literature lest therapists inadvertently bring their personal attitudes and ideas into the clinical space. Hoffman (1996), for example, alerts therapists to the risk of imposing their own values and view on clients. This may prove to be quite a challenge as Luhrman (2000) suggests in her anthropological study of societal influences on the training of psychiatrists in the United States: "We *learn to* perceive. This is perhaps the most basic anthropological insight. People are never 'in themselves' to other people" (p. 275). Luhrman leaves little room for objective perception of facts and issues, as these would be filtered by personal interpretation of societal--including professional--values and interests.

Still, I have encountered no systematic conceptualization that includes influences from therapists' personal, familial and societal histories and current reality upon their ability to be fully present to their clients and create therapeutic space for their traumatic experiences. The closest was Danieli's (1994a, p. 173) concept of "event countertransference." In recognition of difficulties of mental health professionals working with Holocaust survivors, Danieli coined the term "event countertransference" to describe responses to a specific traumatic occurrence, in the case of her study, the Holocaust. I have incorporated this and intend to go beyond it in this dissertation with my conceptualization and exploration of *a priori* countertransference.

And whereas the general understanding of *in-session* countertransference has, over the years, evolved from something to be neutralized, avoided, to a

potential source of information about the therapeutic process and the client's experience, *a priori* countertransference in itself is neither positive nor negative*****; it can predispose therapists towards sensitivity regarding trauma, for instance, or blunt such sensitivity. In this thesis, I will mostly emphasize the potentially negative implications which may result from lack of awareness. The very inevitability of *a priori* countertransference leaves therapists with two choices: ignore at the risk of unintended harm to clients; or explore, monitor, be in an ongoing process of self-awareness in order to remain optimally sensitive and available to traumatized clients.

Societal Context

As already indicated, I consider the societal context in which trauma therapists live and work as a major source for exploration of *a priori* countertransference. My sensitivity to the person behind the role, the profession, in this case the trauma therapist, probably stems from the most dramatic time in my own family's history, the rise of Nazism and the Holocaust. Fortunately, as always, there were individuals who remained true to themselves and their values even at the risk of their own, and sometimes, their family's lives. But a person's profession was no guarantee for moral, or even professional, behavior.

Just how strong societal impact can be on human relationships--professional and personal--could also be seen in the former Soviet Union, and more recently, in neighbor turning against neighbor in the latest Balkan war or the genocide in Rwanda. People are not necessarily aware how societal norms and values may impact their perceptions and actions. As Nathan Durst put it, "It is dreadful to think that in 1935 or 1937, people might have had no idea what they were going to do in 1941 and 1942. But it shows how we people can adapt ourselves, and how enormously negative the influence of leaders can be on their followers." (Tauber, 1998, p. 209). Indeed, a German train driver in 1937 could not have imagined that six, seven years later, he would be driving cattle cars overfilled with humans, destination death camp.

There is some support, in the professional literature, for the understanding of the impact the social, cultural context may have on the therapeutic process. "History demonstrates that psychiatry is embedded in social forces, possibly more so than any other branch of medicine" (Van der Kolk, Weisaeth, and Van der Hart,

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* My thanks to Elisheva Van der Hal for pointing this out for emphasis.

1996, p. 66). In their still relevant article from 1969, Temerlin and Trousdale highlight societal influences on the perception, focus and diagnostic performance of mental health practitioners. Other authors, such as Boehnlein (1987) and Wohl (1989), emphasize the inextricable connection between psychotherapy and the culture within which it takes place. Hoffman (1996) stresses that therapists' attunement is impacted by "cultural, theoretical and personal bias" (p. 122). Panksepp (2003) warns of constraints by "prevailing cultural assumptions" (p. 11), and Davis and Brinkgreve (2002) point out the importance of social context to both the shaping and actual interpretation of personal narratives.

Regarding psychoanalytic approaches to and developments in the understanding of countertransference, psychoanalysis developed differently depending on cultural and national settings, i.e., the United States, Britain, Latin America, and France (Michels, Abensour, Eizirik & Rusbridger, 2002), hence illustrating the importance of societal context. Trauma work too, poses unique challenges in different countries (Danieli, Rodley & Weisaeth, 1996).

Acknowledgement of the societal context is necessary, therefore, not only in order to understand the socio-cultural climate in which the therapists were raised and trained, and which thus has provided many sources for their *a priori* countertransference, but also as a professional context in which certain traumas may be acknowledged and other ignored (e.g.Tauber, Brom, Brinkgreve, & Van der Hart, (2004), [Chapter 5]; Chapter 11). Farber (1997), frequently referring to Moosa's (1992) work on countertransference, emphasizes the unique stresses experienced in South Africa, for instance. Trauma can deeply impact a society and Erikson (1995) points out that "… communal trauma … can take two forms, either alone or in combination: damage to the tissues that hold human groups intact, and the creation of social climates, communal moods, that come to dominate a group's spirit" (p. 190).

Israel

The societal context in this dissertation is that of Israel, the country in which the participating therapists and I live. It provides an exceptionally useful setting for the exploration of societal sources due to the concentration of challenges that the country has had to face since its establishment. It is a society that is still in the process of self-definition and suffers ongoing existential threat; a multi-cultural society made up largely of refugees that, in the very process of its foundation has itself, tragically, contributed to the Palestinian refugee problem. Israel is a society intended to finally provide a home and safe haven for Jews, who

still vary greatly among themselves due to differences in culture, country and language of origin.

Over the years, Jews continued to immigrate to Israel from all over the world, as refugees or for ideological reasons. Many of Israel's residents have histories of multiple trauma, including combat trauma, loss of loved ones, and terrorist attacks. Some suffer the effects of traumatization related to the experiences of new immigrants from countries as diverse as the former USSR and Ethiopia, or due to the particular experiences of the Israeli Arab and Druze populations. The combination of over-crowded roads and drivers who are already under stress because of the nature of Israeli reality, contributes to frequent car accidents. This further adds to the number of traumatized Israelis.

Many Israelis have had to cope with traumatic events in the army. In their follow-up study of Israeli veterans from the Lebanon War of 1982, Solomon and Mikulincer (2006) found a surprising increase in posttraumatic symptoms two decades *after* the war. They related this "to the interplay of posttraumatic residual vulnerability, the course of disease, the aging process, and the unremitting threats of terror in Israel" (p. 664). Therapists must be aware of this also regarding clients who might seek therapy for apparently unrelated problems. Furthermore, therapists, some of whom were, or still are, (reserve) soldiers, can be expected to show a similar pattern of life-long vulnerability to ongoing life stresses.

Acts of terrorism have also injured many over the years of Israel's existence. But after 19 months of intensive terrorist attacks in Israel after the outbreak of the Intifada in 2000, Bleich, Gelkopf, and Solomon (2003) found that "almost half the participants in the sample were exposed to terrorism personally or through a friend or family member…" (p. 618). According to Shalev, Frenkel-Fishman, Hadar, and Eth's (2006) study, around 25% of Israel's population was symptomatic. Laufer and Solomon (2006) studied young teenagers for symptoms of PTSD in this period. They found that only a third were not exposed to any act of terror, while over a quarter were exposed to at least two incidents. According to the Israeli Defense Force casualties statistics (www.idf.il) cited by Shalev et al. (2006), there were 132 suicide bomber attacks causing 666 civilian deaths and 4.447 civilian injured; 276 army deaths and 1843 army injured between October 2000 and April 2004. These were the years in which the interviews for this dissertation and much of their analysis took place.

Israel has yet to know peace despite the wonderful achievement of two peace agreements that were signed in the last decades, with Egypt and Jordan respectively. Politics, therefore, play a decisive role. Israel's left and right wingers have absolutely opposing views as to what steps, decisions and approaches might lead to security and peace, and tend to perceive each others' (voting) behavior as potentially life-threatening. A similar division exists with regard to religion, and

particularly religiosity which typically goes along with specific political sympathies. There is no reason to assume that such divisiveness automatically remains outside the therapists' room; in fact, it might present a major source of *a priori* countertransference.

The Israeli context adds a further dimension to this research precisely because of the all-pervasive sense of threat to security and survival. Such a situation tends to evoke a narrowing of focus on whatever reinforces strength and ability to cope with potential emergencies. At the same time, in order to effectively deal with traumatization and its aftermath, exquisite awareness and willingness to acknowledge are of the essence. Such conflicts whether or not to acknowledge and focus on traumatic events and their consequences can be powerful sources of *a priori* countertransference.

Hopefully the exploration of sources for *a priori* countertransference in such a complex society will result in insights and understanding that will be helpful to therapists that work in other war-torn societies as well as those who live in more peaceful countries.

Structure and Choice of Research Methods

This dissertation developed organically into three studies. While I was reading in the professional literature about trauma-related topics trying to sharpen my focus, the second *Intifada* broke out, in September, 2000. The shock at this sudden violence was particularly acute as the peace talks that were held at the time had been expected to be successful. Unfortunately, this was not to be the case.

By the third month of violence, I felt no longer able to proceed without integrating what was happening around me, and to me. I related some of my anxiety and stress to being a child of survivors and noted that work with Holocaust survivor clients had become particularly stressful. I wondered how other therapists who were working with Holocaust survivors and the second generation were experiencing sharing with their clients an existential threat to themselves and their loved ones – sometimes in 'real time' with explosions occurring very close to where the therapy was taking place, and always aware that very real danger lurked also on the way to and from therapy. I hoped that qualitative research by means of interviews with a number of therapists from different places in Israel--and different experiences of attacks--would uncover not only sources but expressions of *a priori* countertransference. Six therapists participated in individual interviews sharing valuable experiences and insights (Tauber, 2002a; 2003; Chapters 3 and 4).

With this latest reminder of the challenges of Israeli society fresh in mind, it seemed appropriate to explore whether the fluctuations in awareness of trauma in

Western Europe and the U.S. were also reflected in Israel, or whether this country's unique challenges made professionals more, or less sensitive to different forms of interpersonal traumatization. Therefore, I reviewed the nearly 40 years of publication of the Israel Journal of Psychiatry, a respected, English language professional journal for trauma-related articles (Tauber, Brom, Brinkgreve & van der Hart, 2004; Chapter 5). One interesting finding was that a trauma history, whether personal or national, does not by itself guarantee sensitivity to trauma.

Once I had finished these studies, I wanted to do a larger, more in-depth study with a number of mental health professionals who specialized in working with Holocaust and/or sexual trauma, in the hope of uncovering a geography, a possible map of sources of *a priori* countertransference. There already is some recognition in the professional literature that the therapist-as-a-person is a far from negligible variable in the therapeutic process (e.g. Garfield, 1997; Lambert & Barley, 2002; Lambert & Bergin, 1994; Norcross, 2002a; Pearlman & Saakvitne, 1995). What interested me for this dissertation, however, was an in-depth, comprehensive and personal inquiry with a number of trauma therapists into their personal, familial, societal and professional backgrounds and experiences in order to learn what their particular sources of *a priori* countertransference might be, and based on that, to outline areas of inquiry for fellow professionals.

One major research question had crystallized: Can in-depth interviews with trauma therapists help to uncover sources of *a priori* countertransference as well as provide a model for self-exploration for other trauma therapists? I wanted to explore with the participating therapists--against the background of their personal and familial histories, and within their societal context--what might have motivated them to specialize in working with survivors of some of the most horrendous acts people are capable of perpetrating on each other (Chapters 6, 7 and 8); what is it like for them to be trauma therapists (Chapter 9).

Research Methods

For this study, too, qualitative research seemed the obvious choice. I needed research methods that would allow for exploration, insight, uncovering of values, professional motivation and experience that would enable me to use my professional and personal experience in the analysis of the material and, at the same time, provide a model for self-reflection, peer support and training (Chapter 2). This fits in well with Kunneman's (2006) conceptualization of mode three research. He elaborates on Gibbon, Limoges, Nowotny, Schwarzmann, Scott and Trow's (1995) understanding of "mode 1" and "mode 2" scientific research, with mode 1 being pure science, empirical, monodiscliplinary replicable research, and mode 2 being scientific research aimed to find solutions for practical problems such as medication for specific health problems or the construction of faster computer

memory, or techniques for genetic enhancement. Kunneman notes that this leaves out a major field of experience and learning for further exploration which he suggests could be brought under the heading of "mode three" in order to then complement and deepen mode two research: those are issues of self-awareness, morality, values and insight – questions that are part of the exploration for this dissertation. In this way, I hope to also contribute to what a group of Dutch researchers, e.g. Baart, Van Houten, Kunneman, Van der Laan and Van IJzendoom (Van den Ende, 2007) referred to as "normative professionalization." Normative professionalization aims for inclusion of awareness of values, attitudes and other factors, both personal and social, that might add to, or detract from, an optimally respectful and sensitive professional relationship within the definition of professionalism.

Further to my initial work with same-population therapists (Tauber, 1998), this dissertation is an attempt to validate the concept of *a priori* countertransference through a process of shared reflection on their own and their family's histories with each of the participating therapists, their paths to their current work, experiences related to their work, all within the societal context. The interviewed therapists were not involved in the analysis of the interviews and the integration with the existing literature. Hopefully this work will provide a fruitful base to build upon with mode 2 research.

Therapists are not a formulaic equation of the various family and societal factors, but a unique mix of how they have interpreted, understood and been influenced by these factors. Moreover, maturity and changing life circumstances ensure an ever-evolving synthesis of thoughts and feelings regarding personal, familial and societal circumstances. Hopefully, the studies described and analyzed in this dissertation will help therapists become more aware of what might give rise to their *a priori* countertransference, and so meet their traumatized clients with greater openness and ability to set out on a genuine psychotherapeutic journey.

Outline of the Dissertation

Chapter 1 introduces the concept *a priori* countertransference and development of the ideas for, and structure of, this dissertation.

Chapter 2 describes the research methods chosen and an explanation of the choice of methods.

Chapters 3 and 4 are based on a study, previously published in two articles (Tauber, 2002a, 2003).

Chapter 3 provides a history of gradual recognition of the suffering of Holocaust survivors after decades of what has been referred to as a "conspiracy of

silence." With the insight provided by the concept of *a priori* countertransference, I question the usefulness of this concept.

Chapter 4 presents an analysis of interviews with 6 therapists who were working with Holocaust survivors and their offspring during the first months of the Intifada that started in September 2000, in the hope of providing societal background to, and examples of, expressions of *a priori* countertransference.

Chapter 5 is based on a previously published literature survey of the number, year of appearance and content of trauma focused articles in the first forty years of the English language Israel Journal of Psychiatry (Tauber, Y., Brom, D., Brinkgreve, C., & Van der Hart, O., 2004). The chapter aims to provide insight into the possible interrelatedness of societal socio-political developments in Israel and professional interest in trauma. It also serves as a context against which to understand the study presented in the following chapters.

Chapters 6 to 11 present different areas of analysis of the largest study carried out for this dissertation with the aim to uncover and outline sources of *a priori* countertransference.

Chapter 6 concentrates on the therapists' personal and familial backgrounds.

Chapters 7 and 8 explore the therapists' underlying motivation and processes that led them to become trauma therapists.

Chapter 9 highlights the interviewed therapists' experience of actually working with their traumatized clients. The focus is not on their clinical work itself but rather on the implications and ramifications of their work as these might also impact their *a priori* countertransference.

Chapter 10 explores the societal challenges faced by the interviewed trauma therapists.

Chapter 11 traces societal attitudes towards trauma and trauma therapy.

Chapter 12 presents a general discussion of the findings of all the previous chapters and defines issues that merit further study.

The therapist as a unique individual is at the center of this dissertation in an attempt to highlight areas for exploration and self-monitoring prior to the professional encounter with traumatized clients. The histories and characteristics of each therapist as well as his or her attitudes regarding interpersonal traumatization are, however, embedded in a social context. Chapters 3, 5, 10 and 11 attempt to explore the possible influence of different aspects of this societal context upon both the individual trauma therapist and the profession as a whole.

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CHAPTER 2

Research Methods

The psychological impact of enduring trauma was first formally described in the DSM [Diagnostic and Statistical manual of mental disorders, 3rd ed.], only in 1980, and the unique challenges of working with traumatized populations received recognition with the establishment of international professional organizations such as the International Society for the Study of Dissociation (ISSD), later renamed ISSTD, incorporating a specific emphasis on trauma, and the International Society for Traumatic Stress Studies (ISTSS) as late as 1983 and 1985 respectively. While work with trauma survivors seems to have been absorbed within the mental health professions without the creation of a formal specialty of trauma therapist, some clinicians tend to be more aware of trauma than others; these clinicians tend to pay specific attention to the traumatic experiences of clients that, for example, have endured sexual abuse or been traumatized in combat.

Given the difficulties of dealing with interpersonal traumatization and its victims in particular, the question arises what draws therapists to specialize in such a field. Their reasons might shape what they expect of, and from, the therapy. This, in turn, may well impact their work without their necessarily being aware of this. It is therapists' attitudes, values and emotions that fuel their motivation to become and remain specialists in trauma and that may underlie and shape the way they work with traumatized clients, that I refer to as *a priori* countertransference (Tauber, 1998). This form of countertransference is unique in that it exists independently of individual, specific clients. In this dissertation, I have set out to uncover a map of sources in therapists' personal and societal backgrounds that may give rise to *a priori* countertransference. This, in turn, may raise awareness of colleagues of possible *a priori* countertransference that might impact their own work.

My focus is on therapists who work with clients that suffered interpersonal traumatization because of the extra dimension of intent that is absent in traumatic events such as earthquakes, fires or traffic accidents. Two population groups that seem to represent interpersonal traumatization dramatically are Holocaust survivors and the second generation, and people who endured incest and other forms of sexual abuse. Whereas Holocaust survivors were publicly persecuted and abused, often with the full support of most of the local populations, and were at constant and acute risk of being killed, sexual abuse survivors, on the other hand, are secret victims, insufficiently protected by their families and society around them. Valent (2000) surveyed similarities and differences in long-term trauma responses of child survivors of the Holocaust and of incest and attributed the differences to the “culture of the traumatic situations.”

Both Holocaust survivors and their offspring, as well as sexual abuse survivors tend to evoke strong feelings of sympathy and identification, of guilt, revulsion, and a desire to blame the victim, a wish to deny. Therefore, I was particularly interested in exploring what aspects in their personal and professional

backgrounds might have led mental health professionals to specialize in working with clients who belong to one or both of these populations; how norms and perceptions in society at large, as well as within the professional community, might have affected their professional development and may still do so in their current practice.

The following questions seemed most pertinent for exploration: what motivates clinicians to specialize in working with survivors of some of the most horrendous acts people are capable of perpetrating on each other? What is it like for them to do such work? And how, if at all, does the societal context affect their personal and professional development and attitudes to traumatized clients? In the process of exploring these questions, the focal research question evolved (Kleining and Witt (2000); Moustakas, 1990): can a thorough inquiry into personal, familial background, motivation for and experience of professional work as well as exploration of the social context offer clear parameters within which to define sources for *a priori* countertransference? It is my hope that such a process of inquiry can serve fellow professionals as a model for self exploration and self reflexivity.

Methodology

These questions focus on highly subjective experiences related to the personal history and societal context of the individual trauma therapist. It is my hope and intention to uncover and outline how these therapists' perceptions and interpretations of their personal, familial and societal background might provide sources for *a priori* countertransference. Lack of awareness of *a priori* counter-transference might unwittingly prevent therapists from contributing to the creation of an optimal therapeutic relationship with their traumatized clients.

The process of uncovering such sources for *a priori* countertransference demands an in-depth inquiry into the therapist's personal and professional development, personal and professional values and ways of thinking also about trauma and coping with trauma; societal influences and socio-political engagement. This then would entail investigating areas that are difficult to quantify and capture in standard empirical research. Such an inquiry does, in fact, fit in very well in what Kunneman (2006) has referred to as an increasingly neglected realm of research, the realm of values, of personal relationships and meaning as integral to, for instance, the medical, pedagogical, and in this case, the mental health professions. Kunneman (2006) refers to this as mode three research, adding to Gibbons and Nowotny et al's (1995) suggested division of scientific research into mode 1, empirical academic, and mode 2, practice-based scientific research. Mode three, *experience-* and *value-based* knowledge that tends to

be articulated in narrative form complements mode 2 *evidence-based* scientific knowledge. Furthermore, such an inquiry harmonizes with the thinking behind action research (Boog, Slagter, Jacobs-Moonen & Meijering, 2005) and may add a further dimension to normative professionalization (Kunneman, 2006; Van der Ende, 2007) which highlights the normative aspects of professional action especially the biographical, moral and political dimensions, and thus encourages a reflexive attitude with regards to professional relationship.

Much like I draw attention to the fact that therapists cannot but be both professionally and personally present in the psychotherapeutic encounter with traumatized clients, I wanted to utilize research methods that would enable me to be fully engaged professionally and personally (Moustakas, 1990; Reinhartz, 1992; 1997; Rosenblatt, 2001; Schruijer, 2005). On a personal level, I draw on my experiences as a child of Holocaust survivors; on life experience on three continents; living through several wars as a civilian, including the threatening build-up of encroaching danger and the mourning and shock of their aftermath, and through periods of intense terrorist activity; I draw on being a woman deeply inspired by the Second Wave of Feminism as it was unfolding, and having experienced sexual inappropriateness familiar to many women; and on having been a traumatized client in psychotherapy. Professionally, I could draw on more than two decades of intensive work with traumatized clients; regular participation, as presenter at professional conferences (e.g. ISTSS, 1998b; ISTSS 2000; ISTSS 2002b; ISSD 2004) and as a participant, and on my research for professional writing.

Qualitative research methods seemed to be the obvious choice, but I did not want to restrict myself to one particular framework. In fact, Taylor and Bogdan (1998) noted that researchers routinely tend to combine different qualitative approaches to gain most clarity. This was true for me as well, although my basic framework was phenomenological, i.e. Moustakas' (1990) heuristic, phenomenological approach which includes stages of "immersion, incubation, illumination, explication and creative synthesis" (p. 52) and Janesick's (1994) elaboration. This approach has been modified and influenced by feminist thought (Reinharz, 1992; 1997) and aspects of action research, which Schruijer (2005) thought of a process of sharing reflections. The interviewed therapists were well aware that they were contributing to uncovering obstacles to our own, and other colleagues' ability to listen to traumatized clients, by their willingness to explore their personal and professional lives with me. However, my approach differs from action research in that, ultimately, I am the sole interpreter of all the material gathered for this dissertation. The work of other authors such as Atkinson (1998), Maso and Smaling, (1998), and especially Taylor & Bogdan, (1998) has been also shaped this research.

Different authors embrace researcher subjectivity in different degrees. Kleining and Witt (2000) note the importance of introspection in their outline of heuristic research methods. Janesick (1994) states that in qualitative research, there is “no value-free or bias-free design” (p. 212) and that these biases must be clearly stated. Davis and Brinkgreve (2002) also hold that since the qualitative researcher is such an integral part of the research process, it is vital to clarify as much as possible the views, perceptions, values and beliefs that might be guiding and affecting the research. Taylor and Bogdan (1998) too recommend optimal clarity.

In fact, a researcher's subjectivity is not a disadvantage (Smaling and Maso, 2002) but could very well be turned into a valuable resource, and I have aimed to provide clarity by providing autobiographical materials. According to Maione and Chenail (1999), it is through “self-reflective narratives” that “qualitative researchers establish their credibility through an accurate and honest accounting of their actions” (p. 59). However, I have also added the perspective provided by triangulation (Boog, Slagter, Jacobs-Moonen & Meijering, 2005; Maso & Smaling, 1998; Searle, 1999) resulting from extensive reading of the professional literature, ongoing, in-depth discussion with the members of my doctoral committee and other colleagues, as well as repeated immersion in the material, drawing on my professional knowledge and experience and an ongoing process of clarification of my own values and perceptions.

Development of the Structure

In September 2000, while I was still immersed in the reading of the literature on trauma and on research methods, and floating ideas how to structure and develop this study, the *El Aqsa Intifida* broke out. Suddenly, daily life changed drastically from awaiting the results of the peace talks that were being held, to coping with almost daily suicide bombings on buses and café's as well as shootings and stabbings. I found it impossible to not let these sad events affect my research and decided to try to learn how life, at a specific historic time, under conditions of ongoing danger and stress--shared with clients--may impact the ability of therapists to do trauma therapy.

Six experienced therapists from different cities and therefore, different intensity of experience of violence, who were working with Holocaust survivors and the second generation at the time, agreed to my request for an interview. We focused on their current experience of their clinical work and hence uncovered expressions of *a priori* countertransference. Most of the therapists noted that the interview had been a rewarding experience, which is not unusual in qualitative research (Smaling & Maso, 2002).

This study indicated that the need for (psychological) self preservation and coping with existential threat may indeed impact therapists' perception of, and availability to their clients (Tauber, 2002a; 2003). Chapters 3 and 4 are based on these articles. And although not intended as such, the study also served as a kind of sample study (Kleining & Witt, 2000; Maso & Smaling, 1998). It highlighted how even dedicated, experienced therapists can be unaware of their *a priori* counter-transference and thus underscored the need to explore further aspects of *a priori* more extensively and to greater depth, with different groups of therapists (Chapters 6-11).

Next, in order to gain further understanding of the societal setting in which trauma therapists function in Israel, and learn how the fluctuations in trauma awareness that have been documented over the past century (see Chapter1) might be reflected in Israel, I did a content analysis of the *Israel Journal of Psychiatry and Related Sciences* (Tauber, Brinkgreve, Brom, & Van der Hart, 2004, which provides the basis for Chapter 5. This journal has been published for four decades and appears in English, thus facilitating a form of dialogue with professionals abroad. Examination of well over a hundred articles that had trauma-related titles revealed a picture that in some ways reflected international trends but also the influence of local socio-historical developments on (the absence of) acknowledgement of, and preoccupation with different forms of traumatization.

Only then, did I start the third and largest study. The remainder of this chapter is devoted to outlining the research methods and processes employed in the main study involving in-depth interviews with eight mental health professionals lasting around four hours each. The basic approaches and philosophy are similar to those in the smaller study, but precise methods employed in that study and in the content analysis of the IJP are outlined in the published articles that arose from these studies (Tauber, 2002a, 2003, Tauber et al, 2004).

Choosing the Research Methods

This study aims to highlight who the participating therapists are as persons, that is, their personal and family history, their own perceptions of their personal and professional development, and what issues they highlight or ignore (Smaling & Maso, 2002). Interviewing seemed to be the optimal research method as it allows for the possibility of relating to the whole person within their temporal and cultural context, thus, hopefully, enabling me to outline general areas for exploration of *a priori countertransference* and possible implications for therapeutic work.

Guba and Lincoln (1994) point out that "qualitative data" provide "contextual information" (p. 106). The societal context, which over the past century at least, has brought about dramatic fluctuations in recognition of

interpersonal trauma and its impact, would seem best reflected in personal narratives (Atkinson, 1998; Nijhof, 2000) and perceptions, rather than in quantifiable answers to set questions. I wanted to elicit therapists' stories and experiences in order to understand to what extent, if at all, their perceptions of their traumatized clients may be affected by societal changes. As Davis and Brinkgreve (2002) point out, societal context is important to the actual interpretation of life stories, and therefore, possibly, to therapists' ability to perceive and acknowledge their clients' traumas.

Researcher as Instrument

The roles of therapist and interviewer overlap somewhat in the degree of caution and self-awareness they need to employ. They must respect and maintain boundaries (Agger & Jensen, 1994); disclosure (Fontana & Frey, 1994; Reinharz, 1992, 1997) might be appropriate only at carefully selected moments much like in trauma therapy (Dalenberg, 2000); and they need to carefully monitor the impact on both the person being interviewed and the interviewer him or herself (Guba & Lincoln, 1994; Harris & Huntington, 2001). Gilbert (2001) notes that qualitative researchers as research instruments, "naturally draw on elements of their own subjectivity …." (p. 4).

Careful monitoring of my responses from the moment of considering candidates for the interviews, through to meeting with them and doing the actual interviews, followed by the intensive, drawn-out process of immersion in the material and its analysis have resulted in a deepening of my own perspectives, understanding and questions, much like self-monitoring contributes to the therapeutic process. As Gilbert (2001) puts it:

> Rather than objectively reporting observable aspects of the phenomenon, qualitative researchers attempt to enter the subjective world of the researched. In doing this, they report on emotional as well as cognitive elements of some aspect of the lives of those studied. Their understanding of these elements requires empathy, the ability to connect at a feeling and a thinking level with the study participants. Researchers must draw on rational understanding while they also reach within themselves for their subjective views and personal experiences, looking for comparabilityof experience. Throughout the process, their reactions shape the direction and depth of their understandings of the lives of the study participants. As stated before, and in sum, the researcher, in effect, becomes the research instrument. (p.11)

The Interviewed Therapists

Criteria for Choosing the Therapists

I looked for therapists whose client base consisted of a majority of Holocaust or sexual abuse survivors and who were articulate and willing to explore possibly sensitive personal and professional issues with me (Moustakas, 1990; Stuhmiller, 2001; Taylor & Bogdan, 1998). Furthermore, in order to track possible societal influences on attitudes and perceptions regarding trauma in Israel, I wanted to interview professionals who had different lengths of experience in their respective fields, i.e. ranging from several years to several decades. These therapists' own understanding, interpretation and use of their histories and their personal work experience were of major interest in order to gain insight into *a priori* countertransference and its sources.

Relationships with the Interviewed Therapists

The relationship with each therapist--i.e. previous acquaintance, first meeting--is made explicit as it doubtlessly impacted the atmosphere of the interview, the depth of self revelation that was felt appropriate and my analysis of the material (Davis & Brinkgreve, 2000). Contrary to McCracken's (1988) recommendation, and because Israel's mental health community is relatively small, I knew some of the therapists who participated in the study (Appendix I)--Dora, Dana, Ruth and Sara--as acquaintances and/or colleagues. Others, Joseph and Hanna I had met at professional conferences. I first met David and Nell at our interview venues.

Process of Choosing the Therapists

After gathering as many suggestions for potential interviewees as possible from colleagues and friends, I made a list of people to contact. I approached them by phone, email or in person. I told everyone of the purpose of my research and that I would be asking them very personal and possibly painful, questions. I also made sure that everyone was aware that, despite my efforts at hiding their identities, they might still be recognizable to members of the small Israeli mental health community.

To highlight the societal focus on the sources of *a priori* countertransference, my initial idea was to include therapists from different parts of the country, from different settings, i.e. kibbutz, city, and from different population groups. As Israel is such a very small country and many Israelis move through different settings throughout their lives, this proved neither realistic nor necessary. I did choose therapists with different lengths of professional experience in the hope that these differences might also reflect societal attitudes to trauma.

As ultimately, *a priori* countertransference is a highly individual response, even though the sources may be shared and general, I did not want to restrict myself to one gender. Neither did I make an attempt to get even numbers of men and women. The majority of the interviewed therapists are women, which, though not intentional, would seem fairly representative of mental health professionals in Israel. Gender issues as related to both *in session* and *a priori* countertransference are worthy of separate, in-depth study.

Concerted efforts to find Arab, Druze and Jewish ultra-orthodox colleagues to interview and so more richly reflect the societal context failed, although three people did eventually express an interest in participating. An Arab colleague initially responded enthusiastically but soon realized there had been a misunderstanding and he would not be a co-researcher for the whole project. He then chose not to do the interview. A Druze colleague agreed to participate after an extensive telephone conversation. I drove a long distance to meet with her at her apartment and was cordially received. She read the consent form as I set up the tape recorder and became distressed at the warnings about possibly being recognizable. She thought this could be very problematic for her both with regard to her family and among her colleagues, but decided to go ahead anyway. Her discomfort increased visibly with each personal question, however. She accepted my offer that we stop the interview with relief and I erased the tape while we had coffee. I was greatly interested in learning more about her, but not at the expense of hurting her feelings.

The issue of the protection of privacy also prevented an interview with a member of the Jewish ultra-orthodox community. I was delighted when a colleague who had been doing ground breaking work in her community agreed to an interview. She too read through the consent form as I was setting up the tape recorders. When she realized that she would be giving consent to publication beyond what she had assumed would be a doctoral thesis that would "disappear on a dusty library shelf," she decided to consult with her rabbi prior to agreeing to do the interview. The lack of "personal modesty" inherent in an interview and public exposure, unfortunately, proved to be an insurmountable obstacle. All the other therapists immediately agreed to do the interviews.

Consent Forms

Aware that I might be touching on sensitive issues in the interviews, I took great care to write detailed consent forms in both Hebrew and English to ensure that all the participating therapists would be able to easily read and understand them. Participating therapists were asked to sign the first one prior to the interview. I would have permission to actually use the interviews only after they had signed the second consent form.

The first form included the warning described above concerning the difficulty in remaining anonymous in Israel's small mental health community. I also asked consent to use the material not only for the doctorate itself, but for academic work, lectures, articles, in general. Reading and signing this form created a little time-out during which to settle in for the interview, and to set up the tape recorders.

After the therapists had had a chance to read the transcript of their interview, I asked them to sign a second form to finalize their consent. I wanted to make sure that they had an unpressured opportunity to change their minds about allowing me to use the material if they felt they had been seduced by the intimacy of the interview to reveal more than they felt comfortable for me to use, or had second thoughts for any other reason. Almost all the therapists (Appendix 1) readily gave their consent. One therapist, Dana, needed some time after reading her transcript to decide. Her ultimate consent signified a process of personal growth for her. Another therapist, David, suggested I use his real name which I declined to do in the interest of uniformity.

The Number of Participants

Once it had become clear I would interview mental health professionals who specialized in working with Holocaust survivors or victims of sexual abuse, and had various degrees of experience, I needed to decide how many therapists to look for. There are researchers who have found that in-depth study of only one person can suffice (Taylor & Bogdan, 1998). They stated that “there is an inverse relationship between the number of informants and the depth to which you interview each” (p. 93). Others suggested around 25 interviews (Baarda, De Goede, & Teunissen, 2001). What ultimately determined that eight therapists would participate was a sense of balance between a variety of people and experiences and the possibility to still highlight individual experience and issues of interest to trauma therapists and the mental health profession in general. Such a process of reaching the appropriate number of people to interview is in keeping with the chosen phenomenological, heuristic approach (Moustakas, 1990). Relative to the size of the community of therapists in Israel, who specialize in trauma, and Holocaust or sexual abuse in particular, eight therapists are quite a sizable group. And whereas each story was unique and fascinating, there were sufficient shared themes and issues to reach saturation (Maso & Smaling, 1998). McCracken (1988), in fact, recommends more in-depth work with fewer people and considered that usually “eight respondents will be perfectly sufficient” (p. 17). Furthermore, this study is supplemented by the previous study in which 6 different therapists participated (Tauber 2002a, 2003).

The Interviewed Therapists

I divided the interviewed therapists into two main groups (see Appendix 1): those who predominantly worked with Holocaust survivors and the second generation (Dora, David and Sara), and those who predominantly worked with survivors of sexual abuse (Joseph, Hanna, Dana and Nell). Three of the eight therapists either have worked with both groups, or still do. One therapist has consistently worked with both populations (Ruth).

The Interviews

Prior to the explorative, in-depth interviews with the trauma therapists, I did three resource interviews in order to gather "eye-witness" historical background information. I interviewed Prof. Eliezer Witztum, Prof. Haim Dasberg, and Ms Karen Shachar [their real names], all specialists in their field, to learn more about the societal perspective and historical developments of combat trauma, Holocaust trauma and sexual abuse respectively, in Israel.

Most of the interviews with the trauma therapists (Appendix I) were held in May and June, 2002. The interview with Nell took place in early September, 2002. Much of the intervening time had gone into preparing for the three interviews that did ultimately not take place. The rational for having the interviews so close together was the highly unstable security situation in Israel. Over the previous two years there had been many terrorist attacks, such as suicide bombings on buses and in cafes, and during some 'waves' even several a day. Occasionally, there were lulls with relatively few attacks. From my own post-traumatic perspective, I was always on the alert for the next, 'even greater' disaster which might radically impact the interviewed therapist, the interviewer and therefore, the interview. It was, important, therefore, to ensure that all the interviews took place under more or less similar security conditions.

Questionnaire

Initially, I considered doing completely unstructured interviews (Maso & Smaling, 1998), asking, "Please tell me what made you become a trauma therapist and what that's like'" and then mainly listen. This is more or less the model I employed in the resource interviews. However, I did not want to abstain from a conversational, exploratory mode so as not to stray to no doubt interesting, but possibly too distantly related topics. I was also concerned that drastically limiting my responses would negatively affect the atmosphere and therefore the therapists' willingness to communicate openly. In fact, Fontana and Frey (1994) point out that a "distanced style of interviewing cuts the subjects' involvement drastically, "which

rather than bring more objective results, creates a "onesided" and therefore inaccurate picture" (p. 370).

An open-ended, far-ranging questionnaire facilitating in-depth interviewing (Taylor & Bogdan, 1998) seemed most congruent to the research aims. This would enable a more or less structured conversation that would both share common ground with the others and be flexible enough to reflect the individual (McCracken, 1988). Even though I had written out a full questionnaire [see appendix II], I used it as a guide and topic list in what Baarda, De Goede, and Teunissen (2001) refer to as a semi-structured interview. I did not necessarily ask all the questions in each interview and the therapists had plenty of opportunity to volunteer information, initiate topics and guide the conversation. Hence, I occasionally wrote in the text "I did not ask" or the therapist "volunteered" certain information.

The construction of the questionnaire was a lengthy process which necessitated first of all clarification of all possible topics of interest and careful thought as to how best elicit self-revelatory information from the therapists. The first part, which starts with a few formal questions such as name, date and place of birth in order for both the therapist and myself to adjust to the interview, focuses on the therapist's personal story, ranging from extensive family history to personal trauma history. The second part focuses on the therapist's professional development and current experience. The last section elicits the therapist's perceptions of possible connections between the personal and professional. It also includes questions about the interview experience itself. The process of constructing the questionnaire, which needed to allow for "elements of freedom and variability" (McCracken, 1988, p. 25), entailed much thought, trial and error, and intensive discussions and feedback from committee members and other colleagues. Once the format of the questionnaire was more or less agreed upon, I did a practice interview (Stuhmiller, 2001) with a close colleague, Elisheva van der Hal who gave me detailed feedback on the whole process. The scope of the questionnaire could qualify the interview as a "life story interview"; it far exceeded the hour which Atkinson (1998) set as the lower limit.

Interview Process

The interview process itself was as unique as each therapist and formed an integral part of the information gathering of this research. The therapists chose the place and time for the interviews, as I wanted to ensure optimal conditions for them to speak freely and openly (Taylor & Bogdan, 1998). The interviews lasted around four hours and qualify as long interviews (McCracken, 1988). The therapists knew they could call for a coffee break at any time, or suggest we stop and continue another time.

Dora, who was not in good health at the time, had only enough energy for a few hours at a time. We therefore met on two consecutive days at her home but she was very involved and committed throughout.

David asked me to come to his hospital where I witnessed at first hand how generous it was of him to give me so much time. The attempted interruptions were very frequent. When pressed for time, he suggested we continue the following day. The interview flowed easily despite the fact that we had never met before. During our first meeting, there was one awkward moment when he made at a comment that sounded out of character. After completing the questionnaire at our second meeting, I asked him to clarify what he had said the day before as I was concerned that a possible misunderstanding might contaminate my analysis of the interview (Maso & Smaling, 1998). The misunderstanding was, indeed, resolved.

Dana chose to have the interview at my home. Despite her many traumatic experiences, we laughed a great deal throughout the interview which lasted, like most of the others, about four hours. She did ask for a coffee break, in order to recuperate a little.

Hanna invited me to her office for the interview. She had carefully prepared both the space and herself for this experience which flowed comfortably throughout. She was not tired when we finished, also after nearly four hours, and seemed to enjoy talking about the whole experience once the formal part was done.

The interview with Ruth was the shortest and perhaps the most unusual. We met at her place of work, having agreed that she would free up as much time as was necessary. After about two and a half hours, when we had just started to discuss her professional experiences, she suddenly seemed to have had enough. She had spoken at very great length about her parents' history and her own and that seemed to have tired her. She asked me a few times if we were almost done, but did not say she wanted to stop. To my later surprise, I did not think at the time to suggest I come back another day to complete the interview. Instead, we rushed through for almost another hour. After the interview I felt disoriented, confused and in need of a quiet cup of coffee before the drive home. Only during the analysis, when I read her description about her ability, when necessary, to execute a division of labor by internal parts, as it were, did I understand that I might have taken on too much of her emotions, emotions she did not directly express at the interview. Furthermore, we might have both gone into an intergenerationally transmitted 'survivor mode' and thus, regardless of whether it felt right or comfortable, made sure to complete what we had set out do. Wincup's (2001) recommendation for openness to the researchers' sensitivity to their own, and to their interviewees' feelings, is particularly pertinent here. "Keeping them hidden perpetuates the myth that personal feelings do not influence the research process" (p. 31).

Joseph's interview took place at his dining room table. Despite the homey setting, the atmosphere and tone of the interview were highly professional; he made every effort to answer even the most personal questions as fully as possible. Unfortunately, about half-way through the interview, both tape recorders stopped working properly--I used two recorders in each interview to make certain there was back-up in case of technical problems. Some of the transcript, therefore, was reconstructed from memory very soon after the interview itself.

Nell and I, though familiar with each other's work, had not known each other personally before we met for the interview at her office. This did not deter her from being very open despite the obvious pain in reconnecting to her traumatic experiences. She did want us to have an 'off-mike' coffee break during which she asked me a number of personal questions (Reinhartz, 1992). On the basis of my answers, she then decided to speak more openly on tape about personal matters she thought relevant to this research.

Sara had recently had a baby and asked me to come to her home for the interview. She received me with polite hospitality, but appeared to have forgotten our appointment. My offer to come back another time was gratefully accepted. We did our interview in one sitting, during much of which Sara fed the baby. She also asked her husband to bring in food for both of us. The extensive feeding did not seem to stop Sara in any way from concentrating on the questions, taking time to think and allowing her emotions to flow freely.

Participants' Feedback

Towards the end of the interviews, I asked all therapists if they thought there was something I had neglected to ask. In addition to my interest in their perspective and wish to ensure they had been able to say everything they had wanted to, this question was also intended to return us more fully to our positions as colleagues and peers at the close of the interview. Most felt that they basically had covered everything; a few wanted to think about it and contact me if there was anything else, but no one did.

David and Joseph felt strongly about a few issues. David correctly pointed out I had not at all related to "the formal, medical aspects of being a psychiatrist." This aptly illustrates the importance of acknowledging the person, in this case of the researcher and ironically serves as an example of *a priori* countertransference. Blind-sighted by my experience as a clinical psychologist and my perception of "trauma work" as a researcher, I had, indeed, passed over his experience as a psychiatrist proper.

Joseph thought I should have asked specifically about being perceived by clients as "perpetrator or abuser." He also thought I might have asked how work

with sexually traumatized clients affects therapists' sex life though he did not think he would have liked to answer such a question.

As the interview had been somewhat of an emotional rollercoaster ride, I made certain, as a matter of personal concern and professional responsibility, to check how the therapist was doing (Fontana & Frey, 1994) at the end of our meeting. On the whole, the therapists reported having had a meaningful, even enjoyable experience.

Analysis of the Interviews

The analysis of the interviews was an intense, protracted process accomplished in several stages. Taylor and Bogdan (1998) point out that "data collection and analysis go hand in hand" (p. 41). And while they acknowledged the process during which researchers "gradually make sense of what they are studying by combining insight and intuition with an intimate familiarity with the data" (p. 142), they recommended that others read the data as well. In my case, Christien Brinkgreve, Onno van der Hart and Danny Brom read through all the raw material and offered plenty of opportunity for discussion, testing of ideas, and a deepening of understanding.

Tracking of Interviewer Process

I was ready to take notes of thoughts, responses and concerns from the moment contact was made with interviewees, before and immediately after the interviews, as well as during the process of analyzing the material (Maso & Smaling, 1998; Taylor & Bogdan, 1998). Such notes, memos and journaling are an integral part of the process of analysis, and can yield a goldmine of information and give space to emotional responses as well (Harris & Huntinton, 2001).

The process of analysis started during the interview itself, as finding qualitative data requires listening "not only with the tidiest and most precise of one's cognitive abilities, but also with the whole of one's experience and imagination." (McCracken, 1988, p.19). The tracking and self-monitoring continued while listening to the tapes. I started transcribing the interviews whenever possible on the day of the interview, or at the latest, the next day. Despite the amount of work and time this entailed, I did not want to miss the opportunity to 'relive' the interview, listen for nuances, monitor my responses and try to understand the moments in which I missed clues or otherwise did not respond in a satisfactory manner. I would also interrupt the transcription to write notes about the therapists, questions their comments raised, themes that appeared, and other responses. Thus

the transcription of the tapes became part of the process of analyzing the material, noting categories and themes.

The interviews were held in Hebrew, except for the one with Nell which was in English. I transcribed all the interviews directly in English. I then worked from the same transcripts I sent to the interviewed therapist before he or she signed their final consent form.

Further Immersion in the Material

Once the transcripts were complete, I spent months reading and rereading and thinking about them, writing more notes about my emotional responses, associations and thoughts in response to the manuscripts. Throughout, I tried to be as aware as possible of any countertransference reactions such as not thinking to divide Ruth's interview into two meetings, which "also develop in researchers who interview traumatized people" (Agger & Jensen, 1994, p. 264). Such reactions are a valuable source of information. As I went along, I developed and refined a process of coding. I approached the individual interviews much like a clinical case that needed many layers of analysis in order to gain better understanding. I then started a lengthy process of cross analysis, checking for common themes and categories, for individual differences. I took into account the possible impact of the process such as the interaction between us and our prior relationship if there was one. I was helped with the analysis by the literature on trauma, on countertransference, the previous studies I had carried out, my clinical knowledge and experience and critical discussions with experienced colleagues.

The whole process of analysis took a very long time, not only because of the large amount of material and the heaviness of all the explicit and implicit traumatic content (Gilbert, 2001), but also because I wanted to make sure I remained fresh and critical throughout. It is a challenge to find a balance between empathic engagement with the interviewed therapist and maintaining an ability to observe: "This dual vision is what distinguishes a therapist or a researcher from a sympathetic listener" (Agger and Jensen, 1996, p .11).

Moustakas' (1990) suggestion to set aside the material for a while after intense immersion, which he refers to as incubation, was helpful to integrate insights and ideas. I could then return to the material with a fresh perspective. I did this repeatedly with the individual interviews and at a later stage with the entire set of material, and the themes and categories that emerged (Janesick, 1994.) Whereas I fully immersed myself in the material that I organized, interpreted and analyzed by induction, it should be remembered that a prior structure of the material existed in the form of the questionnaire. McCracken (1988) points out that this need not be an obstacle, but may, in fact, be helpful.

Summary and Discussion

During the lengthy process of identifying themes and categories, I kept in mind the focus of this study, highlighting the person while exploring the trauma therapists' personal and familial stories, their professional development and practice, all within their temporal and societal context. Then, based on the themes that had emerged, I decided on the chapters that would deal with the major issues I had explored (Chapters 6-11). Having a sense of the division in chapters, again helped to further structure the themes and categories (Taylor & Bogdan, 1998). Gradually, clear parameters appeared for the exploration of sources of *a priori* countertransference.

With the help of qualitative methodology such as the use of in-depth interviews, documentation from the professional literature and my previous research, clinical and personal experience, taking a mainly phenomenological approach, I set out to uncover personal truths that might enrich collective, scientific knowledge; scientific knowledge that, in line with the thinking informing "mode three" research (Kunneman, 1996), incorporates the exploration of the societal context and the life histories of the participating professionals, both as narrated directly, and as gleaned from what was left unsaid. It is my hope that the studies and their findings as they will be presented, will find resonance in the personal and professional experiences and struggles of trauma therapists and contribute to greater clarity about their part in the therapeutic dyad. The wealth of information yielded in the interviews, especially the individual therapist's perspective, understanding and interpretation of their experiences, hopefully substantiate the phenomenon of *a priori* countertransference and the distinct potential sources of *a priori* countertransference as I will outline in the following chapters.

CHAPTER 3

Conspiracy of Silence?

In the first decades after World War II, individuals willing to listen to the children and adults that appeared like phantoms from among the ashes of the murdered Jews and their destroyed communities were few and far between. This dearth of listeners seemed to be a worldwide phenomenon that included (pre-state) Israel. Survivors for whom remaining silent and trying to 'forget' offered a way of coping with the almost unimaginable horrors and losses they endured, contributed their share of what came to be referred to as the "conspiracy of silence." The appropriateness of this term will be questioned in this chapter.

By the end of the twentieth century, a sizable literature had accumulated in the form of testimonials by survivors and by clinicians writing about survivors and their children. One might, therefore, be tempted to assume that this population is now fully and freely heard. However, as can be seen in chapter 4, a study I carried out (Tauber, 2002a, 2003) exploring the experience of Israeli therapists who continued seeing their survivor and second generation clients at a time of intense, acute, violence and danger in Israel, demonstrated that such an assumption is premature Under certain conditions, such as armed conflict, even well intentioned listening does not guarantee that this population is actually heard.

There has been some recognition as to how countertransference might aid or inhibit psychotherapeutic work with traumatized clients (Dalenberg, 2000; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994b; Wilson, Lindy & Raphael, 1994). Psychotherapy with Holocaust survivors and the second generation raises unique challenges and countertransference issues (Danieli, 1980; 1982; 1988a; 1994a; Dasberg, 1993; Ofri, Solomon, & Dasberg, 1995; Tauber, 1998; Tauber & Van der Hal, 1998). Therapists and traumatized clients are part of their societies and the acknowledgement and perception of trauma and its impact have been closely linked to the socio-cultural context (Herman, 1992). Societal processes and reality are very much present in the therapy room, in the views, values and wounds of both therapists and clients, as well as in their expectations.

The Holocaust is an extreme example of massive interpersonal traumatization. The sheer number of active and passive perpetrators and, at best, bystanders, in so many countries may shatter any assumptions of human decency, morality and the protection offered by seemingly sound democracies. Psychotherapy with people who have been traumatized by the intentional harmful acts by others leads not only the client, but also the therapist, to a (renewed) confrontation with human cruelty and potential for evil. This may bring about secondary or vicarious traumatization of the therapists (Figley, 1995; McCann & Pearlman, 1990).

The suffering of Holocaust survivors and, as the result of trans-generational traumatization and growing up with severely traumatized parents and decimated families, that of their children, the second generation, may remain acute

in the present. Therapists who have worked with this population in recent decades are generally somewhat buffered by the horrendous events of the Holocaust having occurred in the ever-receding past. However, during the *Matsav*, (i.e. the Situation, as the violent conflict that erupted on Rosh Hashanah 2000 was generally referred to in Israel), therapists and clients were sharing a potentially (re-) traumatizing reality. Therefore, the protective barriers of traumatic events having long passed might be temporarily neutralized. Even though this obviously was not the first period of danger and stress in Israel's short history (Chapter 5), the pervasive sense of existential threat created special challenges for therapists. The question then arose for me whether the anguish and actual, as well as metaphorical, shouting by Holocaust survivors and their children could be tolerated and fully heard under conditions of shared, existential danger or whether they were supposed to revert to a hush.

The review, in this chapter, of societal and professional attention or inattention to Holocaust survivors and their offspring is an attempt to understand the long silence towards and regarding this population. It is integral to my exploration of sources, in this case, societal sources, for the *a priori* countertransference to try and understand what made it possible for the vast majority of therapists to not acknowledge, treat or study this population

The Holocaust and its Survivors

Silence

Silence has been a widespread response to the Holocaust in stark contrast to, and the end result of, the brutal noise that accompanied the rushing of people to their deaths. With few exceptions, the world responded with silent acquiescence to the systematic annihilation of the Jews. Silence was the legacy of the many dead, the murdered families, communities. Silence was what so many survivors met with when they "came back" from the war, not only because their loved ones were gone, but because others, people, society around them, in Europe, the United States and Israel, seemed deaf to their suffering. Silence too, was what many chose as a way of coping with their gruesome traumas. Some even succeeded in silencing their very memories beyond the reach of their awareness for decades. Silence was a constant presence in the families that survivors managed to create after the war. For Holocaust survivors and their families silence can have many meanings and nuances but no words exist to describe these silences.

Interpersonal traumatization is ultimately a very lonely experience, for which it is often nearly impossible to find words. And when one does try, it can be hard to find a willing listener. One reason why it is so difficult for trauma victims to

get societal recognition is that the perpetrators tend to act out of (perhaps passive) social consensus. Herman (1992) elaborates this painful point in regard to the acknowledgement of incest and the suffering of its survivors. Haas (1988) points out that Nazi ideology and subsequent participation in its practice gained easy acceptance because its concepts fit with current "religious, medical and academic values" and so felt "intuitively correct" (pp. 391-192). Full acknowledgement of the actions of the perpetrators can shake the foundations of perceived social order and ones own place in it.

The silence cloaking the suffering of the Holocaust was echoed from society through therapists to their clients and back again. Even the name, "Holocaust," is not a translation of what had been fully intended to be the *Endloesung*, the Final Solution. The fact that World War II ended before the intended extinction of the Jewish people could be completed is unlikely to be the reason the term, "The Final Solution" has not gone into general usage (Bettelheim, 1980; Gampel, 1989). Already in 1944, SS officer Merz made a chilling prophecy of societally imposed silence to Simon Wiesenthal: "You would tell the truth to people in America. That's right. And you know what would happen, Wiesenthal? … They wouldn't believe you. They'd say you were mad" (Wiesenthal, 1967, p. 347).

The end of World War II, in 1945, halted the process of extermination of the Jews, which had already reached an advanced stage. The suffering and traumatization did not stop then. The surviving Jews, many stateless--and thus deprived of even the formal belonging awarded by having a nationality, a passport--wandered across Europe learning the extent of the tragedy. Too often, they discovered that no family members had survived. Their communities too, had been destroyed, and if their homes were still standing, these were usually not returned to them. Both adult and child survivors (Mazor, Gampel, Enright, & Orenstein, 1990) had to learn to become members of societies that had but a short time earlier denied them all their rights, and begin to build lives for themselves. Practical matters took priority over attempts to heal any but the most debilitating physical wounds. A novella about the post-war relationship between a *kapo* [camp inmate forced to be in charge of other inmates] and another survivor written by Rosenfarb (1997), herself a survivor of Auschwitz, brilliantly sheds some light on how many of these survivors have been able to remain clinically invisible and live outwardly normal lives, despite their persistent memories and psychological injuries

Child Survivors and the Impact of the Conspiracy of Silence

Except for the very aged, most survivors alive around the turn of the millennium were children in the Holocaust. Even today, it is painful to listen to people who were so cruelly abused and abandoned as children. These traumatized children have remained a part of the chronologically adequate adults in a way that I

conceptualized as a "compound personality" (Tauber, 1996). Gampel (1988) points out that in order to hear this "child" one has to listen actively. At times of loss, such as the death of a spouse, it may be critical to be alert to the reactivation of the childhood traumas against a background of a lifetime of "subtle mourning" (Mazor & Mendelsohn, 1998, p. 82). If it is still so hard to do today, when these people are in their fifties, sixties and early seventies, it is almost unimaginable what it must have been like to listen to what they might have needed to communicate at the time, when they were only three, eight, fourteen.

And very few adults did listen. In fact, Keilson (1992) describes the additional traumatization, and subsequent age-related damage, caused by the way these children were treated in Holland. In other countries too, child survivors were expected to forget and go on without a "post-traumatic embrace" (Tauber & Van der Hal, 1997). Searching through Israeli *Alyat Hanoar* (Youth Immigration) archives, Segev (1994) found precious little acknowledgement of the child survivors' traumatic experiences; instead, there was evidence of misunderstanding and subsequent neglect. Quoting heavily from the literature, Dasberg (2001) stresses that after the war, and in early adulthood, child survivors wanted most of all to be ordinary people, just like everyone else, which was precisely how their caretakers needed them to be:

> In Israel they were pressured to change their old family and personal names and to forget their native language. The early social pressure not to express feelings in regard to the Holocaust was very strong in Israel. It helped the early adaptation but there was a price to be paid for it later, namely: guilt feelings or the feeling of not being valued by other Israelis (or others elsewhere). Furthermore, there existed a relentless striving to belong, which brought about identity problems and insecure self-esteem. (p. 16)

Adult Survivors and the Impact of the Conspiracy of Silence

The title of Citroen's book (1991), translated from the Dutch to *Nobody is expecting you*, reflects the experience of many adult survivors as they came out of hiding or returned from the camps, and not just in Holland. Too many quickly discovered that no one really wanted to hear what they had been through. For some, this did not seem too much of a problem at the time.

> Many survivors might have become part of the "conspiracy of silence" which grew from the survivors' need to forget and to adjust to new social contexts which were not always receptive to the cruel stories of the past. This social context varied according to cultural and historical circumstances of countries in which the survivors started their new lives. Survivors, who got to Israel at the

> time of the War of Independence, were desperately needed and immediately volunteered for, or were drafted into, fighting units. One out of three of the casualties of the War of Independence was a Holocaust survivor. (Segev, 1994, p. 177).

The fact that few survivors sought psychotherapy did not escape attention. Writing in the sixties, Tanay (1968, p. 220) attributed this to their "masochistic defences," though he did acknowledge therapists' reluctance to work with them. Niederland (1968) suggested there might be a kind of cooperation between clients and therapists in denying the impact of Holocaust traumas. Lelieveld (1979) raised the possibility that both societies and traumatized people had to go through a latency period before being able to openly communicate about it. Quite some time had to pass before Bastiaans (1979; 1987) could write that traumatized people should not be expected to ask for help; that, instead, they must be offered help. Davidson (1981) explained survivor silence as a consequence of societal inability to understand: "In this way both the survivors and the surrounding society interacted to maintain, by and large, a shameful silence" (p. 55). In actual fact, this silence was wounding. "The resulting conspiracy of silence between Holocaust survivors and society proved detrimental to the survivors' familial and socio-cultural reintegration by intensifying their already profound sense of isolation, loneliness and mistrust of society" (Danieli, 1988a, p. 116).

Second Generation and the Impact of the Conspiracy of Silence

Much of the literature about the second generation describes characteristics observed in clinical practice (e.g., Bergman & Jucovy, 1982; Kogan, 1995; Van der Hal, Tauber, & Gottesfeld, 1996; Wardi, 1992). Bar-On (1995) provides a sense of how three generations may live with their Holocaust traumas. There have also been descriptions of children's direct preoccupation with their parents' past. Shoshan (1989) has found that the children of Holocaust survivors tend to take over and complete their parents' mourning process. Laub and Auerhahn (1993) have described how memories can be expressed in life themes, rather than in "overpowering narrative" (p. 296). In fact, "Life themes enacted in close relationships are often found in children of Holocaust survivors…" (Laub & Auerhahn, p. 226). Children of survivors may also be more sensitive to additional traumatization. Solomon, Kotler and Mikulincer (1988) found, for instance, that children of survivors are less able to cope with the massive stress of combat, and recover more slowly than their contemporaries. Their vulnerability may not be limited to stress in combat (Yehuda, Schmeidler, Wainberg, et al., 1998). Baider, Peretz, Hadani, Perry et al. (2000) studied daughters of Holocaust survivors with breast cancer and discovered that they were significantly more distressed, psychologically, than other women of the same age. In fact, the findings were

similar to the responses of Holocaust survivors with breast cancer as compared to previously non-traumatized women with breast cancer. According to Brom, Kfir, and Dasberg (2001), children of survivors are indeed different from their contemporaries, though this does not necessarily have to be expressed pathologically.

Survivor parents for whom remaining silent about their horrendous experiences and losses was not an appropriate coping tool were left little alternative but to talk to their own children and fellow survivors about the horrors they experienced (Danieli, 1980). Children of survivors became witnesses of explicit accounts of horror and loss. They completed hinted and partially told stories with their imaginations. Parents, who tried to spare their children by not talking to them about their experiences, did not necessarily protect them either (Danieli, 1989; Gampel, 1982).

Full acknowledgement of the Holocaust and in-depth inquiry into the parents' experiences and history of the extended family are essential for effective psychotherapy with the second generation (Guebrich-Simitis, 1981). Unfortunately, it can not be taken for granted that this is always done (Moses, 1984; Tauber, 1998). Second generation clients might collude in this silence as acknowledging their suffering might mean an intolerable blaming of the parents (Barocas & Barocas, 1979) or breaking the taboo of family loyalty (Fogelman, 1989). In this sense, the silence that turned their parents mute becomes the children's experience as well.

Societal Context

However difficult listening to survivors may be, by giving in to the conspiracy of silence "society adds denial to denial and a fateful spiral of perpetual trauma is initiated" (Dasberg, 1987a, p. 3). Societal responses negatively affected survivors in "their postwar adaptation and their ability to integrate their Holocaust experiences" (Danieli, 1994b, p. 6). Among those unable and unwilling to listen were also relatives of survivors who had not been in Europe during World War II (Danieli, 1989). Societies were unable to create a culture of listening to survivors and hearing what they were made to experience without confronting their own share in having made it possible for the Holocaust to occur. And in many European countries people had to face up to their failure to protect their own Jewish citizens (De Swaan, 1984).

De Swaan (1984) observed that as societal self-confrontation was skipped, the 'job' of listening was passed on to the professionals, and concepts such as suffering, victimization and persecution were 'translated' into such semi-medical vocabulary as "syndromes" and "trauma." Therapists were then supposed to be able to relate to their clients' internal experiences without having to acknowledge being part of the society that participated in the very harm done to their clients.

However, societal attitudes and the extent of confrontation with the issues raised by the persecution of the Jews were expressed in the most intimate relations, including that between therapist and client (De Swaan, 1984). These therapists were left to face the challenge of turning themselves into reflective witnesses (Van der Hart & Nijenhuis, 1999), and keeping their reflexive responses to the unimaginable reality of their clients' traumatic histories in check.

Conspiracy of Silence in Israel

The conspiracy of silence or the lack of acknowledgement and conversation about what the individual survivor endured during the Holocaust and how he or she lives with those experiences was an international phenomenon. But why should this be so in Israel, a state specifically founded as a safe haven for Jews fleeing persecution and discrimination? Contrary to expectation, perhaps, Israeli society, which had to build a new state while absorbing massive immigrations under conditions of (threat of) war, was less than understanding (Segev, 1994). Whereas Israel did not have to cope with the guilt of (assisting) perpetrators, Israelis did wish to avoid awareness that their fate might have been the identical to that of those Jews who were in Europe under Nazi Germany's reign. Were it not for a successful outcome of the battle of El-Alamein and the defeat of Rommel, this would most likely to have been the case (Dasberg, 1988). Israeli society did have to come to terms with feelings of survivors' guilt and helplessness resulting from facts that, for example, for every person who received a "Certificate," permission from the British to enter Palestine, someone else got the Nazi death sentence (Segev, 1994, p. 23). Furthermore, many Israelis had lost most, if not all, of their relatives that had remained in Europe.

Moses (1984) suggests that the Holocaust traumas were too emotionally difficult to deal with, and that the culture being established in Israel at the time, prioritized the interests of the group over those of the individual. According to Dasberg (2000):

> There was no place in the prevailing national myth in Israel in the fifties for nonheroes. Those who had gone like 'sheep to the slaughter' in Europe (and what remained of them) were not respected and were almost treated as taboo, as nontouchable. (p. 26)

Dasberg traces the process of acknowledgement along with cultural changes, the Eichmann trial in 1961, and the wars. "A change of myth and taboo occurred: hubris ended and antiheroism returned, along with a readiness to listen to and understand even Holocaust survivors" (p. 27). By the nineties Ofri et al. (1995) found that attitudes had changed and "… the therapists had more positive attitudes

toward Holocaust survivors than toward combat veterans since the former trauma is further removed than the latter" (p. 240). As will be seen in the study described in the next chapter, the shared conditions of threat during the *Matsav* eroded that protective sense of distance.

Conspiracy of Silence and Countertransference

So, for the first decades after WWII at least, societies, countries, were unwilling or unable to confront their own histories and responsibilities. Survivors, for their part, were only able to stay silent or talk with other survivors and within their families. Few were ever even asked what they had endured. Some found that not talking about their experiences at all was what enabled them to go on. Those relatively few survivors, who consulted with mental health professionals, too frequently discovered that a code of silence ruled therapy as well. This was true for their children too (Tauber, 1998). Danieli (1982), the first to study counter-transference issues in order to understand this silence, came up with both shocking and still relevant findings. Neither good intentions, nor belonging to the same population necessarily neutralizes damaging countertransference responses (Tauber, 1998). Therapists must remain unceasingly alert to what might impact both in-session and a priori countertransference.

Summary and Discussion

International acknowledgement of the implications of the horrors of World War II, and in particular of the mechanics and consequences of the Holocaust, has needed decades to become widespread. It is of interest to this study that the ability of mental health professionals to recognize the suffering of Holocaust survivors, and intergenerational transmission of trauma and harmful consequences for the children of survivors, closely followed these societal developments. It seems to be extremely difficult for individual therapists without some form of societal and collegial support to work differently from their colleagues (Herman, 1992) and allow themselves to hear and absorb what their traumatized clients tell them directly and indirectly. So rather than a "conspiracy" of silence within the mental health world, perhaps it would be more helpful to think of a silence born of fear of societal and personal (self) confrontation and a resulting lack of awareness of the suffering and psychotherapeutic needs of Holocaust survivors and their children. This happens on both a personal and societal level and mental health professionals find themselves in a position to mediate between the two, which demands high levels of awareness and personal integrity of the therapists.

Without in any way questioning the unfortunate uniqueness of the Holocaust, the struggles, by both general society and mental health professionals, as briefly outlined in this chapter, may also help to understand attitudes towards other interpersonal traumatization. With the insight offered by the concept of *a priori* countertransference into the processes that might lead up to such therapeutic failure, i.e. not providing the traumatized clients with appropriate acknowledgement, attuned listening and treatment, therapists, hopefully, can now have greater awareness and therefore choice. Generally accepted ideas, shared attitudes and social priorities prevalent in a given society can all play an important role in the formation of the attitudes, values, judgments and motivation that make up *a priori* countertransference. Considering how, internationally, and over a significant length of time, the collective results of social attitudes have been reflected in clinical work, and may still continue to do so, it is of vital importance that therapists remain optimally aware of societal sources of *a priori* countertransference and explore how they might personally express these in their work.

CHAPTER 4

Psychotherapy with Holocaust Survivors and the Second Generation at the time of Armed Conflict

As has been shown in the previous chapter, societal processes had to take place over many decades before Holocaust survivors and their children could turn to a mental health professional with a reasonable expectation of being heard and receiving recognition for their Holocaust related suffering. In this chapter (based on Tauber, 2002a, 2003), I want to present a case history, as it were, of the possible impact of an acute socio-historical development on the ongoing work and experience of therapists who were working with Holocaust survivors and second generation. In September 2000, there was a sudden change from genuine expectation of a steadily approaching peace -- and its attendant "pre-peace stress reaction, PPSR" (Bar-On, 1999a, p. 221) -- to a massive outbreak of ongoing terrorist attacks, the *El Aqsa* Intifada (El Aqsa Uprising) which Israelis referred to at the time as the *Matsav*, i.e. the Situation. All hopes for peace in the near future were shattered by the start of what would prove to be years of terrorist attacks, suicide bombings, shootings by Palestinians and acts of retaliation by Israel.

The suddenness of this transition made it a particularly difficult time. Israelis are well trained in going on 'as usual' and pretending nothing interferes with normal life although this "leaves a definite mark on Israeli society" (Waintrater, 1993, p. 117). But is it possible to go on as usual, including doing psychotherapy with already traumatized clients, at a time when everyone, including loved ones and oneself, is in very real danger?

Therapists now had to deal with the added burden of sharing a precarious security situation with clients in real-time; a situation that might trigger traumatic memories and create new trauma. They faced a double challenge: coping with the danger to their own physical safety and psychological well being, and remaining available to clients' responses and needs.

It is an unfortunate fact that at any point in time, there is violent conflict somewhere on the globe. If the inevitably traumatized or retraumatized people are to receive psychotherapeutic support locally, the therapists necessarily share the same exposure to danger. In their work on countertransference under conditions of "state-terrorism" in Chile, Agger and Jensen (1996) found that many therapists healed their own traumatic experiences through their work. The situation in Israel differs in that the existential threat in this politically divided, traumatized society is external. Still, the very feasibility of doing psychotherapy with previously traumatized clients should not be taken for granted under conditions of violent conflict that might uncover as yet under-explored aspects of countertransference in trauma work.

Focus and Research Methods

While struggling to come to terms with these drastically changed life circumstances myself, I soon wondered how colleagues were continuing to do psychotherapy with Holocaust survivors and the second generation while sharing a very real, existential threat with them. I was concerned how, at such a time of violent upheaval or war, *a priori* countertransference might manifest in a clinical context with Holocaust survivors and the second generation. I therefore carried out the study described and analyzed in this chapter.

Following phenomenological, heuristic (Janesick, 1994; Moustakas, 1990; Taylor & Bogdan, 1998) and feminist approaches (Gilbert, 2001; Reinharz, 1992) to qualitative research (Chapter 2), including the use of self as a research instrument, I used my personal experiences as a starting point to learn how colleagues were navigating between personal stress and professional demands. As Gilbert (2001) puts it, "… it is dishonest not to draw on their own emotional experience and incorporate those emotions into the final telling of their 'research tale'" (p. 11).

An unstructured interview was the tool of choice as I attach great importance to personal experience and consider optimal awareness of therapist experience an essential condition for doing psychotherapy. Parallel, perhaps, to the importance of careful self-disclosure in psychotherapy (Dalenberg, 2000), Fontana and Frey (1994) suggest that researchers "can no longer remain objective, faceless interviewers, but become human beings and must disclose ourselves, learning about ourselves as we try to learn about the other" (p. 374). And, as Reinhartz (1992) points out: "Receiving feedback from the interviewees… enables the self-disclosing researcher to continuously correct the interview procedure" (p. 34).

The material used in this chapter has been chosen for its relevance to the degree to which the clients are heard, and will hopefully shed new light on the understanding of "the conspiracy of silence" or preferably, silence born of fear, as described in the previous chapter.

The Participating Therapists

Colleagues at Amcha (Israeli center for psycho-social support to Holocaust survivors and the second generation) seemed the most obvious choice. Though Israel is very small, acts of violence such as bomb explosions, shootings and rioting did not occur with equal intensity everywhere in the country. Therefore, I approached men and women, who had a personal background and/or work experience that seemed of interest (Stuhlmiller, 2001), from Jerusalem, Haifa in the North, the central, Tel-Aviv area and the West Bank. I interviewed six therapists:

Anna, Tova, Itai, Avram, Noam, and Rotem (not their real names).

Two of the participating therapists, Anna and Rotem, are children of survivors. Anna is a fairly recent immigrant from the former USSR, another therapist, Tova, is an 'old' immigrant from the USA. Anna and Tova worked only with survivors, including in psychosocial settings. Rotem only worked with second generation clients. Except for those with administrative responsibilities, they all worked up to half time, but most also saw clients in other frameworks. Four of the therapists are women and two, Itai and Avram are men. This is quite representative of the staff at Amcha. The therapists ranged in age from early thirties till early sixties. All were married and had children ranging in age from toddlers to adults with families of their own.

This might be sufficient background information in many societies. But I would be amiss if I did not note political views and religiosity in an Israeli study exploring *a priori* countertransference. People with right and left wing political views tend to have mutually exclusive visions about Israeli society and possible pathways towards peace. At times of tension, they may easily perceive each other as co-responsible for the current danger and violence. As will be seen later, this plays a role in the therapy room, whether the therapists' views are made explicit or not. This holds true for the degree of religiosity as well as, in very general lines, the religious population tends to be right wing. The therapist's and the client's religious beliefs are immediately obvious because of the dress code adopted by religious Jews: modest clothing for women and head cover for men and married women. The majority of the participating therapists held a continuum of left wing views and two, Rotem, and Tova held center to strong right wing views. Tova was orthodox and Rotem lived a fairly religious life style. The other four, Anna, Avram, Itai and Noam were secular.

Responses to my request for an interview ranged from enthusiasm at an opportunity to talk through some feelings, to an interested willingness to cooperate with a colleague. Mindful of the fact that people might disclose more than they might later be comfortable with, I set up a double consent procedure. Before the interview, all the therapists signed a consent form, which included a caution that they might be recognized despite the use of fictional names. They then confirmed their consent after receiving their transcripts. Two people asked for small sections to be edited out before deciding to remain part of this study.

All the interviews took place in the last three weeks of November 2000. At this point, saturation (Maso & Smaling, 1998) was reached and additional interviewees were unlikely to shed any new light. The violence had, temporarily, somewhat abated at that time. The interviews took place either at my colleagues' offices or my home, and lasted around two hours. We spoke Hebrew in most of the interviews, which I transcribed directly into English.

Therapists' Perception of the Matsav

Safety is a major precondition to trauma work (Herman, 1992). In addition to the need for concrete safety in the clients' actual life circumstances, therapists can greatly contribute to their clients' psychological sense of safety. In the professional literature, the safety and stability of the therapists are usually a given. Under conditions of violent conflict, however, this can not be taken for granted which, in turn, may have an impact on their *a priori* countertransference. Hence it is of interest here to explore how the participating therapists perceived the *Matsav*.

The way a potentially life-changing and life-threatening situation is perceived can greatly influence the actual experience of that situation and degree of traumatization. Like most Israelis, the interviewed therapists referred to the violence as the *Matsav*. Naming this eruption of violence that shattered hopes and expectations of peace "*The Matsav*," (the Situation), made it seem something familiar, less devastating, and was thus perhaps somewhat protective against traumatic disruption.

The therapists’ perception of events might also be colored by their reasons for living in Israel, which frequently remains a matter of more or less conscious choice, perhaps the result of wars and trauma and the 2000 year-old Jewish history of wandering on to safer havens. Of the two immigrants, Tova immigrated for ideological reasons, while Anna and her family sought refuge--which one could call practical Zionism--from what she referred to as a *pogrom* that had been rumored to break out a decade earlier in honor of Hitler's birthday. Rotem and Noam decided to go back home to Israel after having lived abroad for a considerable time. Itai's family has been in Israel for generations. He feels very rooted in the country. Avram, born before the establishment of the State of Israel, has dedicated his whole life to building a just and flourishing society. All the therapists spoke about Israel and their living there without being specifically asked. This, in itself, is significant: one might not expect American therapists of Holocaust survivors, for example, to raise the issue of their living in the US, nor of the right and feasibility of the US to exist.

Trauma history and exposure to ongoing traumatic events are a major aspect of "*a priori* countertransference" (Tauber, 1998) and the perception of the *Matsav*. Therapists and their clients have a shared history of national traumas that goes back as far as the length of time they have lived in Israel. Still, the interviewed therapists made an unexpectedly high number of references to national traumatic events, in addition to the *Matsav*. At the same time, no one seemed able to keep all the attacks and explosions since the start of the *Matsav* in active awareness. This seems consistent with the lack of realization the name, Matsav, the Situation, implies. While this might be the result of a degree of dissociation vital for

continued coping, it does raise the question whether therapists would then be able to be fully aware and attuned to their clients during the sessions.

Terrorist attacks, such as exploding cars and suicide bombers on buses and in crowded places, are an ever-present threat in Israel and occurred with great frequency during the *Matsav*. Still, they were spoken about as a part of everyday reality. Itai, for example, said "jokingly" that he knew he risked death by just buying aspirin from a pharmacy in Dizengoff Center (a mall, in central Tel-Aviv where a terrorist attack in 1996 left many dead or wounded). He found it helpful to think that both Israelis and Palestinians were motivated by posttraumatic perceptions, rather than by evil or proneness to violence. Avram felt shaken by this latest outbreak of violence. "It seems that not even Zionism can guarantee the security of the Jewish people in its own land." He was reminded of childhood memories of Israel's War of Independence, during which the Jews felt that not only their hopes for a Jewish State, but their very survival, were at risk. To his great disappointment, "the Moment of Truth," as he called the *Matsav*, exposed a seeming inability, or lack of desire, on the part of the Palestinians to make a genuine compromise. "Both sides must know that they gave something up, but also that they gained something, and that what they gained is something with a future, something that continues".

Noam was concerned that it would be hard to get the Israelis and Palestinians talking again, because of all the rage and anger that have been stirred up. She spoke more about the riots by the Israeli Arabs than any of the other interviewees. Quite conciliatory towards the violent and rioting crowds, she placed responsibility with Arafat. She felt he might not be interested in achieving statehood during his life time. "It may be odd that I hang the fate of two peoples on the psychology of one man, but that's really what I think."

Rotem, aware of the complexities of justice and injustice on all sides, felt Israel was in danger. She was afraid we might “loose the country.” Many “‘reminders’” of the Holocaust, including the indifference and misunderstanding from the outside world, increased her fears. None of the others referred to being reminded of the Holocaust when describing their own responses.

All the interviewed therapists were much preoccupied with trying to understand what the *Matsav* might lead to beyond the immediate violence and danger. As is known from trauma work, it is important to have a narrative, an uninterrupted story in order to facilitate coping and healing. Conceivably then, therapists might, possibly unconsciously, want to protect their narrative from "assault" by their clients. This is a source of *a priori* countertransference that, as will be shown later, was expressed in the actual clinical work.

Therapists' Coping Styles and Availability

The topic of coping was raised in all the interviews as an inevitable

reflection of daily reality. We all had to find our way through the shootings, explosions, sense of threat, distorted international reporting, and our radically changed existential and psychological reality. Nothing was 'over' yet at the time of the interviews, not for the therapists nor their clients. What kind of therapeutic 'contract' was possible at such a time? How available could therapists possibly be to their already traumatized clients?

Anna, for instance, wanted to avoid encounters with "hysterical" adults, in order not to be infected by their anxiety. Avram recommended that therapists share their anxiety with their clients, as this could be "calming" for both. Tova was very frank about her fluctuating availability to her clients. "It depends on the day! I mean, there are days when I don't have any strength…but generally, I would say that I can do better". Noam too, is aware of the degree of her availability. Although she listens, she is aware of being "preoccupied in some way…I feel that I am more exhausted".

Relationships with clients changed significantly. I personally received phone calls from clients after terrorist attacks at central locations to make sure I was OK, that I was still alive. Should this be seen as a breach of boundaries? Acting out of transference? An inability to tolerate further losses, or plain human concern? The degree of clients' anxiety can be overwhelming for the therapist who is trying to hang on to some measure of control and normality.

The interviewed therapists employed techniques to help them cope: reduced exposure to news, humor, support of family and friends, maintaining a routine and taking a historical perspective. Almost all also acknowledged intense (negative) emotions in response to the *Matsav*. And, perhaps surprisingly, some, like Anna, Tova and Avram drew strength from their Holocaust-survivor clients.

A set rhythm helped Anna deal with the nightly shootings into her neighborhood. She got ready for the evening "routine," the "ceremony" of phone calls from worried friends, and a good night's sleep to wake up refreshed the next morning. Occasional shooting in the morning upset her greatly. She put other acts of violence during the day out of her mind as soon as her immediate family was confirmed OK. At work too, she preferred to stay with controllable, routine activities, rather than, for example, organizing outings for the social club members. "You invest so much time and effort into it, and then, suddenly there is shooting, and you have to cancel everything…" And she managed to adjust her internal expectations. "Perhaps I was wrong, with a kind of idealism and naiveté… Now I am more focused on what is, rather than what I would like to happen".

Tova, like her children and grandchildren, was at great risk of sniper fire on the road to and from home in the territories. Not surprisingly, perhaps, our interview focused heavily on her need to cope and how she tried to do it. Her religious and ideological beliefs were helpful for her, as well as the closeness of her

family and community. Professionally, she had reduced the number of clients and was supported by her supervisor who validated her inability to listen to clients at times when the stress felt overwhelming.

Itai, on the other hand, found strength in his perspective on violence. "The understanding that I am a violent person, that we all could be … It gives a sense of great similarity between people". He considered Israel strong and well capable of defending itself, should the need arise. Though aware of the stress in his body, he said he did not feel threatened, personally. He enjoyed his work with traumatized people, difficult though it might be at times, and thought it helpful in successfully coping with his own stress.

Avram saw a clear connection between the personal and professional. "First of all, the therapist has to take care of himself. And to understand that he's in the same boat as everyone else." He felt that therapists should use their professional skills to cope with their own stress, and share their experience with clients, whenever appropriate. Working also helped him cope by freeing him from worrying about what might be happening outside the therapy room. He is aware of the challenge of being genuinely present with clients when, as he described it, "you sit there with one ear tuned inside and one ear tuned toward the outside." Over the years, Avram has also learned the value of being prepared for different kinds of emergency situations. He gains peace of mind by taking steps to ensure the safety of people for whom he feels responsible. "Having certain plans of action prepared in advance is very effective coping, rather than just sitting and waiting…On the other hand, I know… it's also a matter of luck…we are small and vulnerable and we can't control everything."

Keeping a sense of perspective and balance was important to Noam and helped her cope. She did not deny her emotional responses such as sadness, anger or fear, but the depth of anxiety she encountered in second-generation colleagues shocked her. Though fear and death touched her family too in the Six Day and Yom Kippur Wars, she is struck by the responses in those traumatized by the Holocaust even though she herself is afraid too: "…it simply becomes a sharp link, as it were. It becomes a matter of life and death…".

Rotem, a child of survivors, coped by thinking deeply about her sadness, panic, anger, and a sense of betrayal since the start of the Matsav. "I tried to find more of a sense of meaning for what was happening to me." And like Avram and Noam, she took a historical perspective and wanted to think of what was currently happening as part of a process. She conveyed her sense of upheaval in her description of praying in the synagogue on Rosh Hashanah, the morning after the violence had started with stone throwing at people praying at the Wailing Wall:

> All the men in the synagogue were carrying arms. All the men

> carried arms underneath their *tallith* (prayer cloth)! And I noticed that there was someone standing watch near every door, every exit. I suddenly saw that people had organized. Can you imagine what it's like to pray like that? Still, it did give me a good feeling. I felt that not only were people protecting me, but that there was some counteraction.

All the interviewed therapists were actively coping. With so much additional, existential preoccupation, however, is it possible for a therapist to maintain the same degree of openness to their traumatized clients and the same degree of accessibility as before such shared ongoing situation of stress and danger? Furthermore, there was a changed dynamic for those therapists who felt they drew strength from clients who were Holocaust survivors. At other times, therapists were likely to find themselves in situations when they experienced their clients' coping methods and perceptions as threatening to their own stability. Unless they anticipate this, and raise their awareness of their *a priori* countertransference, they may be caught by surprise and unable to listen, as will be illustrated in some of the examples volunteered about their clinical work.

Perceived Client Responses to the Matsav

The Interviewed Therapists' Perceptions of their Survivor Clients

The focus in the interviews was on the therapists' experience, but they volunteered quite a lot of information about their clients. I had the strong impression that they did so with less empathy and engagement than would be characteristic of them in calmer times. It is also safe to assume that their clients would be in greater distress. Stern (1999), for instance, a child survivor of the Holocaust realized as a result of his personal and professional experiences at the time of the Gulf War, that he himself and people around were not just post-traumatic but, as he put it, "pre-traumatic" (p. 55). Solomon and Prager (1992) found that in the first Gulf War, elderly Holocaust survivors felt in greater danger and suffered considerably greater distress than non-survivors of their age group. Cohen, Brom, and Dasberg (2001) confirm this observation with regard to child survivors: "…we can conclude that this group might be at risk during stressful times, irrespective of their good day-to-day adjustment" (p. 9).

Quite a few of the interviewed therapists emphasized their clients' strength, despite their awareness of the risk of retraumatization and the impact of cumulative trauma. Anna worked mainly with new immigrant survivors who were struggling with their ongoing existential difficulties. She would have expected the survivors to have a hard time during the *Matsav*, but instead, she noticed that they

coped. The members of the social club Anna ran seemed determined to go on enjoying life, while she was aware of her own depleted energy. "They want some joy, to know that life continues, to do something fun."

Avram felt that "the survivors seem to be a bit more resilient somehow, even with the whole weight of their anxieties and perception of the world sometimes in terms of black and white, life and death." He pointed out that the violence was still continuing and that, therefore, it was not yet possible to let down defenses and begin to process experiences. He perceived most clients as pulling themselves together for this emergency situation. In fact, he has noticed a gathering of strength, signs of coping, rather than symptoms of retraumatization. Avram's survivor clients continued going about their business, though "the day there was a terrorist attack, the day there was an attack here, the last one, fewer people came."

Interestingly, the therapists generally interpreted a lack of reaction on the part of survivor client as a sign of coping. Whereas that might indeed be the case, they did not raise the possibility this may be a sign of numbing, characteristic of traumatization. Tova had not perceived her clients as having an especially hard time during the *Matsav* either. However, as the interview progressed, she thought of a client who used to talk a great deal about his dreadful Holocaust experiences and link those to his rightwing views. She realized that he had actually become very silent on the subject and that she had not thought to explore this change with him. This prompted her to question her perception of her other clients.

Itai, a native Israeli without a direct connection to the Holocaust, noticed that since the outbreak of the *Matsav,* his survivor clients had become politically more outspoken, "It's a subject that comes up much more strongly, it's expressed in more extreme forms." Noam also noted political outbursts from the first generation, especially when in a group setting, which distressed her.

The question what enables us to hear and be aware of what we hear came sharply into focus for me when Rotem, an Israeli-born child of survivors, told me about her experience at a social event at Amcha when she spent time with a group of survivors--not her usual client population. The stark difference in responses from those other therapists reported might be connected to the setting, but does raise the question to what extent a therapist's *a priori* countertransference influences what a client does or does not speak of:

> I sat down with people and asked them, how are you, how are you feeling? And people just talked. That they don't know anymore, they don't know what will be, and they're afraid, and they're afraid to lose what they have. Terrible. A very difficult feeling. And no, that was no a surprise for me at all. I know how my mother talks.

The Interviewed Therapists' Perception of their Second Generation Clients

In the general context of their professional experiences during the *Matsav*, the therapists shared a lot of interesting perceptions, especially the relative silence of the second generation about the *Matsav* in individual therapy. This immediately alerted me to an expression of *a priori* countertransference that the interviewed therapists seemed oblivious to.

They generally perceived their second-generation clients as apparently unaffected by the *Matsav*. Noam was somewhat troubled by their seeming to ignore the *Matsav* and their own responses in their therapy sessions. The shock of the first few weeks of the *Matsav* gave her personally, a sense of everything having broken. "It's going to take us years to fix it all again." When I asked whether she noticed such a response in her second generation clients, she replied, "No, they didn't express any of it!" Noam did worry that she might be responsible for her second generation's silence on the subject, even though she occasionally even asked them directly. "The second generation are just not there. And it would seem that I'm not there with them either." In this, she might be acting out some of the experience of survivor parents.

The only one to clearly empathize with the difficulties of the second generation was the older, Israeli-born therapist. Avram's second-generation clients did not talk much about what was happening either, nor about Holocaust related issues. But he did not conclude that they were not affected. "It's quite possible that sensations, feelings and responses are intensified, without being experienced as specifically connected." He also perceived them as lacking their parents' "survival procedures."

In contrast, Itai, the younger Israeli born therapist seemed to give less weight to transgenerational traumatization and find it hard to differentiate between the second generation and himself even though he is not a child of survivors. "I don't know. It's easier for me. They're not people who personally, there's a difference between my anxieties, or dreams I might have, and a person who actually went through the Holocaust and dreams about the Holocaust." And though he did note signs of impact, he did not interpret them as signs of possible distress. "And you know, here too, there isn't really a jump to another level. There always were Holocaust dreams, they're more intense now; there were always some kind of reenactments not of one's own that are stronger now."

Rotem, who only worked with the second generation in Amcha, was perturbed by the fact that her clients appeared unaffected by the *Matsav*. She expected them to express their distress with direct references to the Holocaust, which was how she experienced both her countertransference responses to them, and her own reactions to the *Matsav*. Her own countertransference reactions connected right back to the Holocaust, however. When male clients spoke of their concerns about doing their army reserve duties during the *Matsav*, Rotem feared for

her own safety. She linked her sensitivity for insufficient protection to her being a child of Holocaust survivors.

The participating therapists perceived their individual second-generation clients in a strikingly different manner from that of second-generation colleagues or second-generation therapy groups. Both Noam and Avram, for instance, described their second-generation colleagues at Amcha as very disturbed, troubled, and frightened by the *Matsav*. Noam even told a story of a colleague who was wondering how survivors that managed to flee Europe had known when it was "the right time," and whether, perhaps it was "time" to leave Israel at this point. I can only guess that as colleagues and in group therapy, children of survivors might feel free to behave as peers and share distress. In psychotherapy, the extreme conditions of the *Matsav* may well have triggered a replay of their old responses to their parents, as their therapists would obviously have they "own" worries, during this period.

Writing about her experiences with second generation clients during the Gulf War, Kogan (1993) emphasized the need to help them "…perceive the reality of what was happening to them at the time, rather than concentrate on what they imagined had happened to their parents in the past" (p. 811). Therapists seemed unable to pinpoint, or be aware of their possible role in this silence and of perhaps agreeing with the "children" that they could take care of themselves and need not overtax the resources of their already stressed therapists. This would seem to be a dramatic example of what could be referred to as "a conspiracy of silence" or silence born out of fear, but may be more usefully seen as an expression of *a priori* countertransference.

The Therapists' Matsav-Related Anger

When clients and therapists share an ongoing traumatizing reality, not just "*a priori*," but also in-session countertransference issues such as containment, can be very complex. The fact that clients and therapists concretely contribute to this shared reality, not just with their votes, but also with their degree of social commitment and activism, further complicates matters. In the case of the *El Aqsa Intifada*, they all had to deal with the experience of literally being under attack. Under such conditions, anger, which must always be acknowledged in both the therapist and client experience in trauma therapy (Brom & Witztum, 1995; Kleber & Brom, 1988; Tauber, 1998), can present a particularly difficult challenge.

Some of the therapists easily accessed their anger, especially after the lynching of three Israelis by Palestinians in Ramallah. In Anna's words: "I was very, very angry…I understand why they respond that way! But if I'm at war with them, there's no such thing as 'I understand'." Avram too, spoke of his anger at the Arabs:

> Look, it starts with anger, and a desire to punish all those who don't really let us live. Look, my feelings are mixed, from a desire to shift all Arabs out of view so they'll stop with all the problems, and feelings, definitely of anger and rage and hatred. Why can't they let us live in peace? And it is not really just the Arabs, but also about us, about the Jews, about Jewish history, why, what is it about us, that we don't succeed in settling down anywhere? It would seem that the 'globe' is rejecting us everywhere. That's one side. The other side is the exact opposite, actually. Understanding *their* difficulties.

Avram was also one of the few to speak of both his anger at the settlers and his commitment to them. This was important as Tova, for instance, who lived on the West Bank as did all of her children and grandchildren, felt quite isolated and not always sufficiently supported by her colleagues.

> They brought it on themselves and all that…I don't agree with the settlements. They ought to be evacuated. But to say that I don't care what's happening to them, or that they don't deserve protection or don't deserve to travel without being shot at? That's something else altogether. After all, we all have our political views.

Noam struck me as rather conflicted on the subject of anger. She felt none towards the Palestinians. "People get caught up in situations…but I do feel some anger at those who influence the mood and leads things." It was easier for her to express anger at artists from abroad who were canceling performances in Israel. "Of course, I'm angry. It's not that I don't understand but I'm really sorry about it. It's annoying, it's depressing…We live in a state under siege."

Rotem was very angry and distressed and gave free reign to her emotions:

> The whole time, I feel torn between survival--and then I don't care, I don't care if everyone dies, we have to protect this place and all that-- and between 'seeing' the other side. And that is really difficult. And it is all, everything leads back to … straight back to the Holocaust. I keep thinking where will my children be? And me too. …I am afraid. I think that we may lose the country. And it's not that I want to leave. I have no fantasies about leaving. I'm really clear about that, very clear. I say to people…you can live abroad because we are here. While we are here, you can enjoy yourselves abroad. When there is no country, you will become nationless, and even in the U.S. Being nationless is very different from being in the US while there is a state here for Jews. That is very clear to me. I would never in my life give up on that. That also comes from the

> Holocaust. And it really worries me because I'm afraid they won't know how to protect it; that things will fall apart.

The anger the therapists expressed seemed directly related to personal threat and survival issues. This in itself is an important source for *a priori* countertransference. And the fact that most of these experienced therapists did not acknowledge Holocaust echoes in their own fears would seem both a further source for *a priori* countertransference in their clinical work as well as, already, an expression of *a priori* countertransference.

Are Clients Expressing Traumatic Rage or Are They Racists?

Would therapists consider a client who, like Rotem in the interview, allows herself to pour out her uncensored feelings in a psychotherapy session during the *Matsav,* very distressed, or reject her as a racist? In fact, the second generation was reported as ignoring the *Matsav* and things survivor clients said to the interviewed therapists at that time were volunteered to me as examples of hard to tolerate racism. It's worth recalling that in this study, I set out to explore their experience as therapists during the third month of the *Matsav*, and not those of their clients. Could extreme personal stress and sense of danger compromise therapists' ability to shift from their understanding from the concrete to the symbolic?

Itai, for example, who did not describe himself as feeling particularly angry, understood that clients might be expressing trauma-triggered rage and that there was a need to explore the underlying pain in the therapeutic setting. And while he made the interesting observation that "in Israel, the manner of talking is… immediately political," he referred to a lot of the statements he heard in the sessions as racist. Itai spoke of one session that was so upsetting for him, that he had to leave the room for a few moments in order to regain his professional composure and availability to the client. "I can think what I like, but his experience is one of complete reenactment; he feels persecuted and lonely and in danger of extinction; he feels that there is not anyone to trust, and very difficult things like that."

Noam too, was aware that her survivor clients were being triggered by the events and were likely posttraumatic, yet she had great difficulty with their rage and anger and "all those very 'total' and absolute things":

> With survivors, the existential anxiety is much clearer and, I don't like to say it, but the racism is too. The 'other' is so clear, and the sense of persecutor/persecuted is so strong that it's very hard for me, at times.… I sometimes think about what it must be like to be a second generation in a family in which you're either persecuted or persecute the whole time. That's really hard. It really places a weight

> on one's chest…When they begin to talk about the *Matsav*, tensions rise, and there's a lot of anger and rage, and there is no perspective of the other side.

Perhaps it is no coincidence that the two younger Israeli born therapists who have no direct personal or familial connection to the Holocaust seemed most disturbed by their survivor clients' expressions of rage. It is possible that at a time of shared danger, they needed to defend themselves against such, less empathy-arousing, expressions of post-traumatic rage. Children of survivors on the other hand, might find it easier to empathize with such experience-based outbursts in other circumstances or even allow themselves similar, fear-generated outbursts. I can only wonder if similar self-preserving instincts were at work in the early years after the Second World War, rendering veteran Israelis deaf to the ways the immigrant survivors expressed what they endured (Chapter 5).

Sanctification of those killed in the Holocaust, let alone of survivors, is abhorrent to me (Tauber, 1998) and I quite readily concede the inevitability of racists among them, as among any group of people. I am concerned, however, about the clients' right to safely ventilate uncensored "heat of the moment" emotions in their therapy sessions. This is especially important as so many survivors were involuntary witnesses to the most horrendous cruelty human beings have been proved to be capable of. Some survivors may feel compelled to warn whoever will listen that outrageously cruel behavior already sanctioned once, cannot be guaranteed not to be repeated. It may be intolerable for some survivors to just helplessly, watch. Again. At times of shared threat and danger, however, this may be just what pushes an insufficiently prepared therapist's tolerance to the limit.

Some of these survivors may well have been expressing anger at an enemy. It is important, however, to clarify distinctions between trying to deal with an enemy's violence and expressing racist sentiments, and guard against setting up a new stereotype for Holocaust survivors (Segev, 1994).

The very introduction of (political) judgment in the therapy room is noteworthy, though acknowledgement of political reality is essential in trauma work (Brom & Witztum, 1995). Tova volunteered no political comments regarding her clients. Rotem spoke a lot about politics, but not in regard to her clients. Anna, Itai and Noam, however, all emphasized how right-wing their survivor clients were. Interestingly, no one volunteered examples and references about survivors who expressed themselves differently or who shared the therapists' own political views.

I could speculate that it was very hard to combine feelings of anger, betrayal and fear, with empathy for the suffering of those Palestinians not actively engaged in the violence, especially when living with the threat to loved ones' and personal safety and working with such massively traumatized clients. Furthermore, survivors of the Holocaust, for whom every, and any fear of danger, cruelty, and

loss, not only could, but did come true, may evoke a fear of contamination (Dasberg, 1987a; Tauber, 1998) which can become more acute at a time of armed conflict. Still, it is interesting that political observations were not an issue in regard to the second generation.

The subjectivity of perception could be seen most clearly when two therapists described a similar phenomenon. Itai and Noam both mentioned survivor clients who were very preoccupied with having failed to create a safe haven for their children and grandchildren in Israel. For Itai, this was "a good way of joining with their life story. It's a kind of appreciation of life as to what is good and bad, and a kind of closure. Even if it is pessimistic, it gives me a good feeling, professionally." What stood out for Noam, however, was "their sense of failure...They made such a huge effort to build a state so that their children will be safe, and they didn't succeed." There clearly was an under-acknowledged disturbance in the therapeutic relationship. Survivors were perceived as having no problems, being strong, being racist or as racists having a hard time. While these might all be accurate perceptions, the possibility remains that they were colored by insufficient acknowledgment of "*a priori*" and *in-session* countertransference.

Therapists' Awareness of Parallels between Own and Clients' Responses

The highly competent, well-intentioned therapists interviewed for this study seemed only partially aware of interference of their *Matsav*-induced countertransference with their availability to their Holocaust survivor and second generation clients. It proved to be unexpectedly hard to truly listen, without judgment, self-protective silencing or rejection, to what the *Matsav* is stirring up in these clients, especially their sense of threat, doom and rage. This should not mean therapy with (previously) traumatized clients is impossible at times of armed conflict. It does mean that awareness of *a priori* countertransference must be expanded to include therapists' issues triggered by the conflict and possible preparation they need to notice and deal with their clients' ways of expressing their difficulties.

During the *Matsav*, therapists and clients shared stress, danger and anxiety, each with their personal and societal echoes, which include the Holocaust. Without adequate self-monitoring and working through of personal, related issues, therapists may experience Holocaust survivor clients' rageful, fearful warnings along the lines of 'what was done to us once, will be done again' as an intolerable threat to their personal sense of security. This can be especially strong as these clients represent living proof, sometimes loud and possibly offensive, of the well-organized and near-successful annihilation of a whole people, including their, and the therapists' families, with incredibly little (international) interference and resistance.

Some of the therapists were aware of having become less available to their clients. There were days when Tova, for example, was just too stressed to "hear" her clients. Only upon reflection afterwards did I realize I had failed to ask how she presented herself to clients on days when she felt overloaded. This may well parallel to a process in which the client's stress is so 'obvious' to the therapist that no immediate further exploration seems necessary or even possible. But the question of whether therapists can function under conditions of acute danger and traumatization pertains to all therapists and clients in similar circumstances. Should the therapeutic contract be adjusted, temporarily, or ought one to carry on the best one can?

Tova, like Noam and Rotem, was concerned that her countertransference might, in some way, prevent clients from bringing their responses to this situation of warfare into the therapy sessions. Noam felt less overwhelmed than Tova, but had quite a difficult time with the survivors' intensity and found it hard to listen to their predictions of doom. "I think we could take them [clients] to a place of more perspective…I don't just want to go into a big hole and not come out." If she was not directly referring to the "black hole of trauma" (Van der Kolk, 1996), she certainly shared the sentiments behind that concept. She was aware of the impact of the *Matsav* on her work. "At times, I find it hard to be empathic, and I'm less patient." She is saddened by the *Matsav*, drained perhaps, but she feels no existential anxiety.

Existential anxiety was also absent in Itai's conscious experience:

> I don't feel threatened. I explained already.… I have a very strong voice. It's not as if I have no other voices, but that voice is victorious. It doesn't get shaken. I see the small print on the three nuclear submarines that we received. It's also connected to the Holocaust, the fact that we got them from Germany. That's a present from Holocaust survivors! You know? That calms me.… Because I'm the one who has got it! Not the other side!

With fine self-knowledge and irony he added, "Here, I am, the strong one; with the pose of therapist, come here, I'll calm you down. I suppose, I'm calming myself!"

Some therapists felt no need for defensiveness about what they might have in common with their clients, either because of their own connection to the Holocaust or their age. Avram quite comfortably let go off any expectations to be the "all-knowing" therapist. He was in favor of therapists and clients exchanging coping skills. "I think that what is good for us, is also good for them.… Sometimes, our clients have pretty good solutions too…And then you get that sense of sharing, of good mutuality."

Anna discovered that her experience of living in a Jerusalem neighborhood that endured nightly shootings, and hence being "different" from other Jerusalemites, increased her understanding of survivors who say things like, "Someone who wasn't *there*, can't understand." Whereas she used to dislike such comments as a kind of competition as to who suffered most, she realized there is an inevitable continuum. "I am now comparing myself with those who have their windows towards the courtyard while mine face the street (i.e., more dangerous as bullets were aimed into homes). So I understand them better." Her experience may serve as a reminder that problems may well lie in a therapist's interpretation, rather than what a client actually says.

It is unlikely that anyone can confidently assume that he or she is fully aware of all possible countertransference blind spots. On the one hand, Anna, for example, easily tolerated anger, political views differing from her own, and an awareness of mutuality. On the other hand, she did not really allow herself awareness of the fact that she had noted that not all members of the social club were coping equally well. "We didn't check deeply, just sort of the majority opinion. I didn't check further with them."

Rotem felt confident of her ability to be aware of countertransferential obstacles most of the time as she has done a lot of work on herself. However, the *Matsav* triggered new responses in her too. "It is harder to maintain distance with the 'new' events. That's material that is still raw. I really was thrown into it, together with them. Like in the Gulf War." Confrontation with her own fear by seeing it reflected in others is most difficult for her. Rotem also felt a great sense of familiarity and connection with the second-generation group she facilitated. This was especially true in regard to the deep sense of not being safe, of not belonging, of having to be ready to flee:

> that central experience, that we can get kicked out of here…The Arabs know that this is where they live, but the Jews, I feel we have not resolved the trauma of wandering yet. Fifty years [of the existence of the State of Israel] doesn't seem to be enough. People still want an additional passport…I think that is the *Diaspora* part (i.e. the dispersal of the Jews among the gentiles), the Holocaust part that if something happens here, they'll go...This comes out very clearly in the group, also. It really stands out. And it is an experience that I very easily connect to.

These words by Rotem, a second generation therapist about her feelings evoked the second generation group she facilitated seem particularly striking in light of the findings of the other interviewed therapists regarding the seeming lack of difficulties of their second generation clients.

Summary and Discussion

The frank sharing of experiences by the interviewed therapists about their ongoing work with Holocaust survivor and second generation clients while painfully aware of the reality of our living at a time of violent conflict freed up further insight into *a priori* countertransference and the complexity of the conspiracy of silence or rather, silence out of fear. I wondered whether it may not be an instinctive response of self-preservation, particularly at times of danger and stress, to remove oneself from inevitable contamination as a potential listener to first and second hand accounts of the Holocaust and the resulting wounds and suffering. I need only recall Noam's relief at having been on holiday during a week full of particularly dreadful violence: "This (over)load, it is like being under radio-active radiation, and feeling that the radiation is too high. You have to get out of the factory and be somewhere clean for a bit…. Just some distance."

The *Matsav* sharpened existing countertransference difficulties (Chapters 1 and 3) in working with Holocaust survivors and the second generation. Therapists had to deal with the, at least temporary, collapse of the protective buffer of temporal distance from their clients' traumatic experience. They were also at risk of increased real-time anxiety as a result of their clients' experience-based perceptions, despite deflecting these by perceiving them as racist. Even the most experienced and dedicated psychotherapists, such as the ones participating in this study, may be caught by surprise and respond defensively.

The interviewed therapists had to find ways of dealing with the dramatic, violent changes in their own daily reality. They were all actively coping, including during, or even with the help of, the psychotherapy sessions. Therapeutic focus and the perception of how clients were faring seemed directly affected by the therapists' coping styles and personal history, such as being a child of survivors, being an immigrant or *Tsabre* (native Israelis) who 'built' the country. Place of residence somewhat affected issues and events focused on. Religiosity did not seem an important factor, except when related to political ideology.

Clients were, at least potentially, more at risk from expressions of *a priori* countertransference resulting from the inevitable self-preoccupation and self-protection on the part of therapists. It can, therefore, be stated categorically that at times of violent conflict and societal stress such as the *Matsav*, there is no "business as usual" in psychotherapy.

In the clinical examples of survivors, some therapists demonstrated the same trauma-related defense of splitting good and bad, right-wing and left-wing, balanced and racist, as their clients. The second-generation, amazingly, was seen as not affected by the *Matsav*, unless they were colleagues or clients in a group setting. This is strikingly parallel to the childhood experiences of many children of

survivors when their difficulties and hurts paled into insignificance in comparison to those of their parents, and frequently were not acknowledged or even communicated. The children would minimize their own distress or lean on peers (Chapter 6). As we were ending our interview, Rotem, a child of survivors, suddenly exclaimed: "In my own therapy, I don't talk about the *Matsav* either!…like I don't talk about the rain…it's just part of life!"

Client silence is not an unusual phenomenon. "For what feels 'unsafe' about therapy to the traumatized client is in large measure the potential triggering of the therapist's countertransference behaviors…the client fears disruption, either in communication or in closeness in the felt relationship" (Dalenberg, 2000, p. 27).

The therapists reported changes in their availability, in their ability to empathize, refrain from being judgmental and, apparently with their second generation clients, they employed a form of self-censorship. Lahad (2000) and Ayalon and Shacham (2000) warn that therapeutic boundaries may be at risk when therapists are too close to the traumatizing events their clients suffered. For most interviewed therapists, it may, paradoxically, be their need to maintain distance that limits their alertness and accessibility to clients (See boundary issues in Chapter 9). They may do this by maintaining a sense of 'not-me', such as perceiving angry and terrified survivors as racists. Since these are competent and caring professionals, I can only conclude that such demarcation can, in fact, be a natural consequence of sharing an ongoing, potentially dangerous and traumatizing reality with already traumatized clients.

Conditions of war and threat affect both the private and therapeutic realm. Therefore, to reiterate my central thesis in this context, awareness of *a priori* countertransference needs to be encouraged, and access to peer and supervision support provided. Such support may increase therapists' ability to perceive their clients' responses independent of their personal coping styles and find a balance between personal and professional needs that provides increased safety for both their clients and themselves.

A key to ensuring our clients respectful listening may lie in the freedom to make a genuine choice, at any given time, whether to work with this population at all, or how much. Overlooking the possibility of such a choice may give rise to problematic *a priori* countertransference. At times of violent conflict, both individual therapists and organizations and clinics must be acutely aware of the additional demands and their cost--and of course, as always, gain (Saakvitne, Pearlman, Abrahamson, et al., 1996)--to therapists, and their exposure to possibly draining and risky emotional experiences. In my view, it would be professionally irresponsible for therapists not to continually monitor themselves closely in order to be able to recognize whether they have reached their own limits. They might need to reduce the number of client hours, receive additional support or simply

(temporarily) stop altogether. Such limits, whether temporary or not, must be respectfully accepted by their colleagues as part of our professional ethics.

Traumatized clients have the right to the most attentive and respectful listening, and to minimal interference from the therapist' unacknowledged personal and societal issues. Therefore, I recommend normalizing potential difficulties in *a priori* and in-session countertransference instead of stigmatizing therapists who may suffer temporary deafness due to too high a volume of demand on their professional, and under circumstances of (threat of) war, personal resources.

Should psychotherapy perhaps be suspended during times of acute danger and stress? That would be too drastic a measure as the withdrawal of possibly vital support of clients could be damaging. How then can therapists be helped to bridge defensive distances, gain greater awareness of their *a priori* countertransference and enable their clients to express themselves as they need at any given time, without weakening their own coping strategies, or increasing their risk of retraumatization or vicarious traumatization (Figley, 1995)?

At times of societal upheaval as a result of violence and war, it may be helpful to focus attention on three levels. The first one is the development of additional ways for therapists to expand areas of self-awareness and their *a priori* countertransference. Next is the creation of ways of communication with colleagues at their place of work about countertransference complications resulting from societal conditions of stress and war as a natural phenomenon rather than a personal shortcoming, and the provision of the necessary supports. Some of the therapists' responses to the interview process and its impact suggest that nonjudgmental peer and supervisory support is of significant help in safeguarding both the therapists' and clients' needs. Anna, for example, considered modifying her way of working. "If I enjoyed talking about this so much, perhaps it is good for them [clients] too, to talk about it more." Itai jokingly offered to write a check after the interview. "I need this and I really enjoyed it." And Tova called a few days after the interview to let me know how delighted she was to discover that she was listening differently and hearing more. A third level, that was touched upon in the interviews only by Avram, is the development of tools of communication with clients in the sessions, about momentary, or temporary, preoccupation with ones own survival issues.

Wars, unfortunately, are raging all over the world. As therapists often valiantly try to serve their clients at such times as well, it may be worthwhile to further explore the relevant aspects of *a priori* and *in-session* countertransference on a wider scale and in different settings. *A priori* and *in-session* countertransference may be expressed differently by individual therapists of different backgrounds, ages, and philosophies. Special caution and extra attention is of the essence at times of violent conflict, which affects real-time boundaries between clients and therapists. Like

other previously traumatized people, Holocaust survivors and children of survivors might experience retraumatization in addition to possible new trauma at such times. Specific conditions must, therefore, be created to enable therapists to have maximum awareness of the different forms of countertransference, so they will remain optimally available to their clients. These, then, will stand a better chance of really being heard regardless of their style of expression, without negatively impacting the sense of safety of their therapists or themselves.

CHAPTER 5

Trauma and Traumatized Populations in Israel

Perhaps one of the most fascinating phenomena in the international development of the mental health field--psychiatry, psychology, social work--is the cyclical appearance and disappearance of the acknowledgement of traumatization and its impact in both professional literature and clinical practice (Herman, 1992; Shepherd, 2000; Van der Kolk, Weiseath, & Van der Hart, 1996; Weisaeth, 2002). Perception and understanding of psychological suffering seem to be, if not determined, at least facilitated, by the socio-historical constellation of a given time. Historically, trauma awareness has often awakened at times of war (Shepherd, 2000; Van der Kolk, Weisaeth, & Van der Hart, 1996; Young, 1995). The subsequent 'forgetting' of this knowledge may be attributed to a social unwillingness to face up to the consequences of wars. The retention and expansion of knowledge over the past thirty years or so in the US, and then in other countries, has been attributed to the impact of the Vietnam War, and to the introduction of the diagnostic category *posttraumatic stress-disorder* (PTSD) in 1980, in the DSM-III (American Psychiatric Association, 1980; Figley, 2002; Van der Kolk et al., Witztum & Kotler, 2000).

Most of the professional literature and knowledge regarding the psychological impact of traumatic events is based on research and clinical experience in Western Europe and the United States. Rather than assume a direct transposition of professional knowledge, attitudes and interests into the Israeli mental health community, I thought it pertinent to investigate how the turbulent and often traumatizating socio-political developments in Israel might impact attitudes toward, and preoccupation with trauma. Optimal clarity as to societal processes with regard to acknowledgement of trauma might uncover meaningful societal sources of *a priori* countertransference.

I hoped to be able to trace and outline societal sources for *a priori* countertransference in the personal and family histories of the interviewed therapists and the impact of societal and professional attitudes to trauma through their perspectives (Chapters 6, 10 and 11). But it seemed worthwhile to have an external frame of reference as well. A survey of a professional journal provided an effective way to trace possible links between the mental health profession's acknowledgement of, and preoccupation with traumatized clients and socio-political developments in Israeli society. I elected to do a content analysis of The Israel Journal of Psychiatry and Related Sciences (IJP), established in 1963 as The Israel Annals of Psychiatry and Related Disciplines. This journal is geared towards all mental health professionals rather than towards a specific sub-group and does not elicit articles except for special issue initiatives; it judges submissions on quality of research and presentation only (David Greenberg, Editor IJP, personal communication, January 17, 2000) and therefore provides an interesting societal mirror. Furthermore, the IJP is published in English so as to facilitate international dialogue (Winnik, 1963, p. 2). In order to easily distinguish between Israeli and

other authors cited in this chapter, the names of those residing abroad are followed by [r.a.].

It must be pointed out that Israeli mental health professionals who do not easily read or write in English might not choose to turn to this journal. And, of course, many Israelis also publish elsewhere. The IJP has a relatively small circulation of around one thousand. Still, this journal has appeared every three months since Israel's fifteenth year of existence, and can, therefore, provide an invaluable perspective within the given limitations.

After perusal of the tables of content from 1963 till 2002, I selected and read all articles whose titles suggested an acknowledgement of trauma or traumatic events or of the socio-historical background of Israel. I did not limit myself to articles about Holocaust survivors and victims of sexual abuse so as to get a wider sense of possible connections between socio-political events and attitudes towards traumatized clients. And, of course, Holocaust survivors, their children and victims of sexual abuse may well also have experienced traumatic events as soldiers and civilians, as illustrated, for instance, by the biographies of some of the interviewed therapists (Chapter 6).

In order to facilitate clarity regarding rapidly changing current events in Israel and its historical development, the reader needs to be aware that there have, unfortunately, either been war or periods of shellings of civilians from neighboring countries and intense terrorist activity every few years Table 1):

Table 1. Wars and other major societal traumas in Israel's (pre-state) history

1939-1945	The Holocaust -the attempt by Germany and its collaborators to annihilate the Jewish people during WWII
1948-1949	The War of Independence
1956	The Sinai Campaign
1967	The Six Day War
1968-1970	The War of Attrition
1973	The Yom Kippur War
1982	The Lebanon War [Israeli troops withdrawal in 2000]
1987	The Intifada on the West Bank and Gaza
1991	The Gulf War
1995	The murder of Prime Minister Rabin
2000-	Start Intifadat El Aqsa, referred to in Israel as The 'Situation'

I have divided the relevant articles over five time periods (Table 2) that reflect distinct shifts in national mood and preoccupation and are delineated by wars.

Table 2. Division of the 39 years of IJP analyzed (1963-2002) into five distinct periods

I	Pre-independence, in 1948, till the Six Day War in 1967
II	The Six Day War, 1967, till the Yom Kippur War, 1973
III	The Yom Kippur War, 1973, till the Lebanon War, 1982
IV	The Lebanon War, 1982, till the Gulf War, 1991
V	The last decade of the millennium through to Israel's fifty-third year

The first period ranges from pre-independence, in 1948, till the Six Day War in 1967. Israel's victory of that war warded off a threat to its very survival but created major practical and moral dilemmas resulting from the continued occupation of the territories conquered during that war. The second period covers the time between the Six Day War and the Yom Kippur War in 1973. Israel had not anticipated the outbreak of the 1973 war and only managed to win it at great cost of the lives of its soldiers. The third period ran till the start of what would become the first Lebanon War in 1982, that had been intended as a short defensive raid and turned into a lengthy war for which there was no consensus, and thus presented a social turning point. The fourth period continued till the Gulf War in 1991, the first war during which Israel did not defend itself, and the fifth period lasted from the last decade of the millennium through to Israel's fifty-third year of its existence.

I have analyzed the articles within 5 content categories preceded by an introductory section to provide a background of major developments and events in each section: The section Israel's history, society and culture focuses on articles that engaged in a form of story telling and provided a historical perspective which seems to paralel major aspects of therapeutic work on traumatic experiences. The second and third section, combined in this chapter, deal with war trauma as it affected soldiers and civilians. The last two sections focus on the way the impact of the Holocaust and of sexual abuse has been dealt with in the IJP (For more detailed descriptions of the articles used for this survey, please see the original article (Tauber, Brom, Brinkgreve, van der Hart, 2004).

The First Period: Pre-independence, in 1948, till the Six Day War in 1967

Main Socio-Historical Events and Developments

There had always been a small Jewish population in Israel but from the late 19th century onwards, barely conceivable events and changes took place. Waves of Jewish refugees, fleeing the pogroms of Eastern Europe, as well as more ideologically motivated immigrants made their way to Palestine in significant numbers. Palestine was conquered by the British in 1917, during World War I, and subsequently removed from the Ottoman Empire and placed under British mandate by the League of Nations. The Balfour declaration, in 1917, favored the establishment of a Jewish entity, but the British tried to control the influx of Jews. The Jews organized a volunteer defence organization (*Hagana*), in response to serious attacks on them by the local Arab population. By 1941, the *Palmach* (Jewish assault companies) was created and fought along the British in WWII (Bloom, 1993). The *Palmach* formed the basis of what became The Israel Defense Forces (IDF). Women had fought actively as combat soldiers, commanders, saboteurs, etc. (Bloom, 1993), but Ben Gurion, Israel's first Prime Minister, compromised with the religious factions and limited the role of women in the IDF. The resulting inequality is preserved till today-- as is the policy of compromise with the religious political factions.

In the 1920's the Hebrew University was established on Mount Scopus, in Jerusalem, a philharmonic orchestra was formed which was to become the Israel Philharmonic, and in the sand dunes near the harbor of Yaffo, pioneers began building Tel-Aviv. The changes, the hardships, the challenges, the ongoing waves of immigration (continuing to the present day) accompanied by the inevitable cultural shocks, tensions and bursts of creativity are too dizzyingly radical and numerous to even attempt to catalogue here.

On November 29th, 1947, the United Nations voted in favor of two states in Palestine--one of them, the Jewish State. The Arab nations rejected this resolution, and attacks on the civilian population became more frequent, culminating into an invasion by armies of all the surrounding Arab States and Iraq. Eventually, the State of Israel was established on May 14th, 1948, and a cease-fire was achieved on March 10th, 1949. Severe terrorist attacks by Egyptian infiltrators were the reason for the Sinai Campaign in 1956. The closing of the Straights of Tiran and the threats of annihilation by Egypt's president's Nasser, and his alliance with Syria, Iraq and Jordan, formed the trigger for the Six Day War.

Articles referring to Israel's History, Society, Culture

Important insights into Israel's foundations are provided by Palgi's (1963) presentation of historical, cultural information. This article outlines the basis for future socio-economic tensions, lack of recognition of trauma histories, triggers, and new traumatizations. Pioneers in Palestine who had fled anti-Semitism in the early 1900's felt that "the only way Jews, as a people, could return to 'normalcy' and health was through adopting their exalted ideals …" (Palgi, 1963, p. 33). Among those fleeing the rise of Nazism were psychiatrists and psychoanalysts. Palgi pointed out that till the nineteen thirties or forties there were only a few psychiatrists or analysts in the country. People were expected to be tough and eccentrics were well tolerated as long they "accepted the goals of the group" (Palgi, 1963, p. 46). This expectation helps to understand attitudes to later waves of traumatized immigrants, such as Holocaust survivors. The Jewish State, itself, was, Palgi felt even in 1963, considered to have "therapeutic powers" (Palgi, p. 47). The Law of Return, offering every Jew the right of permanent settlement in Israel, was passed in 1950.

It was never possible to plan for waves of immigration as people simply came when they had to. Seventy percent of all Jewish immigrants between the years 1948-1959 came in the first three and a half years of statehood (Palgi, p. 48) and a number of communities, such as the Iraqi, Syrian, Yemenite, Bulgarian, Libyan, and later Cochinian Jews, were evacuated to Israel almost in their entirety. "Thus knowingly, Israel accepted not only the young, skilled and able-bodied, but also the physically ill and the maladjusted such as the delinquent, the mentally retarded, and the psychotic" (Palgi, 1963, p. 49).

Cultural differences were ignored as the ideology of the young State was to focus on unity and common identity of Jews. So no special privileges were awarded, not even to concentration camp survivors. This worked well while there was extreme austerity in the country, but Palgi pointed out that when the flow immigration slowed a little, tensions surfaced.

The first Department of Psychology was established in 1957 at the Hebrew University of Jerusalem, nine years after the establishment of the State of Israel, (Shanan & Weiss, 1963). At the time their article was written, there were close to sixty clinical psychologists in the country. Gumbel (1965) noted that The Palestine Psychoanalytic Society, the 11th Psychoanalytic Institute in the world, was founded in 1934.

The rich cultural diversity of the immigrant groups found some acknowledgement by Hes (1964), who focused on Yemenite and Moroccan immigrations. Most Yeminite immigrants arrived in 1948 in operation Magic Carpet, though immigration from Yemen had started in 1880. Whereas the Yemenites were religiously motivated immigrants, Hes pointed out that for the

Moroccans, Israel offered a socio-political solution. After colonialization by the French in 1912, Morocco's Jews were not given French passports and, discriminated against in the work place, remained without social status. According to Hes, this background fueled their anger at their being housed in development towns and settlements in Israel, whereas later immigrants, such as the Poles and Romanians were given housing in urban areas. Some of this anger was still very much alive in one the interviewed therapists in the second study (Chapters 6-11) as passed on to her by her family.

The large amount of storytelling in the previously mentioned articles is a remarkable phenomenon in the first four years of the IJP's existence. There seemed to be a need to focus on 'who we are,' 'where we are,' and perhaps, 'why we are.' Not only was the country young, but it was constantly changing: size and country of origin of its population, economic conditions, level of acute, personal, existential danger and threat to the survival of the State as a whole. The search for orientation and safety is quite apparent.

War Trauma – Soldiers and Civilians

During this time, there were no articles dealing with war trauma and only one on the possible trauma of forced migration as was the case of many Jewish refugees (Maller, 1966).

The Holocaust

Unlike other trauma, the Holocaust was given attention from the very first issue; perhaps because the editor, Winnik, was himself a Holocaust survivor. Israeli society had only just, after the trial of Eichmann (who had been responsible for the smooth execution of the deportation of millions of Jews to extermination camps) in 1961, begun to gradually confront the horrors of the Holocaust and its attitudes to the survivors (Segev, 1994). This was still restricted to concentration camp survivors (Eitinger [r.a.], 1963) and psychiatric patients (Nathan, Eitinger, & Winnik, 1964). Eliasberg [r.a.] (1964) and Tuteur [r.a.] (1966) addressed the often traumatic impact of the evaluation processes which were a precondition for the submission of reparation claims from Germany. Eliasberg (1964) was outraged by German rejections of claims because they considered the suffering of Holocaust survivors the result of intrapsychic causes.

Women and Trauma - Rape, Domestic Violence, Incest

No articles were published, perhaps as the feminist movement had not yet raised sufficient awareness.

The Second Period: The Six Day War, 1967, till the Yom Kippur War, 1973

Main Socio-Historical Events and Developments

Quite revolutionary changes took place in Israeli society in this short period. The victory of the Six Day War with the subsequent sudden expansion of--historically significant--territory and previously Jordanian and Egyptian local populations now under Israel's control caused a sense of euphoria. A large 'Anglo-Saxon' immigration from North America and Europe and an influx of immigrants who fled repressive regimes in Central and South America further contributed to major social change.

But there was no real respite. The War of Attrition was being fought along the Suez Canal between 1968-1970. Heated discussions whether or not to return the territories occupied during the Six Day War created deep divisions in Israel. The practical, political and psychological implications of Israel's unexpected role of occupier were not really dealt with. An initially small movement of messianic, mostly religious Jews, *Gush Emunim*, began to exert pressure to build settlements on the West Bank, and in the Gaza strip. They referred to the Administered, or Occupied Territories by their biblical names, Judea and Samaria: parts of the historical Land of Israel. The atmosphere of exuberance and invincibility came to an abrupt end with the outbreak of the Yom Kippur War.

Articles referring to Israel's History, Society, Culture

None. The joy and relief of having survived the very real pre-Six Day War threat so victoriously may have dulled the need for introspection and reflection on both historical and possibly future social development.

War Trauma – Soldiers and Civilians

Nothing was published on war trauma, but a few authors, (Bruell, 1969; Ginath and Krasilowsky, 1970; Wangh [r.a.], 1968; Winnik, 1969) addressed different aspects of civilian trauma.

The Holocaust

The focus widened a little beyond hospitalized concentration camp survivors. The Israeli Psychoanalytic Society finally began discussions about the Holocaust survivors only in 1966, five years after the Eichmann trial, and twenty one years after the end of WWII (Winnik, 1967). Considering the dominance of psychoanalytic psychotherapy in Israel, this was an important development.

Child survivors received some attention (Bruel, 1968; Winnik, 1967). Winnik (1967) noted the silence of child survivors about their Holocaust

experiences but did not relate this to social attitudes. Klein (1972) explored the political views of Holocaust survivors who lived on kibbutz between 1967 and 1969. He noted that the survivors made unconscious associations between Arabs and Germans, but found "neither extreme pacifism nor extreme aggression" (Klein, 1972, p. 88).

Women and Trauma - Rape, Domestic Violence, Incest

The advent of feminism was reflected in an article warning of its dangers to the family (Levine, 1972). Magal and Winnik, 1968 studied an incestuous family but did not emphasize the damage to the assaulted child.

The Third Period:
The Yom Kippur War, 1973, till the Lebanon War, 1982

Main Socio-Historical Events and Developments

The unexpected outbreak of the Yom Kippur War, the initial uncertainty as to its outcome, the massive loss of lives, and the huge numbers of injured soldiers traumatized Israeli society as a whole, as well as those individuals and families who personally suffered injury or loss. The shock and upheaval also had political consequences in the form of new parties and the election, in 1977, of Israel's first right-wing Prime Minister, Menachem Begin. Religious and ethnically--Sephardi, mainly Moroccan--based political parties grew in influence and mostly shifted to the right. The settlers (in the administered territories) gained power and the dovish Peace Now movement was established.

The influence of feminism slowly made itself felt: despite much misunderstanding, denial and ridicule, battered women shelters, rape crisis centers and the women's network were gradually established from the late seventies on (Karen Shachar, Chapter 11; Swirski, 1993).

Articles referring to Israel's History, Society, Culture

There was a return to historical perspective in articles regarding community mental health in Israel (Miller, 1977), the decades of stress the country had already endured (Milgram, 1978), and massive bereavement throughout Israel's short existence (Palgi, 1973). This seems to parallel the need for mending a ruptured narrative in trauma work, and acknowledgement of a changed reality. As Milgram (1978) wrote, "In the Yom Kippur War, Israelis not only suffered massive casualties but:

> they realized what had not been evident in the afterglow of the Six Day War, that they might have to live under the shadow of war and attack for an indefinite period.…Zionism had not solved the problem of the physical survival of the Jewish people. (p. 330)

This sentiment is echoed in the experiences and perceptions of some of the interviewed therapists and their clients (Chapter 4).

Another author, Edelstein (1979) took issue with the Israeli psychiatric community for failing to "come to grips with social realities in this country and to appreciate the full extent of the differences of identity and values among its various component groups" (p. 185). This question of social engagement is also one that has preoccupied the interviewed therapists as can be seen Chapters 6-11.

War Trauma – Soldiers and Civilians

In this period, six articles related to different aspects of war trauma, were published, all written by Israelis (Ben-Yakar, Dasberg, & Plotkin, 1978; Dasberg, 1976; Moses, 1977; Solnit & Priel, 1975; Soliman, 1979; Weisman, 1974). And whereas abroad, trauma was beginning to arouse a lot of interest and for the first time, sequelae of trauma in the form of PTSD were described in the DSM-III (American Psychiatric Association, 1980), only one article dealt with civilian trauma (Levy and Guttman, 1976).

The Holocaust

Eitinger [r.a.] (1973), Eitinger [r.a.] & Stroem [r.a.](1981) and Robinson (1979) continued to study hospitalized Holocaust survivors. But in this period other survivors and their children also received attention (De Graaf, 1975; Eitinger [r.a.] 1975; Musaph, [r.a.] 1981; Robinson & Winnik, 1981). Musaph (1981) pointed out how at every-day events, films, the news, or even buildings could become triggers and set off traumatic memories in non-hospitalized survivors.

Two authors turned their attention to countertransference issues (Lipkowitz [r.a.], 1973; Musaph, 1981) regarding both survivors and second generation clients. Roden [r.a.], (1982), himself a concentration-camp survivor, wrote about suicides among survivor clients, friends and colleagues. He made a connection between rehabilitation and suicide, thereby highlighting possible risks inherent in psychotherapy.

Women and Trauma - Rape, Domestic Violence, Incest

None. The IJP did not reflect the growing social awareness of domestic violence and rape raised by (newly) Israeli feminists (Swirski, 1993).

The Fourth Period:
The Lebanon War, 1982, till the Gulf War, 1991

Main Socio-Historical Events and Developments

This, again, was a period of great changes. The Lebanon War was the first in Israel's history that, originally intended as a short incursion to stop the shelling on Northern Israel, was not seen as a clearly defensive war, and therefore was not solidly within the national consensus. A small, but unprecedented movement came into being, *Yesh Gvul* [There's a border/a limit]. It encouraged soldiers to refuse army (reserve) service, initially in Lebanon and later in the Occupied Territories, and do prison time instead. This expressed a drastic change of accepted values, of a sense of social unity; a transition from loyalty to the group and its values, to loyalty to self and personal values. Another phenomenon was the organization of women for peace, called Women in Black. Every Friday afternoon, women, dressed in black, would gather for an hour at strategic places throughout the country, to demand the end of the war in Lebanon.

Economically, life became untenable. In the mid-eighties, inflation was so out of control that prices rose daily. The recently changed national currency--from '*lirot*' to '*shekels*'--was changed again to 'new *shekels*,' just to keep pace. Stabilizing societal points of reference in Israel, taken much for granted in 'older' nations, were either truly ancient, such as archeological ruins and the sacred texts or, like the urban and natural landscapes and even the currency, continually being invented, newly established or changed.

The Intifada, the uprising by the Palestinian residents of the "Territories," which started in December 1987, brought about further tears in the social fabric. There was much discussion about how soldiers ought to respond to the humiliations and physical threats they were exposed to by Palestinian youngsters in particular. Steep divisions appeared between those who worried about possible psychological scarring of soldiers forced to fight a civilian population--something that had always been taboo--and those who feared discussing the issue would be detrimental to morale. Settlers, supported by roughly half the population, demanded the building of more settlements and stepped-up personal protection, whereas the other half of the population became increasingly willing to make, possibly risky, territorial sacrifices in order to achieve a permanent resolution of the state of war.

Articles referring to Israel's History, Society, Culture

During the volatile period of the ongoing Lebanon War and the Intifada, there seemed to be a preoccupation with identity and difficult times. An overseas contribution (Rosenman, 1984) presented Freud's development of psychoanalysis

as an outflow of generations traumatized by anti-Semitism. Goshen-Gottstein (1984; 1987) highlighted the culture of the ultra-orthodox Jews. This population was growing due to high birth rates and immigration and gaining increasing political influence. This could have major consequences as the Zionist State and its humanistic values were anathema to their desire to implement religious laws.

Medini (1988) explored the identity of clinical psychology and considered social context a major factor in professional identity, but made no mention of Israel's wars or other trauma. This might be quite a representative aproach as the therapists I interviewed about fifteen years later, were very aware of societal developments and seemed to have difficulties acknowledging their own traumatic experiences. Rosenberg (1988) also focused on the tensions and stresses inherent in Israeli society. Meanwhile new immigrants continued to arrive and Levav, Kohn, Flaherty, Lerner, and Aisenberg (1990) focused on the Russian immigrants.

War Trauma – Soldiers and Civilians

During this period, there were again, a significant number of Israeli authors (Bleich, Chen, Katz, Levy, & Garb, 1986; Levy & Neuman, 1984; Solomon, 1989; Solomon & Flum, 1986; Solomon, Noy, & Bar-On, 1986; Solomon, Oppenheimer, Elizur & Waysman, 1990; Student, Levy, & Treist, 1988) who focused on different aspects of the risks, experience and treatment of traumatized soldiers. Awareness of traumatized soldiers, and the need to find the best treatment seemed to have grown in the wake of the recent Yom Kippur War, and under the influence of professional developments abroad and the formal recognition of PTSD in the DSM-III (American Psychiatric Association, 1980).

Difficulties of therapists working in the military (Bleich et al., 1986; Student et al., 1988) received recognition, both in terms of loyalty--to the client or the military--and in terms of personal history and traumatization. However, no author mentioned that therapists' conflicts of loyalty might be compounded by the fact that they themselves might still serve reserve duty, be parents of (soon-to-be-drafted) soldiers or have parents who were either killed or injured in battle.

Only one article dealt with civilian trauma. Dreman (1989) studied offspring of terrorist victims throughout Israel's history and found that none of these children lived ordinary, well-functioning lives. During this period, (the threat of) emotional and physical injury to the civilian population, as a result of the Intifada, seemed to be translated into the political rather than the therapeutic arena. The streets were filled with demonstrators demanding peace and/or action against the lack of safety and security. The emotional tone was one of rage and outrage.

The Holocaust

In the period between the Lebanon and the Gulf War, the IJP articles dealing with Holocaust survivors reflected a willingness at long last, to look at survivors' specific Holocaust-related difficulties in daily life. Group bonds, which had been life-saving during the Holocaust, were found to still offer support (Davidson, 1985). Survivors were dealing with their aging (Hertz, 1990) and Roden ([r.a.] 1985) studied possible sexual difficulties. The question how child survivors live with their memories was explored by Moskovitz [r.a.] and Krell [r.a.] (1990). In addition, Dasberg (1987b) drew attention to the children of survivors as a population at risk, noting their difficulties coping with trauma. And Musaph (1990) discussed countertransference and the therapist's use of self in therapy with survivors.

Women and Trauma - Rape, Domestic Violence, Incest

None. As reflected in the IJP, therapeutic issues of traumatized women and children were not yet of interest to the general mental health public. Or perhaps, under conditions of ongoing struggle for survival, the traditional call 'women and children first' was replaced by 'women and children' last.

The Fifth Period:
The Last Decade of the Millennium, 1991, to the Year 2002.

Main Socio-Historical Events and Developments

The Gulf War (1991) proved to be yet another catalyst for the whirlwind of changes. For the first time in its history, Israel did not defend itself; sirens warning that Scud missiles from Iraq were about to fall signaled Israelis to don gas masks and rush to improvised, nylon-sheeted rooms for protection. This was the time when the status of mental health professionals became much more prominent. Although instructions from the government and civil defence units were quite explicit and the Army spokesman was nicknamed “the valium of the nation,” the media invited mental health professionals to reassure the population that their anxiety was normal, that anyone could feel scared and helpless, and that it was good to talk about their feelings.

There were additional social changes, such as a massive influx of immigrants from the former Soviet Union, which caused a mutual experience of culture shock and enrichment, especially in the arts, music and politics. This was also a time when meeting with representatives of the PLO (Palestine Liberation Organization) stopped being the (illegal) domain of left-wing idealists. The Oslo agreements were made official in September, 1993. However, conflicts between the

settlers and their supporters on the one hand, and the Peace-Now adherents on the other, about the shape Israeli society ought to take became ever more extreme, and culminated in the assassination of Prime Minister Yitzhak Rabin on November 4, 1995. Even so, just before the end of the century, peace negotiations with Syria seemed realistic, and the one-sided withdrawal by Israel from Lebanon was actively debated and subsequently carried out in 2000. Peace with the Palestinians also seemed within reach, despite still unresolved difficulties. All hope for a transition to a normal life was shattered, however, with an outbreak of violence on the Jewish New Year, 2000 that escalated into years of a bitter cycle of terrorist attacks and Israeli retaliatory actions.

Socially, the gap between the wealthy and the poor never seemed so shockingly divisive. The secular and religious populations grew even further apart, while a new, Sephardi ultra-orthodox party gained influence. Feminism remained a somewhat alien concept (Lieblich, 1993), but the press regularly covered incidents of domestic violence, sexual assault and incest. The role of the judiciary became controversial, as the High Court was seen by some, especially the extreme religious factions, as the epitome of godlessness, a force to be attacked and curbed. Others regarded the Court as an enclave of enlightened humanism, the last resort to force legislators to respect all human rights.

Articles referring to Israel's History, Society, Culture

The articles dealt with a mixture of topics during this period. Moses (1992) gave a historical overview of the development of psychoanalysis in Israel. Freud had wanted a Chair of Psychoanalysis to be established in Palestine in 1932. Although this did not happen, psychoanalysis became very influential in Israel. Still, both Moses (1992) and Dasberg (personal communication, August 29, 1999) discovered that psychoanalysis was of limited use with traumatized clients.

One of the more dramatic rescue immigrations, that of Ethiopian Jews, received attention from Durst, Minuchin-Itzigsohn and Jabotinsky-Rubin (1993). They called for therapists to be aware of Ethiopian clients' cultural backgrounds but did not emphasize the often traumatic events they endured prior to their arrival in Israel. Bilu and Witztum (1994) drew attention to ultra-orthodox clients and also called for cultural sensitivity. They compared long-term psychotherapy to a socialization process "in which the patient gradually familiarizes himself with the therapist's explanatory model and learns to articulate his or her experience through idioms derived from it" (p. 174), reminiscent of de Swaan's (1979) concept of protoprofessionalism.

Although not mentioned in this article, this understanding has important implications for trauma therapy, such as socialization of the client to the therapist's views as to what is traumatic, or how much attention to give the traumatic event.

Representing the ultra-orthodox perspective, Buchbinder (1994) stated that "it should be noted that for a religiously formed individual, a healthy personality is not an end in itself but rather a means to fully functioning religiosity" (p. 184).

For the first time, an article appeared in the IJP about mental health services in the Palestinian Authority (Murad, 1999). Murad, who lives and works on the West Bank, traced socio-political history and the impact of Jordanian, Israeli and Palestinian rule on the growth of psychiatry. Although he acknowledged societal difficulties, due also to the Israeli occupation, he did not mention the word trauma.

War Trauma – Soldiers and Civilians

The awareness of vulnerability arising from the Yom Kippur War, the Lebanon War so soon afterwards, and, half a decade later, the shock and challenges brought about by the (first) Intifada, may have evoked the need for a sense of a historical continuum as to the acknowledgement and care of traumatized soldiers. Two historical reviews were published during this period (Bleich, 1992; Levy, Witztum, and Solomon, 1996; Witztum, Levy, and Solomon, 1996). Witztum et al. (1996) pointed out the rather striking fact that very few therapists wrote about their work. They speculated that this reflects social attitudes at the time.

The civilian uprising in the Occupied Territories, the Intifada, which started in 1987 "led to differing opinions about the proper role of military mental health professionals" (Levy et al., 1996, p. 98). Arguments were rife whether or not soldiers were harmed and their sensitivity blunted. Denial of the impact of psychic trauma is not uniquely Israeli. They pointed out that despite the "well publicized professional literature on the subject dating back to 1919, armies have often failed to foresee these casualties, have not been prepared to treat them…"(Levy et al., 1996, p. 100). Both Shalev (1996) and Marmar [r.a.] (1996) published laudatory comments on these articles.

While there was no combat in Israel during the Gulf War, two articles (Kaplan, Kron, Lichtenberg, Solomon & Bleich, 1992; Solomon, 1993) were published reporting its negative impact on Israeli soldiers.

In a fascinating study, Solomon and Israeli (1996) polled *Knesset* (Parliament) members about their attitudes toward CSR (Combat Stress Reaction). While most of those they questioned understood that CSR resulted from external causes, right-wing parliamentarians "considered internal causes more relevant than those on the left" (Solomon & Israeli, 1996, p. 110). In this way, Solomon and Israeli beautifully illustrated the interplay between adopted ideology, political approach and the interpretation of events, facts and suffering. Those who had actually encountered CSR casualties were less influenced by their political views, and more likely to attribute CSR to external causes.

For the first time, an article appeared on the topic of Israeli soldiers being held as prisoners of war by former prisoner of war, Neria (2001). This may reflect a further aspect of a a broadening of subjects that can be explored and discussed. He described captivity as "an ongoing traumatic experience" (p. 219).

During this period, there was a significant increase of articles addressing civilian traumatization.The impact of the Gulf War on civilians, the intended victims, was explored in two articles (Ben-Yakar, Kretsch, & Baruch, 1994; Reznik & Sirota, 1999). Shalev wrote three articles (1993; 1994; 1996) exploring different interventions and planning for future traumatic events and mass casualties. Rabin's murder, generally considered a national trauma, warranted only one, very short, article (Melamed, Szor, Solomon, & Elitzur, 1998).

The Holocaust

The wealth and variety of all the Holocaust-related articles in this period attest to how accepted professional preoccupation with survivors and their offspring had become by this time. Dasberg (1991) testified about what Israel had meant to Holocaust survivors. Moses and Moses (1997) described how the Holocaust continued to affect Israeli society politically and socially.

Several authors explored aspects of therapeutic work with Holocaust survivors: group therapy (Lansen and Cels [r.a.],1992); awareness of the Holocaust pasts of hospitalized survivors (Bachar, Dasberg, & Ben-Shakhar, 1995); a new way to conceptualize the personality organization of child survivors, "compound personality" (Tauber, 1996); diagnostics of survivors (Kellerman,1999); countertransference difficulties (Neuman,1998), and a case study of an Auschwitz survivor (Durst, Teitelbaum, & Aronzon, 1999). The question of possible transmission of trauma to a third generation was raised and discussed (Bachar, Cale, Eisenberg & Dasberg, 1994). Kaslow [r.a.] (1997) went outside the therapeutic setting and reported on dialogues between descendants of Holocaust survivors and of Nazi perpetrators.

In 2001, a special issue was published in honor of Prof. Haim Dasberg, focusing on child survivors and the Second Generation (Brom, Kfir, and Dasberg; Cohen, Brom & Dasberg; Dasberg; Dasberg, Bartura & Amit; Kellerman; Kellerman).

Women and Trauma - Rape, Domestic Violence, Incest

There were a few articles, this time, dealing with different issues. Hoffman (2001) presented a major dilemma of orthodox clients, whether to talk about their parents having abused them and disobey the commandment to honor their parents. Hoffman received a rabbinical opinion that parents had to be worthy of being honored and clients ought to freely discuss their maltreatment with their therapists.

The topic of domestic violence was broached by Keren and Tyano (2000) without clearly presenting the abusing father and husband as a batterer. Silverman, [r.a.] Johnson [r.a.] and Prigerson [r.a.] (2001) demonstrated that childhood traumatization can complicate mourning in later life. However, there were still no articles dealing explicitly with rape, incest and other sexual assault of women and children, and the devastating impact of such violence

Summary and Discussion

The IJP has been in active dialogue with professionals abroad but, while reflecting general trends in awareness of trauma, it has remained a truly Israeli journal. This is most apparent in the wealth of socio-historical articles, which seemed to serve more than a purely informative function. In the period pre-1967, these articles may have reflected a need to both build and reinforce Israeli identity, much like Murad's (1999) article might have set out to do for Palestinians. In the following years, prior to the Yom Kippur War, such articles were conspicuously absent. The relief of having been so victorious in the face of extreme danger prior to the Six Day War appeared to suspend introspection and awareness of trauma. This changed drastically after the Yom Kippur War when the main function of these articles seemed to serve the function of creating a narrative continuity in order to counteract and heal traumatic rupture. A need to reaffirm identity in the form of societal exploration was expressed again after the controversial Lebanon War in 1982. From the period after the Gulf War, preoccupation with trauma, both current and in the past has been intense.

Societal Sources of A priori Countertransference

The fluctuation of interest and preoccupation with (aspects) of trauma as represented in the first 39 years of the IJP seem to point less to a reflection of scientific progress than to societal influences. These influences may in turn provide sources of *a priori* countertransference. Without adequate self-monitoring and raising of awareness, clinical researchers and authors may unconsciously reflect prevailing societal attitudes, values and pressures as demonstrated in the IJP articles and thus run the risk of not being fully attuned to their traumatized clients.

Such fluctuations in focus on trauma may, however, also have a protective function; a process of self-monitoring, of uncovering of underlying attitudes, beliefs and emotions may (be perceived to) threaten whatever stability the country has. It may have been particularly difficult, under conditions of constant threat or violent conflict, to be both fully aware of the risks and consequences of traumatization and build a new society meant to provide a *'bayit leumi'* [a national

home], a refuge from anti-Semitism and persecution. These questions are among the challenges -- and possible sources of *a priori* countertransference -- explored by the interviewed therapists and presented in the following chapters.

Acknowledgement of Sexual and Domestic Traumatization

Political agitation fueled by the feminist movement in the sixties and seventies, and intensive scholarship (e.g. Herman. 1992; Freyd, 1996; Terr, 1994) helped to raise consciousness of interpersonal traumatization of women and children in the United States and Europe. Judging by the absence of articles in the IJP about sexual and domestic violence against women, women in Israel have not, so far, become a sufficiently strong interest group.

Additional factors might have contributed to the neglect of this form of traumatization as expressed in the IJP. Hebrew is a gendered language. The presence of even one man in a group of any number of women necessitates the use of the male plural. Any non-specific single address is in the male form. Furthermore, the obvious importance and social status of the, predominantly male, military leave even less opportunity to remind society of the experience and needs of women. Whereas both men and women are drafted into the army at age eighteen, women serve a significantly shorter term and are not allowed to train for and participate in active combat. This used to restrict them to more traditional secretarial and other service functions, but women have increasingly gained access to more technical functions as well. Married women are exempt from reserve duty, whereas men usually continue to serve for about a month a year till middle age.

The influence of the religious and traditional, paternalistic value systems can not be underestimated either as a factor of keeping women, whether or not traumatized, out of public awareness and interest. Further light is shed onto these processes in Israel by the personal and professional struggles of the interviewed therapists, as well the ways they have impacted societal and professional attitudes (see especially, Chapters 10 and 11).

Combat and Civilian Traumatization

Perhaps the most striking reflection of societal attitudes is the way war and combat trauma have been dealt with--or not dealt with--in Israel's still short and tragically war-ridden history. In a country that has had to cope with so much war and terrorism, one might have expected a preponderance of articles on war and combat trauma and the impact of terror. In fact, interest in war trauma only began to awaken after the Yom Kippur War, in 1973, and became a significant focus of interest in the IJP after the first Lebanon War that had broken out less than a decade later. Many Yom Kippur, and Six Day War veterans also fought in this war, with the potential for cumulated trauma and reactivation of previous trauma.

Witztum et al. (1996) and Levy at al (1996) presented impressive historical explanations for both the societal need to be oblivious to the suffering of traumatized soldiers and the social processes that changed attitudes of mental health professionals and their use by the army.

It is noteworthy, that the *Knesset*, Israel's Parliament, debated the plight of battle-shocked soldiers and their families who suffer from their veteran's PTSD, and insufficient social, financial and moral support only in December 1999. This delay illustrates just how difficult it is for Israeli society to deal with the psychological damage wrought on its soldiers by their battle experiences.

Civilian trauma has been particularly sparsely dealt with. This topic might be even more threatening as it so immediately impacts the lives of mental health professionals and their loved ones. For therapists to write about civilian war and terrorist trauma, they have to confront their own fears and defenses, as well as risk professional isolation in society. The intensity of societal pressure to remain silent on certain issues is exemplified by the total absence of professional literature by therapists who were employed by the military during and immediately after war situations in the first decades of Israel's existence (Witztum et al., 1996). Just how difficult it can be to acknowledge traumatization, can be learned from the interviews with the participating therapists in the following chapters.

Attitudes to Holocaust Survivors

Holocaust survivors were initially also an invisible group in Israel as far as recognition of post-traumatic suffering was concerned. This was especially true for those who survived and immigrated as children. I have explored the international history of silence and acknowledgement of Holocaust survivors in Chapter 3. The IJP, however, consistently published articles on this population starting with its very first issues. Both the IJP's first editor and many of the authors were personally affected by the Holocaust. Unlike trauma-related articles in other areas, the number and content of the Holocaust related articles in the IJP seem to follow a momentum that does not seem directly, and exclusively, linked to specific Israeli socio-cultural developments.

The first articles dealt with Holocaust survivors who were psychiatric patients, at a time when survivors had to endure potentially retraumatizing interviews in order to be eligible for finacial compensation by Germany. Applications could be--and actually were--rejected with the argument that extra-psychic events, such as created by the Holocaust had nothing to do with psychological suffering (Eliasberg, 1964). Gradually, perhaps as a result of so many researchers and clinicians being survivors and children of survivors themselves, there was a broadening of interest from psychiatric patients in survivors, including, eventually, child survivors who struggled with daily life, and second generation. The

ways in which interviewed therapists were personally and professionally affected by these attitudes, and contributed to growing awareness, will be explored in the following chapters, especially Chapters 6, 10 and 11.

The IJP as Societal Mirror?

The topics covered in the IJP between 1963 and 2002, the dates articles were published, the manner of presentation, as well as the topics ignored or glossed over, such as all forms of sexual abuse and battery, constitute a fascinating mosaic of attitudes to trauma in Israeli society.

It is difficult to estimate, however, just how accurately the selectivity and fluctuations of professional preoccupation with trauma in Israel is reflected. Though extremely marginal in the IJP, victims of terrorism and sexual abuse, for instance, are not totally ignored in Israel. The government regulated National Insurance Institution has been providing psychosocial and financial aid to terrorist victims since the 1970's. And there are private initiatives such as the influential Community Stress Prevention Center, created in the Eighties to meet the need of the people living in the Northern Galilee that endured decades of shelling from Lebanon, and rape crisis centers that were set up throughout the country (Chapter 11).

I have not sought to take a representative sample of all articles published in Israeli professional journals between the early sixties and 2002. Contributing and other authors from Israel may, of course, also have published in other journals.* However, this content analysis does support the assumption that there is a link between socio-political developments in Israel and the way mental health professionals perceive and relate to trauma and the traumatized. The appearance, disappearance and non-appearance of preoccupation with specific trauma and populations at any given time, as reflected in the IJP, do give a sense of the social climate in which therapist and traumatized client meet.

The question remains to what extent the *Zeitgeist* as presented in the IJP actually represents not just research interests, but the experience within the therapeutic setting with traumatized clients, and how this may give rise to societally influenced *a priori* countertransference. The two studies presented in Chapter 4, and

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* Perusal of the Hebrew language Israeli Journal of Psychotherapy, Sichot (Dialogues), first published in August 1986 did not present a radically different picture of Israeli attitudes to interpersonal traumatization.The similarity was apparent, except for four articles that related to dissociation (Margalit & Witztum, 1997a; Margalit & Witztum, 1997b; Somer, 1989; Somer & Somer, 1997), two on trauma in children (Kuperman & Hoffman, 1991; Somer, 1994) and two related to treatment approaches after massive civilian trauma (Omer, 1991; Shalev & Tuval-Mashiach, 1999).

in Chapters 6-11 aim to uncover the societal impact upon the personal and professional lives of the interviewed therapists, the degree to which their experiences reflect the selectivity of trauma focus in the IJP, and what societal sources of *a priori* countertransference may be uncovered.

CHAPTER 6

Family and Personal Background

In this, and the following chapters, I will present an analysis from the in-depth interviews I held with eight trauma therapists who specialize in work with Holocaust survivors and the second generation (Appendix I; Chapter 2). Each chapter will highlight a specific aspect of the therapists' lives and professional experiences with the purpose of emphasizing the importance of who the individual therapist is as a person and uncovering sources for *a priori* countertransference. In this chapter, I want to concentrate on the interviewed therapists' personal and family histories, and their relevance to *a priori* countertransference.

Traditionally, the training of mental health professionals has focused on providing a sound theoretical basis and imparting psychotherapeutic techniques. This is followed by a period of closely supervised clinical work and a required or recommended course of personal therapy in order to minimize interference by the therapists' own pathology in his or her countertransference. Meanwhile, research has shown that the specific psychotherapeutic approach or techniques are of minor importance, and that the therapeutic alliance and relationship form the basis for a successful therapeutic outcome (Ackerman & Hilsenroth, 2003; Horvath & Luborsky, 1993; Garfield & Bergin, 1994; Marziali & Alexander, 1991).

Countertransference is an inevitable aspect of the therapeutic relationship and over the past two decades, trauma-specific aspects of countertransference have been receiving increasing attention (e.g. Benatar, 2000; Dalenberg, 2000; Danieli, 1988b, 1994a, 1995; Dworkin, 2005; Grubrich-Simitis, 1984; Kluft, 1989; Tauber & Van der Hal, 1998; Wilson & Lindy, 1994a; Wilson & Lindy, 1994b). Connors (1997) states that "because we are viewing patients' needs through our own subjectivity, our countertransference responses may have more to do with us than with our patients" (p. 89). If this is so, far greater attention ought to be paid, in my view, to the subjectivity of each therapist. This might be expressed in their attitudes, values and expectations, for example, their "*a priori*" countertransference (Tauber, 1998).

Until fairly recently, there has not been much focus, within the framework of professional training and the actual work, on who the therapist actually is in terms of personal history, societal and professional context, or what might have led him or her to specialize in clinical work with specific traumatized populations (Tauber, 1998). Still, the importance of the person of the therapist, if not specifically trauma therapist, was already noted as far back as 1845 by Gauthier who is quoted by Ellenberger (1970):

> He [the magnetizer] not only gives of his knowledge, as do physicians, but he also transmits his vital forces to his patients. *For the patient, the choice of the right magnetizer is of paramount importance; certain magnetizers are more successful with some patients than with others.* (pp. 155-156) [italics mine].

More recently, Whitaker and Malone (1953) stated, as cited by Keith (2000, p. 272): “the dynamics of therapy are in the person of the therapist." Thus there seems to be a gradual renewal of attention in the field of psychotherapy, including in psychoanalytic thought (Davies & Frawley, 1994; Greenberg, 1995; Hoffman, 1996) to the importance of the therapist him or herself within the therapeutic equation (Allen, 2001; Bergin & Garfield, 1994; Catherall & Lane, 1992; Garfield, 1997; Pearlman & Saakvitne, 1995).

Freyd (1996) noted in her book, *Betrayal Trauma*, that in social research too, the "person" of the researcher must be taken into account. She considered her own personal history relevant as “…an open and truthful context in which the ideas and information in this book may be freely considered and questioned” (p. 199). Slater (2004) described with some gentle irony how closely related topics of study and interest might be to the researcher's personality or history. At the same time, Freyd (1996) argued, “theory must stand or fall on its own evidence and logic” (p.199).

Over the past decade, some literature has appeared exploring therapists' life stories. Hunter (1994), for instance, looked for possible connections between biographies of a group of eminent psychoanalysts, their socio-cultural contexts and their professional development and approaches. And Figley (2006) edited a book of autobiographical essays by leading traumatologists with the intention of offering deeper insight into the development of the field.

Exploration of people and events in the therapists' personal and family (trauma) history might further our understanding of the kind of subjectivity that filters therapists' perceptions and interpretations of their clients' traumatic experiences and suffering. By promoting “self-knowledge, self-acceptance, and self-monitoring” (Pope & Vasquez, 1998, p. 63) the therapists' “emotional competence” as they call it (1998, p. 63) would enhance the quality of the therapeutic relationship.

In this chapter, I want to present what the interviewed therapists told me about their current life situation, their family backgrounds, i.e. their (extended) families, and their trauma histories, and about their own histories, which included many traumatic experiences. My aim has been to elicit their own perceptions of their histories in order to uncover areas of potential *a priori* countertransference. This chapter is also intended to provide a basis of understanding exploration of additional aspects of their professional lives as described in the following chapters.

Current Life Situation

Exploration of the therapist's current life situation started with his or her marital status, a most important aspect of life in Israel: Only a small minority,

including myself, does not marry and/or have children. All interviewed therapists were in committed, though not necessarily satisfactory, relationships.

Dora enjoyed a strong, mutually supportive relationship with her husband. They raised a large family and maintained close relationships with all their children and their families. *Joseph*, had a close, supportive relationship with his spouse. Their children were already grown up. *Ruth* was happily married. At the time of the interviews, she and her husband spent significant amounts of time apart from each other for work-related reasons. Except for one school age child, their children were already grown. *David* was now happily married after several divorces and had the main care of his child. *Dana*, was currently in a committed relationship. Divorced, she had custody of her children.

The others remained in more complicated marriages. *Sara* had married at a relatively late age by Israeli standards. Her need for a home of her own finally won out over her fear of commitment. Differences in temperament and background complicated her relationship with her husband, but both delighted in their new parenthood. *Hanna* stayed in her marriage as she never felt quite strong enough to make a new start. Relationships with her children and grandchildren were very close. *Nell* considered her husband a good friend with whom she wants to spend the rest of her life. Their children were grown up already. Like Hanna, her close, supportive relationships were with women friends. "My friends have been my life support."

A therapist's family status and current intimate relationships, as well as societal norms and values can reasonably be assumed to impact how he or she perceives their clients' current relationships or absence thereof. Such listening and hearing can be particularly complex when clients have been hurt by interpersonal trauma. A single mother of two, for example, who lost a child during army reserve service, might find very different resonance with a therapist who also has children in the army; with a therapist who rejects the legitimacy of single-parent families; or a childless therapist.

Family and Personal Trauma Histories

The family history of many Israelis starts with an, often traumatic, rupture of continuity. Israeli society is composed largely of immigrants and their offspring from all over the world. Many were refugees from different forms of oppression and active persecution. This raises questions concerning the kinds of families, culture, tradition, traumatic experiences and values the therapists grew up in and how these might affect their *a priori* countertransference. Lindy and Lifton (2001) found, for example, that therapists, who worked in countries emerging from

communist regimes, had to resolve their personal family stories of political oppression and/or collaboration before they were truly able to listen to their clients.

The tragedies and traumatizing events of both the Holocaust and sexual abuse--the areas of specialization of the interviewed therapists--are closely intertwined with family life as these traumas were personally experienced and/or transmitted intergenerationally or, in the case of sexual abuse, quite possibly perpetrated within the family. It seems pertinent, therefore, to explore the echoes from the therapist's family history and how these might affect how they might actually hear their clients.

Dora

Dora's family was uprooted and dispersed because of the Holocaust. She did have some experience of pre-Holocaust family life. Her mother had been orphaned at an early age but her paternal grandparents provided an oasis of affection, warmth and solidity. They had migrated to Dora's country of birth from a country that would remain neutral during the Second World War. Dora's father had kept his original nationality, a fact that was to save their lives several times at the beginning of the War. Dora's grandfather passed away before the war, but her beloved grandmother and other relatives perished in concentration camps.

Dora's mother, "a special woman," probably suffered from an undiagnosed depression and in mid-life, made a suicide attempt. But she lived till a great age and this enabled them to form a closer relationship as older adults, especially after Dora's father's death. Dora spoke of her father mainly in the context of contributing to their survival of the Holocaust. After the War, he remained resourceful and acquired a higher education. A few years after Dora had done so, he, together with the rest of the family, moved to Israel, where he had a meaningful career. She described her father as "not empathic," "too preoccupied with himself," but expressed understanding as to why he had become that way. Dora characterized her parents' relationship as "difficult." Dora's parents, who were very young when she was born, were not very influential in her life. "No, no, I had no one at home."

The Holocaust clearly was the dominant traumatic experience for Dora. When her family fled after Hitler's rise to power, she was placed with relatives in a foreign country where she started her childhood and adolescent years of being "an outsider." Some months later, she joined her parents in another country where she had to learn yet another language and try to fit in. When the Second World War broke out, the family, already including younger siblings, fled again while bombers were flying over them. "That was a feeling of absolute helplessness." Dora had some harrowing experiences, on her own and with her family, including

incarceration from which they were released because of her father's identity papers and, most painful for Dora, separation from the baby who was placed in hiding as the rest of the family fled on. "My heart broke."

At one point, friends of Dora's caught up with the fleeing family to warn them that the Germans were on their trail. They hurriedly made their way to the mountains without proper clothing, food or maps and ended up on a dangerous ledge from which they could neither go back nor forward. By incredible luck--perhaps a condition for surviving most traumatic events--the last shepherds going down the mountains for the winter heard their cries for help and, with great effort, rescued them. The family had managed to cross the border into a neutral country, but was confined to a refugee camp, where interpersonal relations were very problematic.

As soon as the war ended, Dora smuggled herself back across the border, rejoined her old friends and started working with young Jewish orphans. When she heard that her beloved grandmother and other relatives had been killed, she could no longer bear to stay in Europe. "The fact that my grandmother was killed in the Shoah was really *the* trauma for me, personally."

Dora entered British-ruled Palestine with papers she had forged herself. Delighted to be there, life was never easy. The War of Independence was an especially dangerous time. Terrorism directly affected her family too when one of her children was severely injured in a terrorist attack several decades ago.

Dora said she had never suffered physical or sexual abuse. Referring to both her war-time adolescence as well as the years immediately after the War she did not relate to the concept of sexual harassment because "I relied on myself…I didn't have anyone to turn to and say, look what's happening to me! I was very aggressive and pushed people away." When I asked about traumatic losses, she immediately spoke of the tragic death of one of her children due to illness. The family was very united in their grief but the pain remained immense. She also spoke of her great sadness at her mother's recent death.

David

David started his story with his maternal family's banishment from Eastern Europe as Zionist dissidents, after which they managed to get to Palestine in the early 20th century, and become farmers. Members of his father's family had started to come over in the latter part of the 19th century, but his grandfather arrived after serving in the army in World War I. He later served in the defense forces in what was to become Israel.

David's grandparents were an integral part of his childhood but his maternal grandmother was "the central figure" in his life. As a young girl, she and an even younger cousin were the sole survivors of a *pogrom* at the end of the 19th

century. Incredibly, they made their way to Palestine on their own. She spoke of those experiences only to David. She had a great deal of knowledge despite her lack of formal education and "really was an amazing woman, not just in the family mythology." She died at a very advanced age, after refusing to artificially extend her life when she fell ill. "She was a giant."

David's parents, both born in Israel, married during the War of Independence, in which they took active part and his father was seriously injured. "I know it was very traumatic, both physically and mentally, though no one talked about this in the family." Still, his father became a professional soldier and set himself challenges from which his physical disabilities should have disqualified him. He imposed stoicism on the family too. A high fever, for instance, was no reason for the kids to miss school. David's father was quick to anger, but not physically violent towards his family. Due to his work, he was absent a lot, which caused David a great deal of distress when he was small. David described his mother as "a very complacent woman" who worked all her life in a profession she considered a vocation. He has remained close to his sibling, who he thought of as very bright and successful.

David's family was not psychologically oriented. "Everything was very much focused on instrumental coping." His parents had always been willing to help practically, but would not ask about feelings or experiences. Socially, too the family norm was one of giving and dedication, a tradition David gladly continued, both in his job and as a volunteer.

David reported no childhood traumatic experiences. His family had lived abroad for a few years when he was in his teens and David considered the anti-Semitic incidents at the school he attended then, formative experiences. He was back in Israel in time to go to the army and though he did experience combat, he was never traumatized. When asked about trauma history, David referred to his divorces as "complicated," and a traffic accident as causing "physical trauma, nothing special." He thought questions about traumatic loss "odd," but then he spoke at length, and with deep feeling, of the recent death of a close friend.

Sara

Sara started her family's narrative with her maternal grandfather, who brought the whole family to Israel when the anti-Semitism then rampant in their part of North Africa, became too dangerous. "He was a very, very hard man…And because he was religious, extremely devoted to G'd…it was very important for him that the children follow his path." He was physically abusive to his children, but Sara did not dwell on this as she wanted to preserve her "good memories" of him. She was quite young when he died. Sara's paternal grandparents had died in their

country of origin and she said nothing about them or about her maternal grandmother.

Sara's parents married while still in North Africa. "It's part of the tragedy of the women there that they married at a very, very young age." Sara's mother set the emotional tone of the home, partly because of the relationship between Sara's mother and her father. Sara's many uncles and aunts were all "amazingly creative and talented" and "emotionally very, very conflicted." Sara did not speak about relatives on her father's side.

Sara's family felt culturally alienated in Israel, and found it difficult to cope with daily life. They had a hard time adjusting to the socialist, western-oriented, secular values of Israeli culture at the time they immigrated. "They were very offended by it all." Her family was oblivious to the poor *Ashkenazi* [i.e. of European origin] immigrants struggling alongside them, as they perceived *Sephardim* [i.e. Eastern, or originating from Arab countries] as poor and oppressed, and all *Ashkenazim* as well established socially and financially. This is a view Sara shared to some degree, and only since she started working with Holocaust survivors, did she realize that "there were Holocaust survivors in my own neighborhood."

Sara's parents were hardworking laborers who barely made ends meet. Sara was among the last of many siblings, and remembered a great deal of verbal and physical aggression from her mother and among the children. As an adult, Sara had become fond of her siblings, but there was little real communication among them. While pregnant with her, Sara's mother was "informed" that one of the siblings, an infant who had been "in some kind of institution," had died. Her mother didn't attend the funeral and the family doesn't know where the grave is. "There's no mourning, no mourning, and no time for it."

Sara's father had apparently been very violent toward her mother at the start of their marriage, but her mother learned to oppress her him and neutralize his aggression, so that he was "was rarely noticed or heard." She taught Sara that "If you're afraid of fire, you'll be afraid of your husband." Sara loved her father very much. "I love them both a lot, but at times, I feel a lot of pity for him." After Sara's grandfather's death, her mother began to suffer depressions which recently, have required hospitalization. Sara expressed much warmth and concern for her mother and hardly any distress or anger at all the abuse she inflicted on her.

Sara started her trauma history with her mother's attack on her four-year-old self with a knife. Her mother doesn't remember this. Sara recalled with sadness that when she had to be taken for medical help, her mother told her to "say that I had fallen." Physical scars deprive her of the comfort of pretending it never really happened. Sara was one of several siblings that were most frequently beaten by their mother. Her father would be the one to comfort her.

Violence and bullying existed also outside the family. They lived in a neighborhood with many North African immigrants. All the kids used to terrorize a particular old woman every day. "*Today,* I understand that she was a Holocaust survivor." Sara had nightmares about what they did to her. The 'neighborhood' also knew of an individual who molested young girls but did not intervene. Sara too was molested by this man.

She left home when she was twelve, and started a difficult school career at different boarding schools. At fifteen, she was manipulated into sex by an adult she adored and felt dependent on. "I don't know whether I should define that as rape." She also had several abortions. Sara was not sure if any of those experiences were traumatic or merely difficult. She elected to be exempted from army service for religious reasons, and returned to her home-town during a period of deep psychological crisis.

Despite her experiences of being sexually harassed by men, her obvious pain at feeling used, and feeling "so very lost," Sara also spoke of other men she felt fortunate to have met. "The only ones who would get me out of all the mess…or give me new directions to think…They really believed in me. As I grew up, I met really good guys.…it was more luck than wisdom." She also "started to adopt their families, or rather, the mothers of my boyfriends." In this way, she gathered the strength to go back to school and get the necessary matriculation exams and go to university.

Sara considered herself an overly sensitive person. "I feel that my nervous system is very exposed. And inside, inside, there is very great sadness. That is, besides the vitality, or the desire to connect to living things, deeply, I'm a very sad person."

Ruth

Ruth, like so many children of survivors, grew up without grandparents. They were all killed in the Holocaust. But she did know a little about them. Her maternal grandfather had been a gifted bible scholar and her grandmother a "very feminist" business woman, who was away from home a lot. Ruth's father came from a neighboring country. His mother had been tough, possibly physically abusive, and also, apparently, very competent. Her paternal grandfather came from a renowned rabbinical line. Ruth said little else about him other than when he was deported.

Both Ruth's parents survived Auschwitz, but she experienced her mother as more vulnerable than her father. She had been a young girl and had lost most of her family there. She had almost no contact with any of her few surviving relatives after the War. Ruth's father, a slightly older adolescent at the time, survived together with his younger brother whom he looked after. Though literally starving,

he had the strength and discipline, for example, to save his bread to exchange it for shoes, which helped them to survive the horrors of the death march. After the War, Ruth's parents were interned in camps on Cyprus by the British, as their respective boats were intercepted on the way to Palestine. When her father finally arrived in Israel, he was immediately drafted and fought in the War of Independence. Her parents met and married after that war

Ruth said little about her parents' relationship but "there was a lot of love at home." She was glad her parents did not tell too many Shoah stories. She did not really like hearing stories from before the War either. Ruth thought her mother was a good mother. There was a "lot of laughter … part of her is childlike...that made her live through us…She grew up with us, really." This was only part of the picture as "with hindsight," Ruth realized that her mother had always had a "hidden" depression. "I think I absorbed that depression, and I absorbed her dependence on me. I felt a need to protect her, and him too. My father too, though he's very strong."

Ruth's father encouraged his children towards independence, but this never stopped her from feeling deeply attached to her parents. "A real wanderer," her father frequently moved the family from place to place in Israel and even, at a relatively advanced age, abroad and back. She described them both as currently well and independent, despite significant health problems. Ruth was close to her sibling who experienced multiply traumatization as a result of Israel's wars. She also spoke of the closeness between her children and her parents.

Ruth's consciousness was permeated by the Holocaust. Almost at the start of the interview, she dove into a harrowing story of accompanying her mother to Auschwitz some years earlier, at her mother's request. The resulting dynamic between her mother and herself might give some insight into how she grew up.

> The truth is that I didn't dare to refuse. I was scared to death of that trip.…But I couldn't say no, so I decided that I would function as a therapist…I left with a clear decision that if I have to protect myself in order not to fall apart, I'll be the therapist.

She spoke of having to dissociate from her emotional responses during that visit and stay "really focused on getting out of there intact." It was only on that trip that her mother told her that older girlfriends had protected her from ongoing sexual abuse in the camp.

Ruth's family moved abroad when she was a teenager. She chose to stay in Israel on her own for the school year, but missed her family desperately. Only later did she understand that the year had been traumatic for her, and how dreadful their separation must have been for her mother. She joined them the following year, but returned on her own again, to do her army service. While abroad, Ruth

encountered several incidents of anti-Semitism from which she learned that "you're first of all a Jew and only afterwards, you are something else."

She experienced no abuse at home. She did perceive herself as a parentified child. Her protectiveness of her parents was not simple for her but "I can't say that it was pathological." Still, though she said she did not have a hard time at home, she thought that "there are good reasons that I can shift parts aside and say 'You do your processing on your own, and I'll talk to you afterwards'!" She laughed and continued, "I actually learned that a part of my life that might be more difficult, have more difficult experiences, does not have to be so disturbing...I think that the way I talked about things was by diminishing them, that is, not to burden them [her parents] to much."

Ruth's first response to general questions about her own trauma history was about having had a potentially fatal illness. She agreed to surgery at the time, but not to further treatment. "If there's anything I can't tolerate, it is physical pain. I prefer to die in my own time. I don't want anyone's help… ." Instead, she decided to write her testament with instructions how her family should go on after her death. But she had trouble deciding what would be best for one of her children. That particular child then suddenly started suffering "absences." A diagnostic interview exposed the child's fear that Ruth was going to disappear. That was when Ruth allowed herself to cry for the first time. The child's symptoms vanished when Ruth told the whole story.

Questions about traumatic loss amused Ruth as she acknowledged no separations, not even from people that had been important to her and had died. "They don't die for me. I just don't see them. But it's not, there is no *ending*. So, there is no mourning…I go on talking to people in my head, and as far as I'm concerned, they exist."

Joseph

Joseph knew three of his grandparents. His paternal grandmother survived a ghetto, together with her children. He had few memories of her. Joseph's maternal grandmother, his mother and a sibling were separated from his grandfather and transferred from camp to camp. Remarkably, they all survived and for a certain time "were important people in my life." They adored Joseph. However, their tense relationship with his mother became too stressful and Joseph "decided to cut off all contact." Both his parents' families immigrated soon after the establishment of the State of Israel.

Joseph started his parent's stories with their arrival in Israel and some details of the socio-political background of their country of origin. Then he added some personal information. His mother "is a housewife. She's a damaged woman, mentally. Some of that is connected to the War. And my father…is very much a

survivor, but not helpless." His parents have opposing political views. "They have drawn different conclusions from the Shoah." Further into our conversation he shared details about his mother's horrendous experiences as a young girl, which included abuse in the camps, and death marches. Joseph felt that by the time he was a teenager, he was more adult than his mother. He perceived himself as a parentified child, "her psychologist," which was very difficult for him. Joseph volunteered nothing about how his father survived the Shoah. When I asked him specifically, he told me about his father's dreadful experiences in the ghetto, including near-fatal beatings.

His parents' marriage was strained and Joseph thought this often caused his mother's break-downs. He described his father as "warm hearted" but also as "domineering." Joseph was not close to his siblings, one of whom had been suffering with mental illness. He continued to maintain regular contact with his parents.

Joseph remembered no distinct personal traumatic experiences but "the Shoah was in the home." He explained it "was always in the air, things that were reminders." Joseph's mother remained "posttraumatic…She doesn't travel by train to this day. Those are all triggers you have to be considerate about, you have to be protective. Yes." He considered his being a parentified child a formative experience. His mother was very depressed and child-like. She was also under ambulatory psychiatric care, even though this was uncommon at the time. "And she really taught me not to trust anyone. I think that is also a legacy from the Holocaust…I suffered a lot because of that, especially in the army. Today, I'm no longer like that." He absorbed "Shoah-like habits," which caused him social problems, also in the army. "I'd quickly grab food and sit and eat it quickly. That wasn't nice." He had also learned that "if I had something good, I shouldn't share it with others."

Joseph endured beatings from his father, and threats from his mother. He thought that today, this would be considered child abuse and assumed that, at the time, it was "normative." When I asked him if he knew of other children who were beaten, however, he said, "It wasn't talked about. No. It was shameful!" His mother was also verbally abusive. But Joseph repeatedly said that his parents had also been warm and caring people.

Joseph was unsure whether or not he was sexually abused. "I've thought about it occasionally, but I don't know anymore if it's connected to the material I've been working with for so many years in my practice. And I don't have any symptoms." The wars, in which he was a combat soldier, were difficult but what stopped them from being traumatic for him was "professionalism, a sense of mission. I wasn't, I didn't feel helpless."

Hanna

Hanna felt that her story started with her maternal grandparents. Her maternal grandmother's family emigrated at the beginning of the 20th century as one of the relatives had allied himself with the 'wrong' communist leader. All became farmers except for one great-aunt who joined them in Palestine after she had completed her academic studies. Hanna was pleased when I referred to this great-aunt as a pioneer. She had many great-aunts and great-uncles, most of whom had families that still lived in Israel. Hanna was deeply attached to her whole extended family but felt closest to her maternal grandmother. "She was perhaps even more important to me than my mother…My grandmother was really a very special person and I think that I owe most of who I am today to her." Her maternal grandfather had also been a *halutz*, a pioneer, and worked as a laborer.

Hanna's paternal grandparents fled Europe soon after Hitler's rise to power when her father was an adolescent. As her paternal grandmother was a Zionist, they came to Israel, where the whole family worked as laborers despite their middle class origins. Hanna felt rooted in Israel because of her family: "I think that all over the world, people stay where they are because that's where their grandparents are buried."

Hanna's mother "followed the footsteps of her mythological aunt," and always took her career seriously. She met and married Hanna's father after she finished her studies and continued working her whole life. Hanna's father fought in the British army in the Second World War, served as a professional soldier in the Israeli army and after retirement, started another career. Hanna had a happy childhood. "My parents are very good people, they're like the pioneers…excellent at providing all the physical needs." True to the socio-cultural norms of their time, they were not geared towards giving emotional support. "They are…very practical people. Mental health does not preoccupy them particularly…Looking back, I don't think that that's so bad! … Whatever happens…they cope with it because there's no choice." Her parents were still alive at the time of the interview, though her mother had not been well for years. Hanna had good relationships with her siblings.

Hanna had only positive things to say about her childhood, but did describe herself as "not a very joyful person. I don't exactly know the origin of that, it might even be chemical." A general question about trauma, however, elicited the agony of losing her baby very soon after its birth. "That was actually my first experience that life won't behave the way I want it to." She had no one to emotionally support her at the time, as her husband didn't "know how" and her parents "don't know how to give emotional support." Hanna's second major trauma was the death of a sibling in an accident. She describes the two of them as the only ones in the family to be "connected to their emotions".

Israel's wars were hard for her, but she was spared traumatic experiences. "I'm never afraid, really." Such absence of fear is very "culturally appropriate" for the tough *Tsabre* (native Israeli) raised among veteran Israelis, many of whom were high ranking, professional soldiers.

Nell

Nell's grandparents all fled the *pogroms* in Eastern Europe but did not go to Palestine. She had little or no contact with any of them, except for her maternal grandmother who traveled from one child to another. But as she spoke little English, Nell had no shared language with her.

Nell had few memories of her parents together. Her mother had been seriously ill for years when Nell was very small, and over the summer holidays, she and her sibling were sent to stay with relatives. Nell's mother had asked a kind-hearted aunt to look after the children after her death, but this request was not honored. The still very young Nell and her sibling were taken in by another, extremely abusive, aunt. Her husband was fairly passive, but fortunately, their children were kind.

Nell's father, who himself had been orphaned as a child, and been a prisoner of war in the Second World War, disappeared a year before his wife's death. He was "found" years later when it was learned that he had gone into a dissociative fugue, remarried and divorced. Upon his return, the children, already in their teens, immediately moved in with him in order to escape their aunt. He soon married a woman with children of her own. Through it all, Nell and her sibling have maintained a loving, though difficult relationship.

For Nell, responding to a general question about trauma she might have experienced seemed to be a matter of deciding what to leave out: "Do you want all the gory details of my childhood?" She has always remembered being sexually abused as a small child by a relative with whom she spent many summers. "I don't know how it stopped or how it started…nothing probably ever happened after the age of five, but this creep was around all the time." He was known to be "a sexual pervert." Her father told her many years later that she was always watched over very carefully," as we knew he was not OK." Nell later on endured "just the regular run of the mill stuff that women go through, sexual harassment … but no other, thank goodness, revictimization and repetition and all that, fortunately."

In the years after her father's disappearance and mother's death, there were no effective social interventions or support. The abusive aunt with whom Nell had to live, would present a positive picture to a visiting social worker but "we all played along, because, between you and I, there was nowhere else!" No one at their school or synagogue acknowledged the children's psychological distress. But there were "helping witnesses" (Miller, 2001); the aunt's children and later on, their

spouses, were genuinely fond of Nell, and enabled her to experience ordinary caring relationships. There were other uncles and aunts who seemed to have little or no impact on Nell's life. When she finished high school, she spent a year in Israel. She went back home to go to university before returning, finally, to Israel.

Nell, a voracious reader from early age on, was very preoccupied with the Holocaust though this was not a topic of discussion in her family, nor in her synagogue. She knew her family had fled *pogroms*, but there were no stories about this. Her own horrendous childhood has taught her to be ready for the worst, and she was "convinced that if something terrible didn't happen today, it was just by chance because it would happen tomorrow…And that attitude has only changed in the last you know, ten, fifteen years." Nell noted a family history of illness that affected her to the degree that she was certain she would die young herself.

Dana

Dana's grandparents all survived the Holocaust. Her maternal grandfather, who had fought in his country's army, was captured by the Germans, and survived as a prisoner of War. Her maternal grandmother fled with the children. They were the only survivors of that large extended family. Both sets of grandparents also lost their considerable wealth and started from scratch when they arrived in Israel. Dana felt very close to her maternal grandparents, especially her grandmother, and spent a great deal of time in their house. She died when Dana was a young child. Her paternal grandfather lived to old age though he too, had a serious illness. Dana's father died of the same disease at a relatively young age. This shocked the family that had assumed that he would live on for decades.

Dana's father survived the Second World War by joining a group of partisans [Brysk's (2007) autobiography gives unusual insight into early childhood experiences with a group of partisans]. Though he was just a boy, he had managed to make himself useful to them and stayed for several years. Dana said nothing about what this might have meant for him, or his parents. His father, who had not been accepted by the partisans, did manage to stay in touch with him. Dana sensed her parents' deep anxiety that acknowledging trauma and pain would open up a bottomless pit. Neither parent ever considered therapy as the family's style was to get on with things; difficulties, physical and mental pain were not really acknowledged or discussed. "We, the second generation, pay the price." Though well integrated in Israeli society, Dana's parents, who came from the same country, kept their own cultural patterns. And like many children unfamiliar with their immigrant parents' national backgrounds, Dana misinterpreted some of her parents' behavior. She realized this only after visiting her parent's country of origin.

Dana characterized her father as a delightful man, and her mother as a difficult woman, lacking in empathy. Both parents worked as Dana was growing

up. Dana adored her younger, and only, sibling, and took on a protective, mothering role from a very young age, which, Dana noted, “my mother went along with.”

In school, Dana was bullied. She was verbally and physically abused by kids who frightened even the adults, and no one protected her. Only when she was well into her teens did she manage to outsmart her abusers. A few years later, she was raped by a friend. She became pregnant and had an abortion, which was still illegal at the time. She confided only in one friend.

Dana was fairly dismissive about the "ordinary" sexual harassment many women endure, such as by men groping women on buses, for example. But as a child, she was the target of inappropriate sexual behavior. True to the family code of behavior, she never told her parents. Even when she was in physical distress as a child, she would remain silent about it.

Dana gave two traumatic examples of the impact of her parents' responses to death. In one case, her mother woke her up one morning and told her that her adored, maternal grandmother had died, that she should not to cry and go straight to school where there was to be a party. It took decades before Dana was able to cry again. Another traumatic event occurred right after her paternal grandfather's death. She said something about this to her father, not realizing he had not been told yet. Dana's father stopped speaking for quite some time. Dana felt unable to tell anyone about her distress and guilt at his reaction until, years later, her mother told her that her father had once before turned mute during a very traumatic situation in the Second World War.

Dana was spared the loss of relatives or close friends in Israel’s wars, but not of other precious people from wider circles. Dana and her mother were at a site of a terrorist attack quite some times ago. They were not wounded, but people all around them were horribly injured and burnt. Unlike her mother, Dana developed no lasting posttraumatic stress symptoms.

Main Themes in the Therapists' Family Narratives

Despite the geographical and socio-cultural differences, all the interviewed therapists started their stories at a traumatic rupture as a result of *pogroms*, the Holocaust and other outbreaks of anti-Semitism. Dora spoke at some length about why she left Europe for Israel, but none of the others addressed the practical and emotional implications of their relatives' choice of (pre-State) Israel, or other continents as a place of refuge. This may raise issues of identity, belonging, and perhaps, also the question whether the decisions made in previous generations still affected these therapists (Chapter 10). These might all impact expectations and perception of clients and hence create *a priori* countertransference.

Quite a few Israelis seem to have resumed the Diaspora heritage, so beautifully described in Marek Halter's 1983 novel, of wandering from what was no longer a safe haven to what promised to become a safe haven. Questions of personal safety and/or belonging are ingrained in the psyches of Israelis who feel caught between the dangers inherent in an amorphous anti-Semitism that can be energized any time or the dangers inherent in living in the Jewish homeland where peace remains a dream. Hence *a priori* countertransference issues which might cause therapists to block clients from exploring these issues and perhaps underlying traumatic experiences, or perhaps the reverse, prevent therapists from believing clients' genuine sense of safety, are relevant in Israeli reality.

The interviewed therapists had very different experiences of family continuity, with David and Hanna, whose families had lived in Israel for several generations, on the one side, and Ruth, whose personal knowledge of her roots starts with her parents, and who emphasized the closeness between her children and their grandparents, on the other. Such autobiographical differences in intergenerational experiences are bound to create subjective differences in how therapists listen when a client speaks of intergenerational family relationships, or fails to do so; of death and mourning; of social identity and roots.

The therapists were raised in a variety of intra-familial and environmental cultural contexts that complicated their lives, such as the lack of a common language between Nell and her grandmother, Sara's family's sense of alienation or the difference in "culture" between Dana's parents and what seemed to her, normative Israeli. The very issue of family appears to be a complex one for the interviewed therapists. In fact, Dora, Nell and Sara experienced very little intact family life at all as they were growing up. The theme of parental failure stood out, whether concretely, through death or abandonment as in the case of Nell's parents, abuse and neglect, as in Sara's case, preoccupation with survival as in the case of Dora, or resulting from the impact of traumatic experiences as in Ruth's, Joseph's and Dana's families. The therapists described stories of death, abandonment, depression and violence, sometimes over generations. They shared areas of possible *a priori* countertransference but individual therapists must monitor their own sensitivities.

Despite the huge difficulties the families coped with, none sought psychological help to ease their suffering, except in cases when psychiatric intervention was unavoidable (Joseph's and Sara's mothers). Psychotherapy was discouraged either out of fear, like in Dana's family, or as a result of cultural norms, as in Hanna's and David's families. In fact, they exhibited extraordinary resilience: people took initiative in the face of great risk, such as joining partisans (Dana's father), uprooting a whole, extended family (Sara's grandfather), coping with impossible situations, such as trading bread for shoes despite being in a state of

near-starvation (Ruth's father), leaving behind a toddler in the hope of saving its life (Dora's parents) and, of course, rebuilding lives after devastating trauma and adversity as many of the families had to do. Possibly internalized attitudes to coping, resilience and psychotherapy might constitute *a priori* countertransference and filter the therapists' ability to empathically listen to their clients.

The interviewed therapists did not refer to their stories of cumulative personal, intergenerational and societal trauma as something out of the ordinary and rarely pointed to a particular trauma that had affected them personally or professionally without my asking them specifically. Still, they could all be considered "wounded healers." This can be a professional advantage if these therapists have worked through their histories (e.g. Catherall & Lane, 1992; Jung, 1946; Kluft, 1989) and carefully monitor their *a priori* countertransference. Their intimate knowledge of trauma and suffering might increase their empathy, depth of understanding and knowledge, and perhaps a greater ability to hear their traumatized clients. De Wind (1984) found that "[f]ormer victims often visited therapists who, like themselves went through horrible experiences" (p. 275). However, such a history and a lack of personal experience with 'ordinary', more or less functional family life might also give rise to *a priori* countertransference that poses an obstacle to therapists' enabling clients to go beyond the processing of trauma and reducing suffering to living more fulfilled lives; or, as Sara put it, go "beyond survival mode."

The Therapists' Perception of their Own Lives

Though many traumatic occurrences such as rape and other violent assault are facts that cannot be denied, perception of, and attention to, clients' traumatic experiences are not a matter of course in psychotherapy (e.g. Dalenberg, 2000; Herman, 1992; Tauber, 1998). This is where the person of the clinician is crucial. Jackson (1993), for example, examined "clinician factors that influence decisions about the credibility of sexual abuse allegations" (p. 128). Bar-On (1999b) referred to "impediments brought in by the uniquely personal historical and cultural elements in therapists' biographies" (p. 5). Brown (1995) pointed out that whether or not an event is perceived as traumatic rather than difficult or sad might depend on the given societal and temporal context as well as the person's history. If one accepts the premise that personal and social history significantly impact how therapists listen to, and hear clients and which of their clients' traumatic experiences they perceive with greater or lesser openness, then some insight into how the interviewed therapists perceived their own life histories may prove enlightening.

Dora's childhood was shaped by the cruel contrast between the values and expectations of the bourgeois family into which she was born, and the unimaginable horrors carefully prepared and then carried out in a world taken over by Nazis and their collaborators. When asked what words describe her life, Dora expressed the wounds of having been betrayed as a child:

> They lied to me from the start...And our being thrown about, from country to country and everything that happened along with that showed us that the world is *not at all*, in no way like they told me.…I felt unsafe and I couldn't trust anyone except myself. With all sorts of experiences, all sorts, also being approached by men and all sorts of things... And when I got to Israel, I just rejoiced that I'm now in my place…Belonging here was very, very important.

David related to his life as a whole.

> To this day? About my life?…I'd say that the central word is 'difficult but satisfying.' But it's been hard in the sense that nothing comes easy. *Nothing* comes easy. That's the central thing…I can take responsibility for it. For decisions I make. But whether it's my decision or whether I sense it as fate, nothing comes easily. No way. … But all in all, everything is very fulfilling, and perhaps more than that…Even though it sounds polarized or paradoxical, I think that all in all, my life is wonderful, that is, I feel good about it.

Sara had never thought about how to describe her life. "Interesting question…What comes up is an Italian film…smells of a kitchen; laughter versus tears; hugs and beatings. I think it's all opposites, a reality of opposites…What was really missing in my life is balance, balance." She felt that her ability to write has kept her going. "I keep a diary as a life testimony."

Ruth considered herself first and foremost "the daughter of Holocaust survivors." She didn't really know how to describe her life but then offered: "Perhaps strength, pain and necessity." When I remarked that those were very "basic words," Ruth agreed and added, "weighty ones, I think. Necessity, yes." Joseph's perception of his life surprised me. "It's a success story, successful. All in all, I've had a good life. A very good life. I'm almost ready to die, as far as that is concerned. Fulfilled." My expectation had been to hear some acknowledgement of his hardship as a child caring for his mother, being beaten by his father and his social difficulties as a young adult. Instead, his attitude was one of resilience, of looking at achievements and having those color his experience.

If the interview setting can be taken as a parallel to the therapeutic dyad for a moment, then my surprise illustrates the importance of acknowledging the

person of a therapist. Had Joseph been my client, I might have found myself wondering about possible denial and the need to work through trauma, rather than naturally allying myself with his inarguably effective style of being in the world. At the same time, the question arises what it would be like for him to be a therapist of a person like me who tends to gravitate to seeking acknowledgement for the traumatic and painful.

Hanna felt that throughout her life she has drawn on the strength her childhood has given her. As a child, she felt "…very protected. I would say very cared for. I was thought of as very beautiful and smart…I grew up in a very warm environment." Unfortunately, I did not notice Hanna's apparent exclusion of her adult life in this retrospective perception, and so missed an opportunity to learn why this might be so. This omission does raise the question as to the implications for psychotherapy of the therapists' and/or the clients' choice of temporal focus, such as good or bad childhood or good or bad present.

Nell illustrated the possible emotional cost of focusing on one's traumatic history. Though she felt she had worked through her painful history and put it behind her, the interview raked everything up again. "I've thought of it all week that we were going to do this." (Nell cried but wanted to continue). "I mean it was terrible! ... It was horrible." Her intimate knowledge of the ever-present pain of extreme childhood traumatization as well as her having worked through her history and succeeded in creating a successful life might well contribute to a unique therapeutic environment in which clients too can touch the depth of their pain and expect to eventually live satisfactory lives.

Dana focused on her process in dealing with her history. She spoke of having an "internal and external" world. "Both were vital and stormy but one I protected so no one would find out. That was the internal world. And in the external world, I think I functioned more cognitively." Over time, there has been change. "There are more 'meeting points' today, the internal parts are more visible, but yes, I think that that is characteristic of me. It used to be more extreme." It would be very important for Dana to carefully monitor from which "world" she listens to her clients at any given time and how this gets expressed in the therapy.

Whereas Dana, Joseph and Ruth are all second generation, their subjective experiences and coping styles differ significantly. These three therapists exemplify the limitations of 'objective' history or mere biographical facts without exploring personal experiences. All the interviewed therapists expressed clear differences in emphasis, outlook, approach and focus regarding their personal histories and perhaps life in general. There is no reason to assume such differences would disappear in the therapy room. Hence, these too, might create *a priori* countertransference and awareness and self-monitoring are called for.

Spiritual Values

Spiritual values, degree of religiosity, religious identity were touched upon in the interviews, but in a rather "by the way" fashion. The spiritual realm has been acknowledged as an important aspect of the recovery process of trauma, including vicarious traumatization (Pearlman & Saakvitne, 1995). This warrants exploring possible *a priori* countertransference in this area as well. And although spirituality and religion do not necessarily go together, broaching the subject might arouse some discomfort especially in the mostly secular therapists living in a society where religion and politics are so closely intertwined. Furthermore, all of the family histories, and some of the personal histories include traumatic experiences as the result of anti-Semitism, which would seem to necessitate some awareness of the complex meaning of their religious identity (Chapter 10).

Dora described herself as secular and “very sensitive to any kind of dictates or orthodoxy.” However, she deeply believed “in nature and in life …it’s sacred to me." David continued the secular life-style of his parents but was extremely proud of his lineage of famous rabbis. He has also actively engaged in finding his own way of expressing his spirituality. Sara has been actively wanting to develop spiritually, searched for meaning, and considered herself religiously observant.

Ruth was raised to be secular and though perhaps a believer, she is not interested in formal religiosity. She did not speak of a role spirituality might play in her life. Hanna's family has been secular for generations. "I think that perhaps, had I been raised in a religious community, I might have been religious. But my education was very, very secular, and today, I'm also consciously more secular." She felt no need for any of the Jewish rituals. Nell had exposure to synagogue growing up, but never experienced this as helpful, neither spiritually or practically. And Dana’s parents’ families were so assimilated that they had been barely aware of their Judaism until the outbreak of World War II. In fact, she herself grew up in an anti-religious home: “Either there was no God, or God was a Nazi. You could choose.”

None of the therapists mentioned spiritual values to ease their own suffering at different periods in their lives, to ease the processing with the traumatic material with which they are constantly confronted, or as a subject to bring up in therapy. An additional area to check for *a priori* countertransference, therefore, might be automatic inclusion or exclusion of a whole realm of experience.

Summary and Discussion

There are many shared themes as well as differences in the narratives, traumatic experiences, hardships and responses of the interviewed therapists as

presented in this chapter, all of which may contribute to *a priori* countertransference. None of the therapists grew up in environments in which they could openly communicate distress, whether or not that was caused by family dynamics. They described families in which emotion was often sensed, hinted at, but not expressed directly, except for anger and aggression in the case of Sara's mother and Joseph's father. Furthermore, all the therapists experienced degrees of emotional unavailability of their caretakers, with Dora and Nell having been most dramatically and concretely abandoned as children. Dora coped well by minimizing her own suffering and perception of own difficulties while being highly empathic to the suffering of those she perceived as weaker than herself, or those with “worse” stories. Nell soon learned she had only herself to rely on, and despite periods of huge emotional and financial difficulties, she turned to psychotherapists and fought for her psychological survival. No doubt her intelligence and sense of humor were of great help. David and Hanna seemed accepting of the lack of emotional sustenance they received from their parents--perhaps made easier by awareness that this was culturally appropriate rather than personal neglect--and appreciative of their practical support. Getting on with things, taking on social responsibilities and fulfilling them seem to be intergenerationally transmitted, helpful themes in their personal lives.

Ruth, Dana and Joseph were parentified children, as so many children of Holocaust survivors, but all carried out this function differently. Dana took responsibility for caring for her sibling; Joseph became his mother’s protector and ally; and Ruth acquired skills in dissociation, perhaps to enable her to meet her parents’ need to perceive them only as loving and competent. They all still seemed to thrive in the role of caretakers and tended to keep their difficulties to themselves.

Despite the background of persecution, complicated immigration, traumatic loss and wars, the therapists’ families only acknowledged emotional problems when these demanded psychiatric intervention as in the case of Joseph’s mother and Sara’s mother’s hospitalization when Sara was already an adult. Just about all the therapists learned to take care of their own problems from an early age on and continued to do so as adults.

The interviewed therapists' lack of expressed affect at some of their own traumatic experiences was striking though some might have kept their emotions in check because of the interview setting. Nell seemed most affectively connected to her own story through most of the interview. Dana spoke of some anger towards her mother but gave no affective expression, in the interview, at having been alone and unprotected as a child with no support during major crises. While there were times in the interview during which Hanna cried, when she spoke of the loss of her newborn, for example, she seemed to mirror the practical, rather than emotional

support she received from her parents by saying nothing about the impact on her parents at the loss of *their* child.

With the exception of Nell, whose challenge was to decide which traumatic experiences to leave out in the interview as she had endured so much trauma, the therapists volunteered little about their trauma experiences and needed me to elicit their trauma histories by direct questions and engaging them in conversation. David, for example, answered in the negative when asked about traumatic loss, but then spoke with deeply felt emotion about what might well have been a traumatic loss. Similarly, Joseph thought he had not been “abused” as a child, but then went on to describe his experiences of physical and emotional abuse. And Sara professed only love, and perhaps pity for her parents, even though her mother attacked her with a knife when she was a tiny child; likewise, she found it hard to dwell on her grandfather's cruelty and abuses as she "loved him." During the interview, Dana suddenly remembered incidents of sexual harassment as a child.

Perhaps the atmosphere of the interview, my stated interest in their trauma histories, and talking about issues in different contexts helped the therapists to think of some traumatic incidents and to label others, always remembered, as the traumas that they were. This is parallel to the need in the therapeutic setting to create an atmosphere of openness and interest, minimally impeded by the therapist's *a priori* countertransference.

The therapists' stories here are rich in sources of potential *a priori* countertransference. The traumas their families and they themselves have experienced, the ways and degree they have coped, their cultural backgrounds, their communication styles, the level of societal integration, all might therefore affect their individual perspectives and resonance, and hence, the course of the therapeutic work. The following chapter will continue from this point and explore possible connections between their personal histories and their career choices, with the intention of uncovering of further sources of *a priori* countertransference.

CHAPTER 7

Becoming a Trauma Therapist Part I

Trauma work has not yet become a straightforward specialization within the mental health professions like work with psychotic clients or health psychology. In Israel, as elsewhere, professional awareness of the impact of traumatic events has been selective and fluctuating (Chapters 3, 5 and 11). Still, unlike the vast majority of their mental health colleagues, the therapists who participated in this study had decided to dedicate their professional lives to working with populations affected by the trauma of the Holocaust and/or sexual assault. This might not have been a random choice. Pope and Vasquez (1998) pointed out that, "Therapists, of course, bring something to the work they do. Each therapist has a unique personal history…" (p. 65).

It is the possible interplay between the "unique personal history," as presented in Chapter 6, who the therapists are as individuals, and their choice of profession, that is of interest to me. Analysis of the interviews with the therapists has yielded a great deal of information that offers insight into the roots for their motivation for becoming a mental health professional who specializes in trauma work, and some of the main steps they have taken towards their goal. Therefore, I will present this in two parts, in this and in the following chapter.

This chapter is divided in three main sections: The section choice of profession (1) explores the therapists' personal and family histories, and social influences, for motivating factors. The next section, (2) professional development, explores the paths the interviewed therapists followed towards their choice to become clinicians, such as academic and professional training. The third section, choice of specialty area (3) tries to uncover what might have led them to choose their areas of specialization, i.e. trauma, and specifically work with Holocaust survivors and their offspring, and victims of sexual abuse. The process of exploration of why and how they became trauma therapists will hopefully uncover further sources for *a priori* countertransference

Choice of Profession

The interviewed therapists' first step towards their current career was the choice and decision to become a mental health professional. This was not a straightforward process for everyone. And, except for the two newer therapists, Dana and Sara, they specialized in the treatment of trauma survivors only at a later stage. In order to gain understanding of underlying motivation toward their professional choices and uncover related sources of *a priori* countertransference, I will specifically focus on aspects of their family history, their own trauma histories, social support and factors such as social status and a sense of vocation.

Family History

The therapists' perception of their family history and the way it shaped them might provide insight into a possible relationship between their personal histories and their work as trauma therapists. Joseph cautioned against seeing such connections "with hindsight" when there may be no such association in fact. However, people's life experiences, the extent to which they have resolved conflicts, their age and current circumstances do, inevitably, make them shift emphasis and understanding of developments and events, and highlight some issues more than others. Furthermore, real time records were not available during the interviews. What really matters here, however, is how the therapists interpreted their experiences and observations as they were growing up, and continue to do so through to the present time.

Dora had little experience of family life growing up, except for the warmth at her grandparents' for precious few years. For this reason, she did not link her choice of profession to her family life as such. She did see a connection to the fact that the promise rewards for being a good girl were utterly crushed by the events set in motion by the rise of Nazism. Ruth immediately and unhesitatingly attributed her choice of profession to her parents' history. In her understanding, Holocaust survivors assigned their children the task of therapist as a form of protection, to "save them from the stress, depression and the emotional stress of the Shoah and the difficult experiences." She had always felt "empathy for suffering and victims" and thought it would be easier to "touch the pain of others" from whom she could maintain greater distance than from her own parents.

The other children of survivors, Joseph and Dana, made no mention of underlying parental messages to take on the role of therapist. Still, Joseph did link his choice of profession to his relationship with his mother. At an early age, he became her caregiver and later he also organized her mental health care. Dana made no reference to her parents' Holocaust experiences as direct influences on her professional choice. She noted that her enjoyment of working with people during her army service, affected her career choice.

David and Hanna were aware that their relationships with their grandparents influenced their choice of profession. David knew from a very early age that he wanted to work with old people and study medicine. He related his interest in the aged to having had close relationships with grandparents till he was well into his thirties. The rabbinical roots of his family, some generations back, of which he was both aware and proud might also have impacted his choice, although he did not say so explicitly. David considered psychiatry somewhat like:

> the mysticism of medicine….There is the clear and the hidden in psychiatry. There is the 'overt behavior' that is violent or aggressive, but there is also what is beyond it. The symbolization, the entry

> into worlds that in many ways are a little, and perhaps a lot, like the religious world.

Hanna had been expected to care for animals rather than people. "In retrospect…I think that my connection to suffering, to pain, has always been part of an unconscious narrative of mine." She did not speculate on the content of this narrative in the interview, but did point to a "transgenerational passing on of the job of caretaker" through the female line of the family. "My grandmother was a real caretaker."

All the therapists, including Dora, Nell and Sara, were aware of their families' histories and traumatic experiences (Chapter 6) and spoke of these in some detail. While they noted links between their family history and their work, especially when asked, they, with the exception of Ruth and to a lesser degree, Joseph, seemed to have attributed little impact of this on their decision to become mental health professionals. As will be seen later in the section on their trauma specialization, however, this impact has been far from negligible. The therapists may have some blind spots, or simply lack of interest regarding their possible professional motivation. While this does not imply inevitable difficulties in the clinical setting, it may certainly provide a source of *a priori* countertransference and hence, an area for self-exploration.

Personal Trauma History

Therapists tend to come from problematic families (e.g., Briere, 1989; Elliott & Guy, 1993; Follette, Polusny, & Milbeck, 1994; Hartman & Jackson, 1994; Kluft, 1994; Pope & Feldman-Summers, 1992; Ragusin, Abramowitz, & Winter, 1981). This is also true for the therapists interviewed for this study. Clinicians may relate to their traumatic personal histories in a variety of ways. Eckberg (1998), for instance, considered her "own history of violent abuse" part of her professional qualifications. "Knowing the healing process from the perspectives of both the survivor and the professional greatly informs my work" (p. 17). Hilton (1997), on the other hand, described an utter unawareness, as a young therapist, of personal needs expressed in professional life as well as "denial of my own abuse. I find this true of all the therapists with whom I have worked" (p. 73).

It would have been reasonable to expect the interviewed therapists, as clinicians interested in causality and impact of life events, to at least to some degree, attribute their professional choices to their own trauma histories and those of their families and communities. Dora did so very directly. Had it not been for her experiences during the Holocaust, she would have become an artist. But once she had reached the relative safety of a refugee camp in the Second World War, she felt she had to understand "what was really happening." She has since dedicated her life to deepening that understanding in order to ease suffering.

Nell remembered wanting to become "a child psychologist" when she was still very young and living through abuse, neglect, abandonment and upheaval. She considered this childhood wish a cry for help that went unheard at the time, and was certain that her "life story" made her "want to help people." Interestingly, Dora, too, pointed to the fact that she had had to cope on her own as a determining factor in her career choice. She thought that had she received psychotherapy "at twelve years old, I would have been able to just go ahead and fulfill my other ambitions." This would imply a belief that therapy can ultimately bring freedom of choice for people to be who they are.

Both Dora and Nell seemed to share a wish to give others the help and support that they themselves lacked as children. The other therapists made little reference to their own traumatic experiences in the context of becoming mental health professionals. As will be seen later, however, they did note personal, as well as family traumas but more so in connection to the choice of their trauma specialization.

Social Status

People may choose professional careers, including that of a psychotherapist, for the social status they confer. A desire to improve social status was indeed part of the motivation for at least two of the therapists. I had not raised the issue in the interviews, but the way this emerged in the analysis of the interviews highlights a link between personal narrative and the societal context as a possible influence on the choice of profession.

Sara was not sure whether she had really wanted to be a therapist or whether she was motivated by her "curiosity into the world of the 'other' as compared to my own." She apparently was spurred on by a desire to improve her social status and acutely perceived a social hierarchy within the mental health profession. "Being a psychologist means prestige. And a social worker is second. Really, just think about the analogy of *Ashkenazi* and *Sephardi*. I see it at a lot of points in my life, those infinite analogies." Much to her regret, her grade average precluded the option of an advanced psychology degree. Due to her artistic talents, however, she was able to study one of the art therapies. Rather than feeling pride in this, she considered herself at the bottom rung of the social and professional ladder. Dana, on the other hand, seemed untroubled by professional hierarchies. As art was very much part of her life, she chose to integrate that in her professional identity and become an art therapist. "I'm like a street kid and use anything I can, any tool I have that's part of me."

Joseph remembered that when he was trying to decide what to study at university, he wanted to achieve a position of social influence. Curiously, he did not remember why he had registered for psychology. "I was accepted, and I went." A

therapist's insecurity regarding his or her social status might well form the basis of *a priori* countertransference, then, and if not resolved, complicate work with clients who might have the desired status or are struggling to find their place in society.

Vocation

The perception of mental health work as a vocation also emerged from the interviews. Joseph explicitly spoke of a "sense of vocation," whereas David implied as much. Though he disappointed his family's expectation that he become a “civil servant,” David did feel he was continuing a family tradition of contributing to the community as, in his view psychiatry is the most “service-like” of the medical specializations.

It is quite possible that some of the other therapists followed or discovered a sense of vocation without articulating it as such. For instance, both Dora and Nell seemed to have made it their life's work to offer help that was denied them at crucial times in their own lives. While it may be coincidental that only the two men perceived their work as a vocation, it is also possible that the women were less socialized to think or speak in terms of vocation regarding their professional lives.

Encouragement from Friends and Colleagues

A person's profession is a major part of life and hence could be expected to be a very personal choice. However, I learned from some of the interviewed therapists how important encouragement and support had been in their choice to become a clinician. Sara, especially, was very aware of the impact of the vigorous pushing and encouragement of a boyfriend who believed in her intelligence and empathic abilities. "Except for him, no one ever saw anything in me." Hanna attributed her becoming a psychotherapist to one of her supervisors who believed she should be a clinician. Subsequently she "just fell into the profession." Nell only dared to fulfill her longstanding ambition and switch from non-clinical work to study psychotherapy and start seeing clients after receiving intense support and encouragement from friends and professionals she respected.

Social support both on a personal and professional level seems to have been a major factor in enabling several of the therapists to take the step to embark upon a clinical career. Their need for such support raises questions what might have held them back, and why the support and encouragement were helpful. The answers, in turn, are fertile ground for further exploration of *a priori* countertransference.

Professional Development

Professional development is, of course, an ongoing process. The focus here is on the interviewed therapists' academic and clinical trauma training. Additional aspects of professional development, such as personal psychotherapy, which so often is a formative experience for mental health professionals (Goldfried, 2001), will be explored in the following chapter.

Academic and Clinical Training as Psychotherapists

The interviewed therapists have followed different paths towards, and during, their professional careers. Their choice of program of studies and their style of career planning, or lack of conscious planning, all seem closely linked to their histories. With Dora, this was most obvious as her life was directly altered by the Holocaust. Once she had successfully fled Nazi ruled territory, she started her psychology studies which she interrupted when the War ended to work with orphaned children. She resumed and completed her studies in Israel, where she worked with different populations before specializing in Holocaust survivors and their children became an option (Chapter 11).

In contrast, David followed a smooth career track. He studied psychiatry straight after his army service and built his career as a hospital psychiatrist, eventually becoming head of his department. Similarly, Joseph progressed purposefully towards a specific clinical and academic career but radically changed specialization after encountering a highly traumatized client.

The newer therapists, Sara and Dana, needed time before they felt up to the challenge of becoming psychotherapists. Sara did her graduate training as an art therapist, which she considered an inadequate substitute for becoming a clinical psychologist. However, at the time of the interview, she was unsure whether she would continue in the profession at all. Dana put off becoming a therapist as she felt “too young.” She was most explicit about linking the personal and professional in the sense that she felt she had to first get some “life experience.” Dana did several university degrees, including a postgraduate degree in a related field, and only became an art therapist around her forties. Nell had studied social sciences, but lacked the self-confidence to compete for the clinical track. It took her many years of non-clinical work before she dared to get training as a psychotherapist.

Ruth and Hanna did full or partial degrees in different fields prior to their advanced clinical degrees. They also prepared for careers in academia. At the time of the interviews, Ruth, Joseph and to a lesser degree, David and Hanna were teaching at academic institutions, in addition to their clinical work.

Clearly, there were many differences in the career development of the interviewed therapists. In Dora's case, her whole life was disrupted and perhaps

defined by her Shoah experiences. David and Joseph's careers seemed to follow a clear course, while leaving flexibility for their continuing development. Some of the others appeared to need quite a long time in order to feel sufficiently confident to start training and working as clinicians. Their varied course of professional development could be understood against their personal stories (Chapter 6), but few made such references themselves.

Four of the eight therapists were currently also engaged in teaching and training psychotherapists, something Dora used to do as well. One can speculate whether this is related only to their personal histories or also to their being in the forefront of a new specialization. Israel's relatively small size might also make it more likely that these expert clinicians would be the ones to teach their colleagues and students even though the number of teaching positions is clearly limited as well. Whatever the process of the therapists' decision to become mental health professionals, the impact of their individual histories, personal insecurities and interests may all serve as sources for *a priori* countertransference.

Training in Trauma Work

As of 2005, no formal training in the treatment of traumatized individuals was available at Israel's universities or psychotherapy training institutes (Chapter 11). But the most recently qualified therapists, Nell, Sara and Dana had at least heard mention of trauma and dissociation during their studies. Dana, like David, also completed an Integrative Psychology program which she enjoyed but which offered no specific trauma training.

Dora started ‘practical’ work with young survivors in the chaos of post-War Europe. She only specialized in working with Holocaust survivors and their children several decades later after meeting and working with Hillel Klein (a Holocaust survivor himself who was one of the first to encourage psychotherapy with Holocaust survivors) in a group of like-minded professionals (Chapter 11). She has subsequently been training and supervising therapists and has also taught academic courses.

Hanna, Ruth, Joseph and Nell all spoke of encountering clients who had suffered sexual abuse and realizing that they would need specific knowledge and skills in order to help them. They then conscientiously set about acquiring such skills. Joseph noted the importance to his professional development of having been mentored by one of the icons in the field after he encountered his first severely traumatized client, who presented an unusual clinical picture. Apart from that, he has kept up to date on traumatology by regularly participating in international conferences and by reading extensively.

When I asked Ruth if she had ever had any specific training for working with sexual abuse, she laughed and said, “I teach it! No, I never went to a course.”

However, like Joseph, she, too, has been an active participant in international conferences. While Hanna also spent a significant amount of her time teaching and training professionals to work with traumatized women and sexual abuse issues, she made sure to continue developing her general clinical skills by adding qualifications and trainings. She placed great emphasis on the importance of keeping up-to-date with the latest trauma literature.

Once Nell decided to switch to psychotherapy, she did a clinical graduate degree and qualified as a psychotherapist without receiving any training to work with trauma. Her attempts to raise awareness of sexual and Holocaust traumas in the courses she was taking were met with little enthusiasm and even less patience. Her experience was reminiscent of Herman's (1992) description of the isolation of therapists acknowledging their clients' traumatization in settings in which this was exceptional. Nell did take many non-academic trauma trainings that were being offered in Israel over the years.

David never received any specific training in trauma work, and shrugged off questions about trauma specifically. "The subject of trauma, the traumatic experience…is so much part of the psychiatric concern. It is like, I don't know, it's as if you'd ask a surgeon about his attitude to blood. It's inherent." We did not discuss David's metaphor in the interview but it is an intriguing one. I understand it to mean that trauma is implicit in psychiatric symptoms, though not the actual focus, much as blood is inevitably present in surgery, but only gets specific attention if the patient is at risk of loosing too much of it. The challenge faced by those who specialize in working with the traumatized is that they make the implicit, explicit, the focus of work. Neither society at large, nor the profession has always been open to such a focus (Chapters 3, 5 and 11).

Dora and Joseph started their careers as trauma specialists after fateful encounters with groundbreaking professionals. None of the others could point to specific supervision or encounters that provided them with training. However, in recent years, independent courses and training workshops in techniques such as EMDR (Shapiro, 2001) and Somatic Experiencing (Levine, 1997), as well as courses in dissociation sponsored by the International Society for the Study of Dissociation (ISSD), were gaining popularity throughout the country (Somer, 2005), and many of the therapists availed themselves of at least one such course to acquire more specific tools and understanding.

Despite little or no trauma training and professional awareness, the interviewed therapists did have the openness of mind and sensitivity to notice trauma their clients endured. Many of their contemporary colleagues did not. A further finding of the interviews was the subsequent seriousness, dedication and depth with which so many therapists have taught themselves to work with trauma, and then went on to teach others. I can only presume that the way they grew up

and interpreted their own and their family's histories afforded them an *a priori* sensitivity to trauma and the integrity and courage to recognize it and try to help their traumatized clients.

Choice of Specialty Area

Preparation and training for their profession as psychotherapists, and as therapists with traumatized clients seems to have started within the interviewed therapists' families of origin against the background of their history and societal context. The question remains to what degree they were aware of such a link to their choice of specialization and articulated this directly in the interview. One way to get some sense of their particular sensitivities and interests was by inquiring which, if any, early encounter with a traumatized client stood out for them.

First Encounter with Traumatized Client

Mental health professionals inevitably encounter traumatized clients in their clinical practice, regardless of the specific populations with which they work. The question arises, therefore, what it is that makes such encounters meaningful for some and even motivates them to specialize in trauma. Was there an element in the interviewed therapists' histories that affected their ability to notice things other therapists did not, allowing them to be impacted in a different way from many of their colleagues? The actual question I asked in this context was whether they remembered their first encounter with a traumatized client. Not all of them did.

I felt a little silly asking Dora this question. She was already working in a context of traumatization during World War II and did not remember any particular client. "There were lots of times. So many times. Very serious trauma."

Ruth, who specialized in sexual abuse in addition to her work with Holocaust survivors and second generation, immediately recalled her first case of suspected sexual abuse of a minor when she was a young social worker. This was a long time before she had become a clinician and well before there was any societal awareness of incest (Chapter 11). She proudly remembered her successful struggle to get the child out of her abusive home. I could speculate that she had been sensitized by the pain of her own mother who, at the same age as the child she managed to 'rescue', was being perpetrated against with no one to rescue her. But this would not have been conscious as, at that time, Ruth's mother had not yet told her about the sexual abuse she endured as a child in Auschwitz.

Joseph did not really remember any traumatized clients prior to his first sexually abused client who suffered symptoms of complex traumatization. He recalled being "excited, confused…It was a therapy that invaded my home, my

private life, it really engaged me in different ways…Those were different responses from regular therapy…I wanted to know more and I listened and found more." He felt that his interest and absence of fear made it possible for him to commit to this population and fight for their interests outside the therapy room as well (Chapter 11). Like Ruth, he made no reference of his mother in this context, but his relationship with her might have made him exquisitely able to respond sensitively to this client.

Dana spoke of a participant in a group she facilitated who had unexpectedly chosen to work on a combat trauma. She remembered her initial apprehension. But what stood out for her was this person's ability to sense his own boundaries. "At some point, I started to really trust him. I saw that he knew how to take care of himself." Perhaps it was reassuring to her that he did not fall apart and she did not need to become absolutely responsible for this traumatized client. This experience, consciously or not, might have eased the anxiety she might have absorbed from her parents who had carefully avoided going to therapy for fear of collapse and losing their ability to remain functional.

Hanna recalled her first meaningful encounter with an incest survivor. She noted that she "had always ended up with clients everyone else was afraid to take on." This particular client entered Hanna's "heart" but also, like Joseph's client, invaded her life by her lack of boundaries. "She challenged me on every possible level, intellectually, emotionally, behaviorally...But I told you, I'm a thorough person, so in order to treat her, I started reading all the literature on incest that I could lay my hands on." One could surmise that Hanna's "inheritance" of pioneering values, her grandmother's constant care for her less able siblings, and her own sensitivity for the unspoken suffering in her family were transformed into an ability to respond to this challenging client.

David did not speak of trauma as such, but recalled a severely mentally ill Holocaust survivor among his patients when he was a psychiatry intern. The Shoah was a frequent topic in their conversations even though this was not normative at the time. David explained that he addressed the Shoah with him because of his interest in the "whole life cycle" and his need to know as much as possible about a person in order to allow for "dialogue." David did not refer to the silence about trauma in general, and the Holocaust in particular, as dictated by the culture and values his parents represented. It is quite possible, however, that he unconsciously found a way to give content to those silences.

Like Dana, Nell spoke of a meaningful encounter early on in her career that was not directly connected to her chosen specializations. Nell thought of several traumatized youngsters but focused on a distressing memory of guilt and her own traumatization as a result of having collaborated--in her experience, colluded--with the parents of a handicapped youth. She helped to manipulate that

client into making a life changing decision. "Without being aware of the details of it, I participated in having this person go through this terrible, terrible trauma. So when you asked, that's something that's been on my mind for, you know, twenty years." Possibly, her own sense of betrayal as a helpless child that resulted from the death of her mother, the disappearance of her father and the abusive treatment by her aunt rendered her experience with this client, whose trust she feared she betrayed, so full of impact and hard to forget.

The youngest therapist, Sara, who has also worked for several years with multiply abused children, surprised me by not referring to any of them. I can only speculate that her own unresolved history, which was similar to some of those children, served as *a priori* countertransference blocking her empathy towards them. However, my surprise is itself an example of my own *a priori* countertransference, in that I just assumed that an encounter with a child who has been willfully abused by an adult must be most searing of all.

Sara immediately thought of a mentally unstable participant who unexpectedly joined a group of Holocaust survivors she had been working with. This person's presence had been overwhelming for her. "That, actually, was the first time I felt the power of trauma."

All therapists in Israel, whether or not they specifically work with trauma, are likely to have clients who are Holocaust survivors, children of survivors and, of course as elsewhere, people who have endured sexual abuse. What made the interviewed therapists different from so many of their colleagues was their sensitivity to those traumatic histories and their decision to explore further, train themselves and change their professional identities. Though they did not necessarily draw the parallels themselves, the encounters that proved to be professionally formative experiences for them clearly seemed to offer them opportunities to correct or complete traumatic memories from their families. In Sara's case, the meaningful encounter she spoke of enabled her to fully realize the impact of trauma, something she had had to learn to minimize or ignore in order to get through her childhood as intact as possible. Nell's formative encounter was one that shocked her when she realized she had unwittingly sided with the instigators of the traumatic event. Both Hanna and Joseph responded deeply to their first client with complex posttraumatic symptoms, but their descriptions of their responses illustrate how highly individual sources for *a priori* countertransference can be.

In order to perhaps find additional sources, it is worth exploring further whether Pearlman and Saakvitne's (1995) perception that therapists rarely "enter the field of trauma therapy with full understanding of the implications of their choice" (p. 279) also holds true for the interviewed therapists. It would be interesting to see whether there is a connection between their life stories and their sensitivity, openness to the (specific) traumas in which they specialized.

The Traumatized Client Populations

The first, possibly formative, encounters with traumatized clients had decisive effects on many of the interviewed therapists' careers and choice of specialization. Focusing on the characteristics of the populations with which they chose to work -- Holocaust survivors, their children and survivors of sexual assault -- may help to gain some understanding of what might have drawn the interviewed therapists to these clients rather than remain in general clinical practice, as did most of their colleagues.

Holocaust Survivors.

Israel was not unusual in its ambivalence towards Holocaust survivors (De Swaan, 1999; Segev, 1994; Chapter 3). One complicating factor was that many Israelis lost family and friends that, unlike themselves, had not been able to "get out in time" (Solomon, 1995b) and thus perished in the Holocaust. Both those who had "got out" and made it to Palestine "in time," and those Jews who had already been living there, went through very hard times themselves. This fact might have contributed to their relative insensitivity to the survivors. In his autobiography, the author Amos Oz (2002) gave a unique perspective on the layers of traumatic human experience that went into the foundations of the Jewish State and the particular hardships these people endured at the end of the British era and the early years of the foundation of the State of Israel. They were the "lucky" ones who came to Israel prior to World War II. They were also the ones who, in addition to the loss of their families who stayed behind and the danger and poverty they endured under the British Mandate, fought the War of Independence that was intended to push all the Jews out of the area. Subsequently, they also had the task of absorbing huge masses of immigrants and helping them integrate into a rapidly evolving society (Chapter 5). Among them were Holocaust survivors and refugees from Arab countries, all with their own hopes, needs and expectations of Israel, all with their own languages and customs, all with their traumatic histories and experiences.

The interviewed therapists were all directly or indirectly connected to the Holocaust. Dora was a child survivor of the Holocaust as were Joseph's, Ruth's and Dana' parents. Hanna's father and his family had fled Europe in time. It was only very few generations back that Nell's, David's and Hanna's families fled *pogroms* in Europe and so saved their offspring from having to go through the Holocaust. Sara's family in North-Africa endured vicious anti-Semitism, and had the War developed slightly differently, French-ruled North-Africa would most likely also have delivered its Jews to the extermination camps. Both Nell's and Hanna's fathers had enlisted to fight in World War II. Hanna's and David's families would, together with the other Jews living in British-ruled Palestine, have shared the fate of

Europe's Jewry, had Rommel's army not been stopped in Africa by the Allied Forces.

Neither Dora nor any relatives of the other therapists had received therapeutic help to process their Holocaust traumas. Dora, who had a hard time recognizing the extent of her own Holocaust traumatization, was very aware of her husband's traumatic Holocaust experiences. What seemed to have drawn her to work with survivors, decades after the War, was her perception of them as most in "need of empathy, therapy and attention." With this she meant "to really understand what's absolutely missing there." Joseph and Ruth grew up as caretakers of their very vulnerable, damaged child survivor parents. This population, too, rarely had psychotherapy (e.g., Cohen, Brom, & Dasberg, 2001; Mazor, Gampel, Enright, & Orenstein, 1990).

Whereas they might have wanted to give the help neither they themselves nor their parents ever received, David had apparently no personal reason for his career choice. He stated that he had specialized in working with Holocaust survivors because "the overrepresentation of Holocaust survivors in psychiatry of old age in Israel is an epidemiological fact…In their old age, they become more ill. …Old age is a *dreadful* time for survivors."

David's associations and sense of obligation to survivors are intimately linked to Israel and its history, and in this he appears to be reflecting his family's traditions and values. David made no explicit links to his family's history which has known persecution as in the case of his grandmother who survived a *pogrom* and the rest of his family of that generation who had fled *pogrom*s; it is also permeated by a sense of responsibility for providing safety for Jews, as in the heroism of both his parents, especially his father, during Israel's War of Independence.

David was very aware that Holocaust survivors made up a substantial part of the population at the time of the creation of the State of Israel. He also felt that the Holocaust made the threat to survival of the all Jews explicit: "Civilized people who twenty years earlier had composed concerts, twenty years later burned Jews..I think that the place of this country has become a lot clearer." David might have wanted to correct this neglect of his parents' generation: "…that generation didn't want to hold that dialogue. Perhaps they were not able to. They were busy establishing a nation."

But for all his remarkable sensitivity and willingness to go against current fashions and interests by dedicating his professional life to Holocaust survivors, David did seem to have a blind spot about both the numbers of child survivors of the Holocaust and the levels of distress from which they suffered. He noted the diminishing numbers of Holocaust survivors in Israel but was dismissive when I reminded him of the child survivors who were beginning to grow old.

Hanna's father, whose family escaped with him soon after the rise of Hitler, belonged to a population rarely mentioned in the Holocaust literature (Tauber, 1998). The refugees' stories remained largely untold so far. Perhaps it was no coincidence that Hanna had read "obsessively" about the Shoah as a youngster and so "enjoyed taking testimony" from Holocaust survivors when she was working with the elderly early in her career. For a time, she also worked as a therapist at a center for Holocaust survivors and their children (Chapter 9).

Nell, too, enjoyed working with survivors for a time (Chapter 9) and has remained aware of the second generation among her clients. She has always felt a close personal connection to the Holocaust. In fact, though she did not come from a Holocaust survivor family, as a young child she believed herself to have been "a child who died in the Holocaust."

Sara's conscious motivation to work with survivors did not appear to extend beyond her pleasure in being part of the team of colleagues she joined as an intern. She did, however, speak of the prejudice against Holocaust survivors she had absorbed from her family and neighbors who had emigrated from North Africa. "Those *Ashkenazim*, they just came here after the Shoah and think they deserve everything! They didn't really have such a hard time. All sorts of things like that." She also still felt troubled about her share in harassing a Holocaust survivor neighbor when she was a child (Chapter 6).

Second Generation

Does the same motivation for work with Holocaust survivors hold true for work with their children? In Israel, this was generally not a population that was perceived as having distinctive characteristics. Still, children of Holocaust survivors may have been traumatized by transmission of the trauma itself and/or inadequate parenting by emotionally injured and depleted parents. Hoffman (2004) suggested that the "second generation's story is a strong case study in the deep and long-lasting impact of atrocity" (p. xvii). Many were burdened by their parents' inability to mourn their huge losses (Shoshan, 1998). But they are a different population than their parents and demand different interests and abilities in therapists. Grubrich-Simitis (1984), for instance, remembered how, initially, the second generation were not seen as having specific needs. She encouraged therapists to initiate exploring the family's Holocaust experiences if the second generation clients did not do so themselves.

By now, a rich literature exists, exploring and highlighting different aspects of second generation issues (e.g., Brom, Kfir, and Dasberg, 2001; Kogan, 1995; Solomon, Kotler, and Mikulincer, 1988; Tauber, 2003; Wardi, 1992; Yehuda, Schmeidler, Wainberg, Binder-Brynes, & Duvdenavi, 1998). The easy sense of kinship and shared experiences that exists so frequently among children of

survivors also characterized ongoing, open group meetings we held for them at Amcha (Van der Hal, Tauber, & Gottesfeld, 1996).

Second generation clients can be found among any client population and not necessarily turn to therapy with Holocaust related issues. Among the interviewed therapists, it was mainly Dora and Ruth who specifically focused on work with this population. Hanna, Nell and Joseph were aware of them in their practice, though Joseph tended to pay little attention to the impact of the Shoah and more to the results of inadequate parenting, despite the fact that he himself occasionally had Holocaust-related dreams. Dana made no mention of the possibility that some of her sexually abused clients might also be second generation.

Dora made working with Holocaust survivors, and especially their children, who often found it hard to acknowledge their own trauma and hardship, her life's work. She felt strongly for the second generation who had placed their own development and needs secondary to those of their parents. She wanted to free them of the shackles of victimization and helplessness – much as she had fought for herself. Perhaps she was able to complete or correct their parenting and so work through her own absence of parental support which she had experienced after her family had become refugees prior to the outbreak of the Second World War (Chapter 6).

Ruth has done extensive clinical work and research with children of survivors and issues concerning the survivors themselves. In a similar fashion to Dora, she might have been able to vicariously address some of her own second generation issues while helping her peers. Thus both Dora and Ruth seem to have found ways as clinicians, to give meaning and use to their own hurtful experiences.

Sexual Abuse

Sexual abuse is one of the most secret and controversial forms of traumatization (Chapters 10, 11). And like (children of) Holocaust survivors, sexual abuse survivors often do not seek specific treatment for their traumatization, but turn to 'regular' psychotherapists for help with general difficulties. David heard many stories of abuse from his Holocaust survivor patients while exploring their "whole life cycle."

Therapists must meet the challenge of creating an environment of trust so that abused clients can dare to speak of the horrors they had to endure in isolation. The therapists' belief and acceptance, rather than critical searching for truth, seem crucial (Chapter 9). Sexual abuse, and particularly incest, is shockingly widespread (Courtois, 1988; Davies & Frawley, 1994: Draijer, 1990; Herman, 1992; Russel, 1986), but attempts are being made to push awareness back into the shadows (Dalenberg, 2006; Dallam, 1998, 2002). In recent years, the suppression seems to be the result of the vigorous efforts of organized parents' groups, and those who

dedicate themselves to preventing accused parents from being convicted in courts of law (Slater, 2004). A thorough report regarding disputed memories which was submitted to the Dutch government (Health Council of the Netherlands, 2004) by a highly qualified group of experts in the field, acknowledged that sexual abuse of children is widely underreported. The report recommended that therapists maintain an attitude of open-minded listening, i.e. that they not decide in advance that everything their clients say is exactly what happened, nor take a stance of suspicion and demand for proof. Shapiro (1997) posed that awareness of sexual abuse is so threatening because it "knows no racial, cultural, religious, or class bounds" (p. 105). Work with sexually abused clients therefore, implies not only exposure to secret horrors clients endured, but also taking a stand professionally and perhaps socially (Chapter 11) which might have serious repercussions on the therapists' lives.

Is there anything in Joseph's, Ruth's, Dana's Hanna's and Nell's backgrounds that can help to understand why these therapists should have chosen to specialize in working with this population? Two of these five therapists, Dana and Nell, had endured sexual assault and abuse as a child or adult. Two others, Joseph and Ruth, had sensed that their mothers had been sexually assaulted as children. Biographical facts by themselves do not predict professional choice, however. Hanna was not aware of any sexual abuse in her family at all while Sara, who herself had been sexually abused, did not feel drawn, in the interview, to even speak of the sexually abused children she had worked with, nor did she wish to continue that work. However, though sources for *a priori* countertransference may be general--family background could be one source--the content of each person's *a priori* countertransference is highly individual. So perhaps influential factors could be traced for each therapist. It is noteworthy that four of the five clinicians working in the field did have direct or indirect personal connections with the subject.

Dana's parents required less emotional caretaking than Ruth's and Joseph's parents, but seemed to have had difficulty in parenting. Dana perceived them as unavailable to her when she was in distress and she learned to remain silent (Chapter 6). This was especially acute after suffering sexual inappropriateness as a child--she realized in the interview that she had forgotten two incidents of sexual molestation--and after being raped as a young adult about which had kept silent at the time. Perhaps these experiences increased her responsiveness to sexually abused clients whom she worked with, initially, as an intern. While Dana had not consciously chosen to work with sexual abuse and incest, she realized this was meaningful work for her. She wanted to continue working with this population but had not yet decided whether sexual abuse was going to be her major or only area of specialization.

Nell had always been aware of having been sexually abused by a relative as a small child (Chapter 6). She also experienced the professional deafness of her therapists (Chapter 8). She would mention that she had been sexually abused but "it wasn't picked up. And the fact of the matter is, it was a subject I never could touch." During the time of her graduate studies, she immersed herself in the subject and "sort of did self-therapy....In the end, I became an expert on the subject and I also worked through my stuff."

Ruth realized that her parents' trauma history not only led her to focus professionally on the Holocaust but also on sexual abuse even though her mother told her of some of her experiences of sexual abuse only during their recent visit to Auschwitz. It was then that Ruth understood the source of her "preoccupation with sexual abuse in childhood…apparently, something in her anxiety got passed on to me." Joseph's mother had endured similar traumas and was the parent that needed his caretaking. His experience, or his interpretation of his experience, was one of boundary violation, of being a "parentified child." He referred to his relationship with his mother as "sort of incestuous but then the other way around."

Hanna, like David in his way, continued the family's heritage of pioneering by breaking new ground professionally in her specialization, and actively setting up new projects. Hanna has done this with her work in raising awareness on the subject of violence against women and in training professionals to work with sexual abuse. She assured me, in response to my repeated questions about possible traumas she might have experienced, that her specialization in trauma work, initially with Holocaust survivors and then with sexual abuse, was "pure accident" as she has no personal trauma history. She did say that she had never intended "to work with trauma but I found that I've been working with it for at least fifteen years. I think it comes from my basic understanding of people in general, that guides me in those directions." She added, "I think I'm led intuitively to all sorts of places, while I don't think too carefully how I get there." Perhaps there was some parallel process in effect during in the interview as I did not lead her more specifically in an exploration of the possible impact on her choice of work of the fact that her father and his family had had to flee the Nazis, that her father might have had traumatic experiences as a soldier in World War II, and her own traumatic loss of both her baby and her sibling (Chapter 6).

The specializations the therapists have chosen offer them all an opportunity to complete the untold stories of family and social traumas (Davoine & Gaudilliere, 2004). They have all brought different aspects of their biographies and personality styles to their work. David, for instance, seemed to continue his parents' share in their fight for the independence of the State of Israel as a refuge for all Jews, most urgently so, survivors of the Holocaust. Ruth has found ways to creatively and effectively deal with different aspects of her own and her parents'

suffering; whether in her sensitivity to physical abuse (second generation) and sexual abuse -- echoes especially pertinent to her mother's childhood traumas; her focus on the second generation generally, which gives her a chance to work through personal issues and let go of the need to protect the 'parents;' and her research, which provides her with additional understanding of her family history. Hanna seemed not only to have taken on the family's legacy of pioneering and taking up challenges, but has specialized in sexual abuse victims whose suffering so easily remains unseen and unmentionable. In this way she perhaps illuminated her own family's traumatic history that has remained in the shadows to this day.

Summary and Discussion

Neither the interviewed therapists' own statements nor the analysis of the interviews could ever justify a claim that their professional choices derived exclusively from their personal histories and traumas or those of their families. What I hope to have demonstrated, however, is that these therapists' choices and motivation for their work are rooted in the ways in which they experienced and interpreted their families' and their own histories and the societal context.

This became apparent during the interviews when we discussed their trauma specialization and set a clearly stated “trauma context.” Only then did the therapists more readily, and in more detail, refer to their own traumas. In fact, one of the lessons I learned from the interviews was the importance of context, or setting--which in this case included my expression of interest and expectation of openness, and the importance of repetition and approaching the topic from different angles in order to allow for dialogue about personal traumatic experiences. As we elaborated details and highlighted different aspects, relevant information about the therapists' personal and family histories and about possible links to their underlying motivation towards their professional choice flowed more freely.

All of the therapists' family histories were steeped in persecution and existential threat, starting from the *pogroms* in Eastern Europe, through, of course the Second World War and the Holocaust, to dangerous anti-Semitism in North Africa. The therapists were all touched by these events, whether directly or by intergenerational transmission. Traumatic experiences did not cease upon arrival in Palestine or later, in Israel. Several therapists' parents fought in the War of Independence, and later, siblings, the therapists' themselves, their spouses and their children, were either in the army during war, or ready for call-up. In addition to historical and national traumas, they endured traumas such as verbal, physical and sexual abuse, various degrees of neglect, illness and traumatic loss.

The family dynamics of many of the interviewed therapists included reversal of the caretaking role. Ruth and Joseph, for instance, took on emotional responsibility for their mothers. Tauber and Van der Hal (1998) noted the ultimate impossibility of success of such a task which can lead to a sense of being, what we called, "defeated children." Other therapists suffered a different lack of parenting (Chapter 6). Sara and Nell survived multiple abuse and severe neglect. Nell, however, grew up believing that children could, and should, be helped; perhaps the early years with her mother and the "enlightened witnesses" (Miller, 2001) she fortunately encountered (Chapter 6) enabled her to trust that there was support out there in the world.

Kottler (2003) posed that people chose to become mental health professionals out a desire to be voyeuristic, have control, appear smart and demand respect. Analysis of the interviewed therapists' narratives, occasionally helped by explicit connections they made themselves, did not show these factors to be prominent. And a desire for social status or a sense of vocation only partially motivated a few of the therapists. The question of status seemed irrelevant by the time they entered the field of trauma therapy which, especially with people traumatized by the Holocaust and sexual abuse, was an unpopular and undeveloped field.

Others might have taken a sense of vocation for granted, however, or, like Dora and Nell, considered that part of their own healing. Trauma work provided the therapists with a welcome opportunity to (finally) be effective in relieving suffering. The therapists' personal histories were also reflected in their attitudes towards the social status of their profession. Dana and Sara's different attitudes toward their being art therapists demonstrated this well. Dana liked the chance to utilize her many talents while Sara remained acutely aware of belonging to the bottom of the Israeli hierarchy of mental health professions.

A few therapists attributed their clinical and trauma career to chance. They seemed hesitant to take conscious responsibility for their choices, though upon reflection, they did not deny an emotional and historical logic. They offered no explanation for these "unplanned" choices. I hypothesize that a family background of upheaval, such as having to flee one's country of origin, and intra- and extra-familial traumatization may well induce a sense of insecurity, lack of self-confidence and perhaps some survivor guilt. This, in turn, might pose obstacles to wholeheartedly pursuing personal and professional self-fulfillment. Similarly, an additional finding from the interviews was the importance of encouragement and support by friends, supervisors, mentors or peer groups, in making the choice to become a clinician or to work with traumatized clients.

Once the interviewed therapists started working with trauma however, their dedication and commitment--perhaps with the exception of the relative new-

comers--were unwavering. In the absence of formal trauma training within the academia, they taught themselves by immersing themselves into the relevant literature, by peer consultation, attending trauma conferences and studying specific approaches whenever courses were available. Most of them then went on to teach and train colleagues. In this too they reflected and continued family values and styles of coping with trauma.

The first meaningful encounters with traumatized clients the interviewed therapists reported were particularly enlightening. These vividly illustrated how the therapists resonated, on both a personal and professional level, with these clients' particular situations to the extent that they dedicated their subsequent careers to trauma work. In Nell's case the link was not so much with the clients' particular trauma as with her own attitude, her awareness of the need to protect boundaries and maintain the utmost respect for the needs and integrity of each individual, however damaged or dysfunctional. Some of the echoes of the therapists' own struggles and histories were obvious to them, others became apparent either during the interview, or to me, in the later analysis.

Analysis of the interviews made clear that mere facts, whether pertaining to their own and their family's histories or to the socio-cultural context, do not explain the motivation for the therapists' professional choices. At times the therapists explicitly shared their awareness in the interviews of how they experienced and interpreted those "facts;" at other times, it was possible to deduce or imagine those interpretations from the tone and content of their words.

The interviewed therapists all clearly brought aspects and echoes of their own conflicts and trauma histories into their work through which they hoped to relieve the suffering of others, whether or not this was similar to their own. There were shared themes as well, such as family dynamics, social support, a wish to correct, ”coincidence” and a pervasive context of traumatic circumstances and events in their own and family's histories. Regardless of the topics they touched upon in the interviews, they clearly illustrated how vital it is to acknowledge the person, the individual, in addition to, or as part of the professional, and how easily expectations, attitudes, ways of perceiving can accompany the most well-meaning therapist into the therapeutic encounter.

All the aspects of the therapists' histories, their perceptions of trauma, the reasons why, and the way in which they entered the profession and became trauma therapists, provide fertile ground for *a priori* countertransference and can serve as starting points for self-exploration. In the next chapter, I will continue exploring formative experiences and perceptions that may have affected the interviewed therapists' choice to become a trauma therapist.

CHAPTER 8

Becoming a Trauma Therapist Part II

The very choice to become a mental health professional who then specializes in trauma work, and the reasons motivating that choice, may contain significant sources for *a priori* countertransference. In the previous chapter, I have explored processes that led the interviewed therapists to their choice of profession, their academic and professional training as well as encounters with traumatized clients. In order to uncover further sources for *a priori* countertransference, the focus in this chapter is on additional routes of self discovery, exploration and preparation the therapists have engaged that might have affected their choice of profession and specialization. The first section deals with their experiences as clients in therapy and what possible sources of *a priori* countertransference these may reveal. In the second section, the focus is on possible sources for *a priori* countertransference in the therapists' actual perception of trauma and of ways of coping with trauma.

Personal Therapy

Congruent with the view that the therapist as a person (Chapter 6) and the therapeutic relationship (Cloitre, Stoval-McClough, Miranda, & Chemtob, 2004) are essential, integral parts of the therapeutic process, the therapist's own therapy may certainly be considered worthy of exploration within the context of *a priori* countertransference. It is not only a necessary but perhaps a formative experience in shaping professional approach, listening ability and perception (Goldfried, 2001; Norcross, Geller, & Kurzawa, 2000; Pope & Tabachnick, 1994). For instance, Kowsun (1999) considered her varied experience as a client dealing with traumatic history part of her professional training.

Therapy offers the therapist(-to be) the opportunity not only to work on personal psychological injuries and difficulties but also to experience being in a position of need and dependence and hopefully receiving, rather than providing, empathy and help. Furthermore, as a client he or she is exposed to the vulnerability and risk of trust building that is conditional for the success of any psychotherapy.

Still, two out of the eight interviewed therapists, Ruth and Joseph, never really experienced the psychotherapeutic process as clients. Ruth's very long-term relationship with a supervisor made her feel that she did not need therapy. She did not dispute the importance of therapist self-awareness but, perhaps true to the independence she learned as a daughter of (child) survivors, she was confident she could go it alone. "I do a lot of work on myself. I'm absolutely convinced that a person who doesn't work on himself…can't be a good therapist."

Joseph received no psychotherapeutic help when he was a boy despite the difficulties at home (Chapter 6). Therapy was not part of the general culture and "it would have been an admission of failure if they'd sent me to therapy." As a student

returning from the Yom Kippur war, apparently suffering from posttraumatic stress, he did start seeing a therapist. But, not surprisingly at that time (Chapter 5), this was not appropriately addressed and he soon stopped therapy. Joseph later participated in a group that was run along the lines of Humanistic psychology. However, he was troubled by "a lack of boundaries." A subsequent attempt at analytic therapy was very short-lived. Joseph did not think he would try again. "I have hang-ups that are to do with my mother. I'm sensitive, a bit vulnerable, but basically, I think I'm quite a balanced man."

Ruth and Joseph both seemed to have learned early on, to rely on their own intelligence and coping skills, and have not felt a need--they never said they had felt reticent or afraid--to engage in a relationship of trust and reliance on the availability and understanding of a therapist. Dana perceived herself as an "open person," but she too had always kept her own worries, unhappiness and fears to herself. "My whole life, I've been exploding inside." Eventually, however, in her thirties, after a marriage to a "non-talking" man, she started group therapy as that "demands less exposure." She felt grateful to those who pressured her to risk opening up. Upon completing her art therapy studies, she had several years of individual psychotherapy that was very meaningful to her. She was hoping to return to therapy as soon as she could afford to do so.

Dora sought therapy when she already had children and was working, and regretted she was only able to afford it for a few years. But it had helped her understand "things in greater depth, and it became clear that I really wanted to treat people. I wanted to use that understanding to treat people." Some time later, she joined "other young colleagues" in an "eclectic" group therapy. This group enabled her to "lead groups later" herself. Dora was the only one to clearly link her own therapy experiences with her desire to be a therapist.

David was very matter of fact about his lengthy therapy experience, which he considered necessary both professionally and personally. He had started therapy as an intern, which was normative at his hospital. Over the years, he occasionally returned to therapy with a specific issue for a limited number of sessions. David also enjoyed being part of a group while doing his integrative psychology training.

Hanna went through several courses of therapy: for help mourning the loss of her baby; for marital problems; and the last, long-term therapy, which she described as "the major therapy of my life." She stopped when she had a sense that she had achieved what could be achieved, but "to tell you the truth, if I had a choice, I'd spend my whole life in therapy. I need someone to talk to...My women friends are wonderful and close and I love them, but I can't talk about everything with them."

She raised the interesting point of the purpose of therapy. People seek therapy for a multitude of reasons ranging from seeking relief from extreme

distress, to curiosity, gaining awareness and personal growth, to professional training. But perhaps, an additional reason is the one Hanna expressed here, a search for intimacy, a safe place where everything can be discussed.

Nell saw her first therapist when she was in college. Over the years, she participated in group therapy and further courses of individual therapy. She remembered all her therapists with gratitude and acknowledged different gifts from each, such as warmth and being challenged towards self-responsibility.

Sara, who has also had multiple courses of psychotherapy, never really felt helped. The first therapist she saw, as an adolescent, was a kind man with whom she still has occasional social contact. But subsequent therapists proved unsatisfactory. Some made genuine attempts to build an empathic relationship with her, others less so. Sara despaired of the ability of psychotherapy to heal her wounds and ease her distress. A few years ago, she left her last therapist because she felt she had not really changed and had remained "self-preoccupied, so focused on myself!" Instead, she decided to have a child. "Things aren't simple, especially with regard to identity, identity, identity, identity."

The children of survivors, Ruth, Joseph--both whose mothers were children in concentration camps--and Dana had learned, like many of their peers, to keep quiet about their distress and try to solve their own problems (Chapter 4). Dana eventually sought individual therapy as she was getting ready to become a psychotherapist herself, and has since cherished the value of the experience.

Except for Sara, the therapists who had psychotherapy felt that it had been of great personal benefit and that it was salient to their own clinical work. Joseph and Ruth expressed no personal need for psychotherapy and seemed not to consider it an essential experience for psychotherapists. The clearest impact of personal therapy on professional development might be that of Sara's case. Though she did not make the point herself, it would seem quite possible that her sense of disappointment in her own therapists, and not really feeling helped, was a factor in her current uncertainty whether or not to continue in her profession. The interviewed therapists' responses seem to indicate that therapists could usefully explore whether their personal therapy histories and experiences might give rise to specific expectations of their clients, and hence to *a priori* countertransference that might affect their ability to be present for their clients.

The Interviewed Therapists' Responses to Their Therapists

I was hoping to get further insight into who the interviewed therapists were as people--and so uncover further sources for *a priori* countertransference--by their responses to their own therapists: which qualities they experienced as helpful, which approach, and perhaps what importance they attached to their gender or ethnic background. We discussed these issues in the interviews in order to explore

how, if at all, their personal narratives and motivation were reflected in their responses and perhaps to gain some insight as to how they perceive their own roles as therapists.

Therapeutic Approach.

Without minimizing the importance of therapeutic approaches, there is a growing literature emphasizing the impact on the outcome of the therapeutic process by the person of the therapist and the therapeutic relationship (e.g. Ackerman & Hilsenroth, 2003; Garfield, 1997; Garfield & Bergin, 1994; Lambert & Barley, 2002; Norcross, 2002; Pearlman & Saakvitne, 1995). Still, one might expect psychotherapists who speak of their personal therapy from the perspective of modeling and out of professional appreciation, to emphasize their therapists' clinical approach and skills.

This was not the case with the interviewed therapists, although some did mention their approach. Dora, for instance, saw a psychoanalyst who as she noted, had been a somewhat rebellious student of Freud's. At the time, psychoanalysis and psychoanalytic therapy were the only options available in Israel. Nell stated categorically that she would "never" choose a psychoanalytically oriented therapist like the first therapist she had seen. But she knew then that she had to deal with the past. "We talked a lot about my mother and father and about my childhood." But whether or not the interviewed therapists mentioned their therapists' professional approach, they did not say anything about approach or techniques as a factor that made the therapy successful for them. They seemed to confirm findings (Lambert & Bergin, 1994; Beutler et al., 1994) that clients value personality style and characteristics such as empathic ability and intelligence over therapeutic approach and technique.

Important Personal Qualities in Own Therapists.

What did stand out for all the interviewed therapists as highly significant was their therapist's capacity for empathy and warmth, which Buckley, Karasu, and Charles (1981) had found to be essential to effective therapy. The therapists also valued their therapists' intelligence, trustworthiness and personality. Sara seemed, as yet without success, to look for a mentor in her therapist, someone who embodied qualities and characteristics that could provide a personal rather than professional model for her.

Therapist's Gender and Age.

Some of the interviewed therapists, such as Sara, Hanna and Nell said they preferred to see a man or a woman at a given time, and gave different reasons. However, on the whole, what seemed to matter most were the personal qualities,

rather than the gender of the therapist, which strengthens Tallman & Bohart's (1999) findings that it was the personal qualities of therapists that made them effective.

The therapist's age seemed even less of an issue. None of the participating therapists, themselves ranging in age from their early thirties to early seventies, mentioned a preferred age for their own therapists. Dora had noted the very advanced age of her analyst more as a curiosity than as an issue. It is, of course, possible that the interviewed therapists did have some idea of a desired age range for their therapist, but they did not make this explicit and I did not specifically ask.

Socio-cultural Background of Own Therapists.

Cultural similarity between clients and therapists might be beneficial (Beutler, Machado, and Altstetter Neufeldt, 1994). Kortman (1995) pointed out that too great a difference in socio-cultural backgrounds of therapists and clients can negatively impact the ability to be empathic. However, it is worth keeping in mind that, as Wohl (1989) put it, “Similarity is not identity; each person carries a unique version of the ostensibly same culture… There is always a cultural gap to be traversed” (p. 343). It is noteworthy that in a country that is made up of people from so many different countries and cultures of origin as Israel, the interviewed therapists made almost no mention of the socio-cultural backgrounds of their therapists. Only Sara regarded that background as a matter of importance and relevance; she despaired of her kind "Anglo-Saxon" therapist's ability to really understand her. The fact that the other therapists did not mention their therapists' socio-cultural background suggests an internalized *a priori* attitude which was prevalent in Israel, that of officially ignoring individual differences.

I was particularly struck by the fact that the interviewed therapists had not sought out therapists with a trauma history, particularly one similar to their own. This might indicate that their own trauma histories were not the intended focus in their therapy. Not one of the other therapists said that they even knew anything about their therapists' trauma history. Only Ruth mentioned that her 'therapist substitute', her long-term supervisor, was a Holocaust survivor, a fact that had been significant for both of them.

The Importance of Trauma in Own Psychotherapy.

The interviewed therapists' descriptions of their psychotherapy offer some insight into their attitudes towards their own, and possibly their clients', traumas. Hanna said she had felt helped at the time of her traumatic loss but Nell noted that her sexual abuse was never processed in therapy. Even if she did mention it, none of her therapists did more than hear her say it. None of the other therapists mentioned whether they had been able to work on their trauma histories in their

personal therapy. When I asked Dora specifically, she said that her Holocaust experiences had remained outside the focus of her analysis, but understood that as to be the norm at the time (Chapters 3 and 5). This has not been an uncommon experience of survivors and their children (Tauber, 1998) especially in the first three decades after the War.

The interviewed therapists clearly demonstrated aspects of their personality styles and attitudes to the psychotherapy they had, and also those they did not (choose to) have. And although some did note the professional benefit they gained from having been in therapy, they mostly described their experiences on a very personal level as having disappointed or satisfied their personal needs.

There seems to be no reason to assume that such individual differences disappear in their clinical work. I therefore repeat the main theme of this work, that it is of the essence that therapists monitor their emotions, thoughts, expectations related to their personal therapy experiences and so increase their awareness of possible *a priori* countertransference. A specific example is a therapist who, like several of the interviewed therapists, does not expect their own therapist to take an interest in his or her traumatic experiences and is not able or willing to insist on working on them in therapy. Monitoring possible *a priori* countertransference would reduce the likelihood that he or she would be "deaf" to specific traumas, or perhaps on the contrary, overly enthusiastic in pursuing this avenue, not necessarily in attunement with the client's needs.

Perception and Definition of Trauma

As the whole person of the therapist is engaged in the process of psychotherapy, rather than a neutral, non-involved professional carrying out professional techniques, one may safely assume, as documented throughout this dissertation, that individual therapists have unique ways of perceiving trauma. Their subjective formulation might certainly be expected to influence how they listen to clients' accounts of traumatic events, and what they hear. Pearlman and Saakvitne (1995) noted the omission in psychoanalytic literature of therapists' personal meaning of trauma. In fact, it would seem that such omission might more generally be obscured by the focus on professionally useful and acceptable definitions.

It seems imperative to explore how individual therapists perceive of, and define trauma. As can be learned from the personal therapy of the interviewed therapists, perception and definition of trauma, as well as coping styles, may determine the experience of trauma survivors, the therapists who work with them, and the ensuing psychotherapeutic process. Furthermore, in trying to understand their underlying motivation for specializing in trauma work, it makes sense to know

what the interviewed therapists actually perceived as trauma, and how they defined it; to discover whether they would adopt the professional definitions prevalent in the literature or whether they would come up with a definition reflecting their personal narratives, styles and issues. An additional vital question with regard to possible *a priori* countertransference is whether they linked their perceptions and definitions to their personal histories and possibly as having motivated their choice of profession.

Dora's account of some of her Holocaust experiences highlights aspects of the, perhaps adaptive, difficulty of recognizing trauma as it is occurring. Most illustrative is her experience of being stuck on a mountain ledge with her family having hastily fled to the mountains after being told the Gestapo was on their trail. They spent a night fully cognizant of the likelihood that they might die there (Chapter 6). For years she related to this experience as exciting rather than traumatic because, against all odds, they were rescued. It might have been very complicated and perhaps counterproductive for anyone, contemporary or not, who heard Dora's adventure-like version to prematurely attempt to allow for the possibility that this had been a traumatic experience. Decades later, she came to the realization that this had, indeed, been traumatic for her.

Perceiving events as traumatic might then be a factor of time, of hindsight and societal confirmation, such as the community's ignoring the serial molestations of young girls by a neighbor, which made it almost impossible for Sara to fully acknowledge what had happened to her, and how it had affected her (Chapter 6). Perception of events as traumatic might also depend on personal maturation, as in the case of Ruth who by the time of the interview, recognized the traumatic impact of her having remained behind as a teenager while her family moved abroad (Chapter 6). She also made an interesting distinction between difficult and traumatic events based on her personal experiences: "I don't forget difficult experiences. But I am capable of not remembering traumatic experiences." Ruth might be protecting herself from experiencing events as traumatic with a form of dissociation. As an example, she referred to her visit to Auschwitz with her mother. "It's as if a part of me wasn't there. So it can't be traumatic. And also, I didn't lose anyone. There was no loss. I, I managed to keep my mother." Ruth summarized: "A traumatic experience changes me, I think." She did not elaborate what such a change might be like.

Joseph stressed that the experience rather than the event itself defined trauma, but tended to speak more of victims and victimizers than of the traumatized and perpetrators. Dana initially defined trauma in a manner similar to Janoff-Bulman's (1992) conceptualization of it as a rupture. Dana stated that trauma "necessitates a reorganization of the whole system, so that what was, no longer is. That means, there is an *until* and an *after*." She then expanded with a

definition that reflected her personal experience. "Trauma is when I had to create something because what used to work, no longer does so, and I had to find new ways!" Dana's description already included her style of coping. According to her definition and her own personal history, it appears that there is little room for collapse, helplessness or being too overwhelmed. She seemed to have internalized the "partisan" values (Chapter 6), which her family had also applied as refugees, as penniless immigrants and in their culture of silence around difficulties and trauma.

Hanna did not draw on personal experience in her perception and definition of trauma. She reported an absence of trauma while she was growing up. In fact, she felt "protected" and she cherished both her memories and dreams of those times. David spoke of suffering rather than trauma. He rejected the automatic reflex in our culture to alleviate it in favor of "respect." He searched for words to explain his view that maintaining a level of private, internal suffering can sometimes be "honorable, something with integrity." I was immediately reminded of his description of his father's silent coping with his war trauma and injuries, though he made no reference of this here. It struck me that none of the others mentioned the word "suffering," nor did I ask about it. Perhaps here my being a child of survivors interfered and made suffering too obvious to comment upon, or maybe, too overwhelming or even taboo.

Nell, like Sara, survived an intensely traumatic childhood and family background. They were the only therapists not to try and downplay their histories. When a person's history is so complex in suffering and trauma, the word trauma itself apparently takes on a different meaning as does the degree to which personal experience can be communicated. Nell also related her own traumatic experiences to her work philosophy. She felt that for her and other victims of sexual abuse "life is never going to be just simple and easy. And it is not going to be cleaned off and 'oh, that's behind me'." It would appear that in clarifying perception of trauma, it is not sufficient to attempt to merely define what might be a traumatizing event in order to be able to fully acknowledge clients' experiences. It is equally important to clarify what the therapists believe the consequences and impact of those experiences to be.

Sara struggled with her own history, trying to clarify her perceptions and definition, and to indicate which experiences could be singled out and described as traumatic. Initially, in our interview, for instance, she was not really clear whether she had been sexually abused (Chapter 6), nor whether to classify the experience as traumatic. This might illustrate how personal insights and attitudes flow from one's own life rather than training or theory. Just like professionals need a contextual frame to perceive and acknowledge trauma (Chapter 5, 10 and 11), individuals apparently need their families or their immediate environment to provide a similar frame within which to understand their experiences. As the interview progressed

and Sara perhaps took on more the perspective of an adult professional rather than that of the neglected child she had been, she did define the molestation she endured as sexual abuse.

If people's personality, history and possibly, support system can affect whether or not they experience and/or name events as traumatic, there might then also be differences in their perception of *others* as traumatized. For example, both Joseph and Ruth perceived their fathers as strong and mothers as weak. Despite the fact that both parents had experienced horrors as child survivors in the Holocaust, they seemed to only consider their mothers traumatized child survivors.

The differences between the therapists' perceptions and definitions of trauma highlight the relevance of Van Dijk's (1995) question what meaning people from different cultures attribute to comparable events, and which events are universally accepted as shocking. I would anticipate, therefore, that therapists might not always easily resonate with what their clients do or do not experience as traumatic.

The therapists based their perceptions and definitions not only on their personal stories, but apparently also on their family's coping styles, as will be elaborated more in the following section. An interesting exception to the variety of reflections of their individual personalities and background was the way they all related similarly to the *Matsav*, the existential threat and frequent eruptions of violence in Israel at the time (Chapters 4 and 10). They referred to it as stressful rather than traumatic, which may be a necessary perception to facilitate coping with it especially as there seemed to be no immediate improvement in sight.

Coping with Trauma

A major aspect of coping with trauma is the meaning one attributes to the traumatic event. As Brown (1995) put it, "Social context, and the individual's personal history within that social context, can lend traumatic meaning to events that might be only sad or troubling in another time and place" (p. 110). It might therefore be useful to explore whether the interviewed therapists had distinguishable coping styles, of which meaning-making is one aspect. And if so, to see what, if any, relevance there might be for their professional motivation and development.

A therapist's expectation of how people are supposed to cope with trauma can seriously impact the therapeutic process, as was first so richly demonstrated by Danieli (1982). Such expectations may be related to the therapists' attitudes towards specific traumas like the Holocaust (Danieli, 1994a) and to their entire *a priori* countertransference. Increased awareness of individual therapist's coping styles with their own traumatic experiences will therefore add understanding to their motivation for working with traumatized clients.

Dora illustrated this perhaps most clearly. She refused to consider herself a victim, but was deeply conscious of the suffering of other Holocaust survivors. The idea of a "hierarchy of suffering" is not uncommon among Holocaust survivors, and can elicit feelings of guilt for making a big deal over very "little," or even jealousy of the recognition of someone who has "really" suffered, for example in Auschwitz (Tauber & Van der Hal, 1997, 1998). Dora seemed to cope by minimizing her own experiences, but never those of people who came to her for help. Being a caretaker was the antidote to being a victim. Like Frankl (1985), Dora discovered the power of finding meaning in her own hardship, which for her was to help others.

Dana tended to cope by "growing into" traumatizing situations which would then somehow become ordinary and tolerable. This raises questions that are highly relevant to trauma therapy and are not answered here. If a person learns to cope, adjust, live with trauma as it is occurring, does that mean that a situation stops being traumatic or that the person will not experience consequences of that traumatization at any point over a life time?

The interviewed therapists all coped sufficiently with their traumatic histories to do quite well in their lives (Chapter 6). They used a range of coping skills, from silence, denial, distancing, minimizing, dissociation, transformation, integration, emotional processing, finding meaning, doing research and teaching, to trying to be active rather than passive. The style and techniques they applied corresponded with other aspects of their personal and family histories. For some, working with traumatized clients offered an opportunity to heal personal wounds, much like the need of the wounded healer (Agger & Jensen, 1996) to heal through helping others (Sussman, 1992; Schulenberg, Elliot, & Kaster, 2003). However, there is also an element of not just healing traumatic injuries, but contributing to a better world, in the spirit of the Jewish philosophical concept of tikkun olam, repairing the world. This is a striving to correct and repair our behavior and experiences through learning and action and thus create a better, more just society.

None have disavowed their own or their family's traumatic histories. The combination of their family dynamics, their roles in their families, as well as their awareness of trauma and styles of coping seem all to have contributed to their choice of profession. Awareness of related *a priori* countertransference would demand ongoing alertness to the possible impact of their styles and perceptions on the therapeutic relationship with their traumatized clients.

Summary and Discussion

If family and personal history are important to learn about motivation and attitudes therapists might bring to their work, then their own psychotherapy -- and

how they worked on these histories -- provide a further window to understanding. Some of the therapists found their personal therapy helpful, or even necessary for their work, but no one reported being inspired professionally by their therapists or their professional approach. The interviewed therapists focused on their therapists' personal characteristics, such as empathy and intelligence, and said little about their gender, age or trauma background. Perhaps most surprisingly, considering their own backgrounds and Israel's cultural diversity, Sara was the only one to mention her therapists' socio-cultural background, which she felt might have impeded effective communication: the depths of familial and societal alienation, lack of protection and resources she experienced apparently were hard to communicate in therapy with even highly professional, well-intended therapists. Dasberg's (1982) understanding of the needs of soldiers who were traumatized in battle seems pertinent here:

> At a certain stage, therapists must be able to abandon their professional stance and try to impart to their patients the experience of belonging. They must help them to regain faith in new values. Essentially, battle breakdown is a solitary encounter with the Angel of Death, and the ultimate treatment is a moral one: a renewal of faith. (p. 150).

Particularly noteworthy was the fact that the therapists apparently attached little importance to the lack of attention to their own traumatic experiences in therapy. They thus seemed to mirror the prevailing professional and societal attitudes to trauma (Chapters 5 and 11). It would appear that they had not really expected to focus on trauma. This absorption of societal attitudes had seeped into my own *a priori* countertransference to the extent that I did not even question this during the interviews and only really noticed it during the analysis of the interviews. There were two exceptions: Hanna, in her first course of therapy, received adequate support for the traumatic loss of her newborn and Joseph quickly left therapy after failing to get help specifically with the aftereffects of his combat experiences.

In spite of the lack of attention to their traumatic experiences, the interviewed therapists were generally satisfied with their own therapy. Still, they did go on to specialize in working with others who experienced trauma. It is possible, then, that they were unconsciously attempting to bring some repair to the field of psychotherapy, or to vicariously heal their own emotional wounds. The choice to work with Holocaust survivors, the second generation and/or survivors of sexual abuse in particular, seemed to be directly connected to aspects of the the therapists' personal and familial narratives that seemed particularly meaningful to them (Chapters 6 and 7).

The way the interviewed therapists perceived and defined trauma offered further confirmation of the link between the personal and professional arenas: No one used professional definitions nor made reference to objective criteria. Instead, they drew on their personal experiences as well as (familial) coping styles. These ranged from denial to transformation, from dissociation to doing research (Chapters 6 and 7).

While it is not possible to show a causal connection between their perception of trauma and their choice of profession, the therapists demonstrated clearly how personally involved they were with trauma. Both their perceptions of, and styles of coping with trauma, regardless of the extent these might have motivated them to specialize in trauma work, provide ample sources for *a priori* countertransference concerning clients' perceptions and coping styles. Their actual experience of being trauma therapists is the focus of the following chapter.

CHAPTER 9

Being a Trauma Therapist

Being a trauma therapist implies an ongoing choice to maintain a practice consisting predominantly of traumatized clients. The question arises then concerning a possible meaningful interplay between who the therapists are as people, their (family) histories and social contexts, and the way in which they experience being a trauma therapists as well as what keeps them working in their specialization. In order to find answers, I focused on what the interviewed therapists said about their work environment and attitudes towards clients.

This chapter is divided into four main sections: (1) working as a trauma therapist, considering aspects such as work setting, relationships with colleagues and attitudes towards supervision; (2) clinical work, highlighting issues such as approach to trauma work, attitudes to clients, including believing clients, and boundaries; (3) life as a trauma therapist, which explores different aspects of their experience as trauma therapists, including the impact on their private lives; and (4) personal history and professional life in which the therapists discuss possible connections between their histories and their work, as well as their plans for their professional future. In the analysis of these different areas of experience, I hope to uncover possible sources and expressions of *a priori* countertransference.

Working as a Trauma Therapist

A major question in this study is whether the responses and attitudes the therapists expressed in the interviews demonstrate, in addition to shared themes, the uniqueness of each person and how that influences the way they perceive their roles and behave as trauma therapists. In order to find answers, the focus in this section is on their actual work setting, relationships with colleagues and attitudes to supervision.

Work Place

The setting and framework in which therapists work may have a definitive influence on therapists' professional life by encouraging them to grow and develop, as well as stimulate normative professionalization (Chapter 2). On the other extreme, they may inhibit the therapists' professional development and perhaps even compel them to change their specialization. Mental health centers that specialize in traumatized populations could reasonably be expected to offer greater support to their staff than therapists in relative isolation might receive (Hartman & Jackson, 1994; Herman, 1992). The experiences of some of the interviewed therapists, however, indicate that this is not necessarily the case. Insufficient awareness of countertransference processes that characterize trauma work (Chapters 1, 2, 3 and 4) can also cause difficulties on an organizational level.

Four out of the eight therapists encountered serious problems at centers specializing in work with trauma survivors. Judging from the ways they were asked to leave and/or prevented from fully contributing, the staff in charge might not have sufficiently acknowledged their own countertransference (Herman, 1992; Hopper, 2003a). Ruth felt she was rejected for being too independent as she had offered to initiate projects for the center, rather than joining the 'family.' This did not deter her from working with survivors and the second generation. Hanna and Nell were more or less asked to leave centers specializing in work with Holocaust survivors as they apparently were considered 'outsiders;' unlike most the other staff members, they had no direct, personal link to the Holocaust. Though both had felt committed to their work with this population, they subsequently specialized in therapy with sexual abuse survivors.

Dana had worked for several years at a center for survivors of incest and other forms of sexual abuse. Without any advance notice, the center suddenly closed due to financial difficulties. "It just happened, one day, out of the blue! They never shared with us that this might happen…Staff were in shock and clients retraumatized." One possible explanation for the alarming manner in which this situation was handled may be attributed to parallel process: for example, the people running that center were functioning under a cloak of secrecy or consistent with other dynamics characteristic of families in which there is sexual abuse.

Of course, some workplaces do offer sufficient support and space. Sara delighted in the warmth and support she experienced at the center for Holocaust survivors and second generation where she interned and stayed on as a regular staff member. Both Nell and Hanna reported that their current places of work offered them essential (Van der Hart, Defares, & Mittendorff, 1995) professional and collegial support. David, too, felt a deep sense of belonging to his hospital which was generally supportive of all the innovations he introduced with the creation of the special ward for Holocaust survivors. Dora had been one of the founders of a center for Holocaust survivors in which she had been very supportive of the staff and Joseph had set up his own center and was therefore free to create his own culture at his workplace.

The interviewed therapists' experiences point to the importance of what I refer to as "countertransferential fit" between the therapist and workplace--i.e., first a compatibility of attitudes towards the traumatized client population held both by the therapists and the workplace leadership. Second, the degree to which attention is paid to the fact that therapists are personally impacted by their clinical work with the specific trauma population served. This means that beyond making available the continued acquisition of professional skills by workshops and supervision, clinicians need the staff in charge to appreciate other essential support requirements that may be more personal in nature, illustrated in Chapter 4 by the

extreme demands of the Matsav. Third, recognition of the risk that staff in charge may act out insufficiently processed traumatic experiences that are similar to those of the clients they serve.

Colleagues

Relations with colleagues might provide one of those junctions at which professional and personal life meet openly. One of the common consequences of traumatization is a sense of isolation. Therapists, too, may experience such isolation (Herman, 1992, 1995) if their trauma work is not respected and supported by colleagues. Pope and Vasquez (1998) place great importance on peer support. "Our colleagues constitute a tremendous resource for helping us to avoid or correct mistakes, to identify stress or personal dilemmas that are becoming overwhelming, and to provide fresh ideas, new perspectives, and second and third opinions…" (p. 68). Relationships with colleagues had different meaning for the interviewed therapists along a continuum of need and importance.

Dora expressed appreciation and liking for her colleagues, and Dana greatly valued the colleagues with whom she shared supervision. Sara cherished the warm and respectful relationships with her colleagues at the center for Holocaust survivors. She keenly felt the absence of support at her work place with traumatized children.

The degree of overlap of being colleagues and friends also differed among the therapists. Ruth, who from a very early age on received the message to be independent and self-reliant, felt no need to belong to professional groups and organizations. Joseph did have "professional reference groups" but felt little desire for social contacts with colleagues. David drew a clear line between colleagues, a "peer group" with whom he felt a sense of belonging "in a very collegial sense," and personal friends. Hanna and Nell on the other hand, maintained close personal friendships with colleagues.

As professional isolation can be such a big challenge for trauma therapists (Herman, 1992), I was somewhat surprised to discover that on the whole, the interviewed therapists did not seem to consider relationships with colleagues a topic particularly worthy of attention. This might flow from having been raised in traumatized families (Chapter 6) that were not exactly models for mutual support and constructive sharing. Quite possibly, some echoes of Shoah-related isolation also affected some of the therapists. Joseph, for instance, spoke of his social isolation as a youngster in that context. Ruth emphasized her extreme independence, which her father, a child left alone in Auschwitz with the responsibility for his younger brother (Chapter 6), might have considered the best survival skill to impart to his children.

On the other hand Dora, Dana and David easily expressed liking and appreciation for their colleagues. And Hanna and Nell perhaps reflected the feminist culture in which they worked in their ability to form close friendships with some of their colleagues and so merge personal and professional areas of their lives. Both spoke warmly of the importance of their relationships with women who were also colleagues.

Again, objective facts alone, such as, for instance, being a child of Holocaust survivors, do not offer sufficient explanation for attitudes towards colleagues. Both Dana and Joseph are children of survivors. It is their unique experiences as second generation, and the way they have interpreted them that shaped their attitudes, including those regarding relationships with colleagues. The individual differences the therapists bring to their (attitudes regarding) relationships with colleagues seem closely connected with their personal histories.

Supervision

A supportive work setting and good supervision are essential to enable therapists to work with traumatized populations (Herman, 1992; Pearlman & Saakvitne, 1995)). Lonegan, O'Halloran, and Crane (2004) note the importance of supervision and the fact that it has to be specifically adjusted to trauma work. It seemed worthwhile, therefore, to explore whether the interviewed therapists' attitudes towards supervision also reflected their personal narrative.

Most of the therapists spoke with much appreciation of the importance of supervision. Some considered it part of professional hygiene. Hanna firmly believed in the importance of supervision: "When you do therapy with incest victims, you can't ever have enough support. Because each therapy is very lonely and every therapy is very hard." Nell also considered regular supervision with different "experts" as "part of my job." David too, has always valued supervision, and tried to ensure it was available for his staff.

For Sara as a beginning therapist, her supervision for work with Holocaust survivors has been a very precious experience. She felt contained and supported. Dana also thought highly of her current supervisor, and the group supervision she received. It not only helped her with her actual work with sexually abused clients but also with processing the tensions and fears resulting from the stress of intense terrorist attacks at the time, which then enabled her to deal with their clients' issues. Recognizing the extent of the impact of external threats and danger, Shamai (1998) noted the need to help the helper to cope with existential insecurity by means of an "empowering" supervision group. Dana was the only one to refer to supervision in this context.

Ruth spoke of a rather unique experience. She had supervision from the same person for an unusually long period of time that came to an end with the

supervisor's death. She considered this 'semi-therapy' and thought that, as she was a Holocaust survivor, "it was also therapy for her." Joseph reported having had excellent experiences in supervision as a beginning therapist. He would still like to have supervision but thought it would be difficult to find a suitable framework at this point in his career. He was not part of a peer group either but supposed he "could create one." Dora has always benefited from individual and peer supervision regardless of her professional status. She had trained therapists to work with survivors and second generation and was still continuing to give supervision in addition to seeing a few, mainly second generation, clients.

Supervision can offer meaningful professional support which therapists may or may not make use of. This study has shown how the interviewed therapists expressed their individual differences and personal histories, and as expressed by Hanna, Nell and David, work ethic. Especially striking were Ruth's loyalty and inability to "abandon" a survivor, or Joseph, at the height of his professional career, having no one to turn to for help, much like when he was a child. These differences reflect who the therapists are and in turn, highlight the highly individual nature of the process of exploration of *a priori* countertransference.

Attitudes to Clinical Work

The emphasis in this section is not on the actual therapeutic process, but on the attitudes the interviewed therapists revealed regarding their trauma work in general when they discussed approaches to trauma therapy, questions of boundaries and other related issues.

The Approach to Trauma Therapy

The major focus here, as throughout this study, continues to be what could be learned about the therapists themselves. In his exploration of what might have motivated Freud, Marks (1978) noted that it was "both Freud's personality, including his own personal neurosis and his genius…" (p. 354). I had not asked the therapists to do the interviews as representatives of specific therapeutic approaches (Chapter 2), but found it interesting to learn that they all chose approaches that suited their personal style and the populations they worked with. Except, perhaps, for Dana and Sara, who were still actively learning the profession of psychotherapy, they seemed to have developed styles and approaches that reflected their personal stories.

Dora, for instance, emphasized the need to create a safe environment to enable clients to be as open as they might need to be. While safety is a vital aspect of trauma therapy, this focus reflected her own life theme of lack of safety and

openness, and desire to provide this for others. Mainly as a result of her group therapy experiences, she moved on from the psychoanalytic and psychodynamic approaches she was trained in, to working more eclectically, interpersonally. And while she was already pioneering work with children of survivors, together with colleagues from that group, she was of the opinion that "you can't treat survivors." Though she had since helped to establish a center that specializes in working with both survivors and their children and had become much in demand as a supervisor, she felt very strongly that therapeutic work with Holocaust survivors was unlike other psychotherapy. She was the only one to make such distinction, perhaps as her work predated theory and techniques of "trauma therapy."

Ruth liked "dynamic short term therapy" combined with different approaches as such a format has a "beginning, middle and end." She felt that people needed to live their lives, rather than spend them in therapy. If clients were in some crisis or difficulty, she felt the therapy should "then go through some process and the client goes in a kind of remission, as it were. You have to have a period to regain balance. And then if he needs to, he'll come again." Her preference for focused, short-term work reflects her fear of getting lost in other people's pain, first and foremost, as she had stated, in that of her parents.

For Joseph, who grew up trying to protect and care for his seemingly overwhelmed and helpless mother, effectiveness and success were of the utmost importance. His professional style reflected this. Joseph described his approach as "pragmatic, integrative, and eclectic." He used long-term dynamic therapy or short term behavior focused therapy as needed. "I'm very interested in being effective, not right. So the question is where to look, what works, which therapies are research based…"

Hanna, too, no longer restricted herself to the psychodynamic model she was trained in. She described her style as "dynamic with a focus on intersubjective elements. I also use other approaches. I work cognitively, quite a lot … I use EMDR … whatever approach I sense that can most effectively help my clients." In her ongoing search for the latest methods, and her desire to develop new models of work, she would seem to continue her family's pioneering roots.

David favored Integrative Psychotherapy because it was "optimistic, existential." He worked in a "dialogue" fashion and always listened for trauma; hospitalization itself might be traumatic and his patients had a life-time of possibly accumulated trauma. He greatly enjoyed the psychopharmacological aspect of his work and chided me for not having asked about that. David considered activities, such as celebrating the holidays with his patients, part of his job. He laughed when I asked him why. "What do you mean, why? Who else will be with them for the holidays?" His almost egalitarian, though highly professional approach as well as his willingness to share actual life events with his patients reflected the spirit of

community service, caring and sense of optimism that characterized his family of origin's values (Chapter 6).

Nell, similarly to Hanna, also adjusted her approach to the needs of her clients. She learned many of the latest techniques found effective in trauma work. "I integrate. I believe that I have to work with what is necessary for the client." This is in sharp contrast to her childhood experiences of being abandoned, of having her most basic needs for nurturing and safety neglected, of remaining not seen. Nell's personal experience of therapists never really *hearing* her mention sexual abuse and ignoring the topic, taught her to ask her clients direct questions about possible sexual abuse:

> It's easy to get away from that. People bring it up and then they start bringing in their everyday lives. And I can also choose to flow with them or I can choose to connect it back. … I quite often take the initiative to double check it. And then I have to ask myself … is this your personal thing and thereby you keep going back to it, or is this what they really came for? What's the contract?

Like Dora, she seemed to directly draw on what she had lacked most and to ensure her clients won't be similarly deprived.

Several aspects of trauma work did not come up in the interviews. It is noteworthy that most of the therapists did not initiate emphasizing the unique, or at least, specific requirements of trauma work. This lack of mentioning of specific challenges of trauma work might illustrate how deep involvement can sometimes blind one to the obvious, and create areas that are so taken for granted that they do not invite exploration. This, in turn, might also explain why no one mentioned a vital aspect of trauma work, that of being a witness to the survivor's testimony (Herman, 1995; Laub, 1995). And no one made mention of diagnostic issues. As Tobin (1986) pointed out, these can be highly subjective: "Even diagnosis reflects a combination of the patient's mental condition and the therapist's emotional needs, as mediated by the therapist' conceptual strengths and limitations" (p. 12).

Only one therapist, David, raised the issue of therapist disclosure which is so vital and delicate in therapy in general and in trauma therapy particularly (Dalenberg, 2000; Tauber, 1998). In the psychoanalytic literature, too, there are an increasing number of voices questioning the wisdom of the bland anonymity of the analyst (e.g. Gerson, 2001; Renik, 1995). As David put it, he "won't do 'striptease' in the therapy room" but he had no problem sharing relevant personal experiences if those seemed relevant to a client.

Two therapists, David and Nell, raised the issue of suicide which is not an unusual response to trauma, or even to successful processing (e.g., Roden, 1982). David expressed his conviction that doctors must always do their utmost to

maintain and preserve life. But Nell, who intimately understood those clients' despair, was conflicted about inviting clients into a lengthy, painful therapeutic process without being able to guarantee them complete relief from pain:

> Do I do a service if I brought them back from the verge of committing suicide? I don't know. We do it because we worry about our reputation, you know? How to live with ourselves, you know? ... I'll try to do my work as good as possible. But I can't pretend that I'm a savior.

Considering the kinds of trauma--Holocaust and sexual abuse--these therapists work with, it is rather surprising how little discussion there was on the subject of death at all in the interviews and the clinical trauma literature in general (Tauber, 1998; Tauber & Van der Hal, 1998). Here, too, while all the therapists are highly dedicated to providing their clients with the best possible therapy, the differences in their approaches and the issues they chose to highlight, reflect who they are as people, and their personal and familial backgrounds.

Attitudes to Clients

Attitudes towards clients are greatly informed by countertransference responses. Regardless of the broadness of definition of countertransference (Rowan & Jacobs, 2002), the therapist is, to some degree, always involved on a personal level. We did not directly explore countertransference, such as "empathic strain" (Wilson & Lindy, 1994b) or other forms of countertransference (Dalenberg, 2000; Davies & Frawley, 1994; Tauber, 1998; Wilson & Lindy, 1994b) in the interviews. But a focus on therapists' attitudes to their clients inevitably includes their *a priori* countertransference (Tauber, 1998, 2002a, 2003).

Therapist attitudes towards their clients are crucial to the therapeutic process. Kortman (1995) referred to Karasu's (1979) thought-provoking findings on this topic. The therapists Karasu studied considered their older clients to be least insightful. Three months later, fifty percent of their young clients, 87 percent of the same-age group but only 37 percent of the older group were still in therapy. One of the most fascinating examples of the importance of therapists' value systems and expectation of the client is a case of DID from the Sixteenth Century (Van der Hart, Lierens, & Goodwin, 1996). Jeanne Fery was cared for by her fellow nuns after her experience of exorcism. Van der Hart et al. (1996) pointed out her good fortune to be with the Order of the Beguines.

> Not only were the Beguines familiar with the reality of violence against women, but they also had ideas that women could take control of their lives and function in areas usually restricted to

> men…. This connection with the Beguines may account in part for Jeanne Fery's ability to narrate her violence history and the willingness of her exorcist to allow her to advise and control her treatment plan. (pp. 32-33)

There is much to learn about *a priori* countertransference from the kinds of clients a therapist feels comfortable with and which ones he or she would rather avoid. Joseph was very open on this subject. He liked working with seriously traumatized clients as it was important for him "to have a positive impact on the lives of people who were hurt, or stopped or pushed to go into bad directions." He felt confident of his professional competence because of both his academic interests and his personal history. "Posttraumatic pathology is something I understand; sometimes more so than other personality pathologies." Joseph was aware that some of his sources of understanding could be problematic. Clients who resembled his mother too much by being "weak, demanding, overly dependent and complainers" required a great deal of internal work for him be able to be "empathic and professional." Just like weakness in clients could be difficult for Joseph, so were "aggression and criticism" though he usually managed to diffuse difficult situations. He referred neither to the Holocaust nor his father's occasional violent outbursts in this context. However, the Shoah and other expressions of extreme cruelty were very much part of Joseph's professional awareness and, unlike the others, he actually used the word "evil." But possibly as the result of his childhood experiences (Chapter 6) he stressed that traumatization should not serve an excuse to hurt others. "I also consider my own clients 'accountable' … they can not hurt others because they were abused themselves. Now, I'm not in a position of judge, but I'm not neutral in the face of evil."

Joseph did not speak of the impact of the Holocaust on children of survivors, nor of intergenerational traumatization, or "transposition" (Kestenberg, 1982). He noted only the effects of inadequate parenting (Chapter 7). Like Dora and Ruth, he encountered many children of survivors who had endured physical abuse from their parents, but no sexual abuse.

Ruth's main professional focus has been trauma in childhood, whether in the Holocaust or as the result of sexual and physical assault. Unlike Joseph, she did not draw emotional parallels to her own life beyond the obvious link to the Holocaust. However, she said she never worked with "those who abuse sexually," and "I can't work with retarded people, and also not with mental patients." It struck me that she seemed to reject both perpetrators and those who do not have the strength and ability to cope independently, and by association, perhaps, to survive as her parents had been lucky enough—without an element of luck, no one was able to survive the Holocaust--to be able to do.

Nell's main concern was not to assume the client had endured the worst traumatization. She also realized she had to take care to remain sympathetic with clients who had "trivial" complaints. Sara's attitude to her clients at this stage seemed dependent on her professional support system and sense of belonging. I wondered whether this seeming insecurity did not reflect her life story as well. The absence of team support left her especially vulnerable in her work with neglected and otherwise abused children but she did not initiate discussing that experience. Domestic violence was the most difficult issue for her, made worse by her sense of professional isolation which seemed reminiscent of her sense of isolation as an abused child.

David's attitudes to clients were also affected by the setting, but for him this was a matter of choice. In the "public sector," at his hospital, David felt obliged, perhaps even as a matter of ideology, to save no effort with any of his patients. "Their being survivors, or the trauma, is something they bring into their old age. It comes with them. It appears 'ingrained' in their, I wouldn't say, personality, but their life story and their behavior and their perception of the world." Following the service ethic of his family, he unstintingly gave of himself, personally and professionally to his patients. In his private practice, however, he only took people on as patients with whom he felt a sense of connection.

David consideredchildren and young people "boring" as clients. He was fascinated with the "wholeness" of the lives of the old, the "life cycle of experience." David offered no clear explanations for his dislike of working with younger people. Perhaps against the echo of his special relationship with his grandmother (Chapter 6), David said that "that 'phase of life,' old age,' that to me, is delightful in a positive sense."

The literature and general discourse about Holocaust survivors is generally very respectful and perhaps, at times, too cautious to allow them to be fallible humans. Dora maintained her independence of mind on this subject. She had no problem acknowledging that some survivor parents had been abusive to their children, even if the children themselves tried their best to keep these experiences out of their ongoing awareness. "The violence of parents, especially of the fathers, usually, who were survivors … those things that they experienced entered in 'the big secret' and that was also never talked about, not in school, nowhere....But it's very traumatic, yes." She seemed to enjoy sharing her understanding that the second generation needed help to claim "their right to be an individual who really doesn't owe anything to anyone anymore because of that, especially in regard to the parents."

Hanna's practice consisted almost entirely of traumatized clients. This made sense to her:

> Between you and me, a person who comes to therapy usually has experienced trauma. He doesn't come for a cosmetic fix because everything is wonderful … Only social workers and psychologists get therapy because everything is wonderful and they want it to be even more wonderful!

She laughed, and said, "We are the (car) mechanics of society, aren't we? It wouldn't do any harm to get people in for periodic check ups!" In her choice to function as such a mechanic she certainly took on the values of her pioneering family in not shirking any challenges but rather looking for responsibilities and ways to contribute to others.

The attitudes the interviewed therapists expressed towards their clients clearly reflected the influence of their personal and familial histories and experiences, and therefore might provide useful starting points for more in-depth exploration of *a priori* countertransference. Some therapists also directly expressed *a priori* countertransference, such as Joseph's lack of acknowledgement of the impact of the Holocaust in the lives of second generation clients or Nell's fear of too much listening out for extreme traumatic experience.

*Multiple Trauma*s

The interviewed therapists were asked to participate in this research on the basis of their specialized work with people who were traumatized by sexual abuse, or by the Holocaust. Quite a few of these therapists had a significant number of clients from both groups in their practice. This, of course, does not mean their clients might not also have experienced additional traumas.

In fact, awareness of the possibility of multiple traumas guided the clinical styles of many of the therapists. The absence in professional circles of open discussion of domestic violence in Holocaust survivor families brought Ruth to routinely ask children of survivors direct questions about possible battering and sexual abuse and to offer groups for battered second generation. Nell noted that some of her second generation clients were traumatized as adults as a result of their combat experiences. Thus, while second generation clients can present with a variety of complaints and traumatization, this should not preclude the Holocaust from being explored as a salient influence. This can easily happen even with an excellent therapist like Joseph as discussed earlier in this chapter. He demonstrated not only how personal coping mechanisms could color perception of clients but also how symptoms can become egosyntonic.

David mentioned a series of additional traumas he encountered in the life stories of his Holocaust survivor patients, such as sexual abuse to which women were especially vulnerable during the Holocaust, and combat trauma in Israel. Other therapists mentioned these and other traumatic experiences of traumatic loss

and physical illness. David was the only one, however, to name specific horrors, such as the cannibalism some survivors were reduced to as a result of their extreme starvation. “Cannibalism as survival, that’s an insane trauma.…Cannibalism itself was not ‘Nazi-driven.’ … It’s, as it were, a trauma that was added to the annihilation.”

The therapists' personal and familial trauma histories may well have sensitized them to their clients' possible experiences. They did not comment on multiple traumatization themselves and in fact, seemed to have paid little attention to these histories in their own psychotherapies (Chapter 8). But it would appear that such personal knowledge had welcome professional uses. Still it is important to keep in mind that awareness of certain traumatizing experiences does not automatically imply a therapist' consistent alertness to the possibility of other trauma as this too might be blocked by *a priori* countertransference.

Dissociation

The interviewed therapists proved to be impressively innovative and courageous in their professional choices (Chapter 7). As the field of trauma developed, and awareness of dissociative disorders was just beginning to take hold, it provided an opportunity to learn how they related to new developments in the field. Exploration of their attitudes regarding dissociation might provide some insight whether their sensitivity to potential trauma automatically included a process of expanding awareness how traumatic experiences might manifest themselves.

Dissociation is actually a fairly common response to massive or chronic traumatization, awareness of which had waxed and waned similarly to awareness and acknowledgement of trauma (Van der Hart and Dorahy, in press). Boon and Draijer (1993) pointed out that the “relation between trauma or severe psychological stress and dissociative reactions was already recognized by Janet and other clinicians more than a century ago” (pp 30-31), but that knowledge had seemed largely forgotten until the publication of Ellenberger’s *The Discovery of the Unconscious* (1970). Histories of sexual and physical abuse can lead to dissociative symptoms (Boon & Draijer, 1993; Draijer & Langeland, 1999) which, according to Boon and Draijer (1993) might be part of the difficulty in maintaining dissociation in professional awareness.

In their comprehensive survey of the use of the concept of dissociation since Janet and their presentation of their model of structural dissociation, Van der Hart, Nijenhuis, Steele, and Brown (2004) provided a base for professional clarity on the subject. Van der Hart, Nijenhuis, and Steele (2005) suggested that structural dissociation is inherent in complex PTSD, and provided both historical and

cutting-edge neuropsychological insights on the effects of chronic traumatization (2006).

Surprisingly, perhaps, most of the interviewed therapists had neither knowingly worked with dissociative disorder clients nor heard about them in group supervision. It is further indicative of the limited familiarity with dissociative disorders that, of all the dissociative phenomena and disorders, we only discussed the most extreme one, Dissociative Identity Disorders (DID). Paradoxically, this may be a sign that there is at least some awareness of dissociative disorders. The perception of DID symptoms might depend on the therapist' openness and awareness (Mollon, 1999), which his colleagues at Tavistock did not share. Pope, Oliva, Hudson, Bodkin, and Gruber (1999) found that two thirds of the responding psychiatrists in the United States had reservations about including dissociative amnesia and dissociative identity disorder in the DSM (Diagnostic and statistical manual of mental disorders).

At the time the interviews took place, dissociative disorders were not yet an integral part of professional discourse in Israel, but were "gradually gaining some recognition" (Somer, 2000, p. 27). As it is such a small country, a few committed and energetic professionals, such as Somer (1995, 1997, 2005); Somer, Dolgin, & Saadon, (2001); Somer & Somer, (1997); Oz (2005) and Oz & Ogiers (2006), can have a significant impact. A new Israeli organization, affiliated with the ISSD (the International Society for the Study of Dissociation), organized its first, and very well attended, conference on dissociation in Tel Aviv, 24-25 May, 2005.

The newer therapists, Dana and Sara, had already heard mention of dissociative disorders during their training. And although Ruth had not encountered DID clients as in her work as a therapist nor as supervisor, she thought she might work well with that population. She spoke freely about her own ability to dissociate when she had to deal with difficult or traumatic situations on her own, like visiting Auschwitz with her mother. Only two therapists, Nell and Joseph, had any formal training in work with dissociative disorders. Nell started working with DID clients only fairly recently, while Joseph had already a great deal of experience and expertise.

Believing Clients

Even when therapists are confronted by the devastating impact of interpersonal traumatization on their clients, it is not always easy to fully believe their descriptions of their traumatic experiences. This has been true not only for mental health professionals but for society at large (Wilson & Lindy, 1994a). Van der Hart and Nijenhuis (1999) proposed that automatic belief or disbelief could be problematic. They suggested therapists adopt an attitude of a "reflective belief" (p.

38) which might evolve as a result of "the therapist's sensitive and ongoing analysis of complex indications both for and against prior traumatic exposure" (p. 39).

Holocaust survivors and victims of incest and other sexual abuse belong to populations that have suffered the consequences of either outright or partial disbelief. As Edkins (2003) put it: "The reduction of suffering and trauma to a question of truth silences the voices of survivors…They have something important to say, something that is almost impossible to communicate, and we should listen" (p. 169).

Being a survivor, a witness or a contemporary to traumatic events does not guarantee belief and acceptance inside or outside the therapy room. I wondered whether the personal and familial background of the therapists interviewed for this study give rise to *a priori* countertransference, regarding whom and what they believed in their clinical work, i.e. make them especially receptive, even overly so.

When Dora visited a Jewish family that lived just beyond the Nazi occupied zone in the Second World War, she told them what she and her family had endured. They did not believe her and later perished. Another example from the Second World War is of Jehovah's Witnesses who somehow had been released and managed to return to Holland in 1943 after they had already seen the gas chambers. They had great difficulty finding anyone who would believe them (Gilbert, 1979). The editorial staff of the New York Times during the Second World War included those who chose not to believe and those who seemed incapable of acknowledging the genocide of the Jews that was taking place (Leff, 2005). Holocaust atrocities are being denied to this day (e.g., the court case in England, in 2000, of Holocaust denier David Irving versus Deborah Lipstadt or, in the political arena, Iran's president Ahmadinejad).

Rape victims have regularly been blamed for the crimes perpetrated against them, including, unfortunately, in courts of law. Clients who dare to confront their own history of sexual abuse for which they may or may not have had continuous memory may present serious challenges for their therapists (Dalenberg, 2006). The False Memory Syndrome Foundation (FMSF) has created a climate in which it has become risky for therapists to believe their clients as they might subsequently be sued by relatives of some of these clients. Price (1997) asked, "Is it for us to silence our patients, provide quick assessments or cures or believe that any thought or feeling related to childhood abuse is proof that it has occurred?" (p. 130). Price also worried about countertransferential consequences. On the other hand, Loftus, like other professionals, has committed herself to protecting those whom she assumed to be the wrongly accused (Slater, 2004). Except for Joseph and Nell who were very aware of the FMSF situation, the interviewed therapists did not relate to the question of believing clients' accounts of their traumatic experiences as a socio-political issue.

A thought-provoking study (Jackson, 1993) demonstrated just how subjective--and not necessarily reflective -- the process of accepting the reality of sexual abuse can be. Women were more likely than men to believe sexual abuse, social workers more likely than psychologists or psychiatrists. Certain factors increased believability, such as children who showed affect, which “greatly endangers children who use dissociative defenses” (p. 136) or, for example, the existence of “behavioral changes in the victim” (p. 138). Jackson found that both the age and the abuse history of clinicians significantly impacted whether they believed their clients’ reports of sexual abuse. Younger clinicians and sexually abused clinicians were more likely to believe that abuse had occurred. This means that whether or not some sexually abused clients will have a respectful, healing therapeutic experience --which is not possible in the case of automatic disbelief, rather than an attitude of open-mindedness and willingness to fully hear and try to understand the client's narrative and experiences-- might still depend on the luck of the draw, on who their therapist is as a person.

Victims of sexual and other abuse sometimes also find it hard to believe their own memories or suspicions. One explanation for this might be the phenomenon of "double-speak" ((Gartner, 1997, p.18), in which the child learns to name the traumatic acts and events as pleasure or love. Traumatizing events remembered as an adult may then be confusingly misnamed and so disbelieved by both the client and therapist.

The interviewed therapists reflected personal differences in believing clients' accounts. With some humor, David first made a general comment:

> Yes, yes! Often they don't tell me the truth. For all sorts of reasons. Because they're manipulative, because they want to get something, because they lie, just like ordinary people. When someone becomes ill, he doesn't suddenly become "full of integrity, full of good manners" and sincerity, "honesty". No! There are people who are ill and who are liars and just unpleasant. Illness doesn't turn you into a wonderful person!

When we discussed traumatization specifically, David did not think that:

> The truth is the issue…how relevant is it in the therapeutic dialogue … at age 72, after being hospitalized … for 32 years, how relevant is it as a historical fact? What *is* relevant is what I can do, here and now, for someone who says her father touched her or even raped her in the *Shtetl* [pre-World War II Jewish village in Eastern Europe] at age 8 or 2, before the Shoah.

David seemed to draw here from his family's value system of providing practical help. "You can't be a psychiatrist and deal only with the truth. There are, I don't know, judges and lawyers for that."

Similarly, Dora has never focused on whether or not to believe her clients. The Holocaust taught her that the worst is possible and her coping style was to concentrate on how horribly others suffered. "I have never come across something which I thought was made-up. And I don't really care!" For Ruth, too, believing clients is a non-issue. "It's not a question of believing. It's accepting … accepting what he tells me."

Nell and Hanna found it easy to believe their clients as they've come to accept the reality of what people are capable of doing to each other. Hanna has learned that "anything can happen." And as Nell put it, "There are such cruel people, so that yea, I believe it all." She then continued, sounding much like clients who struggle whether they can believe t*hemselve*s, "I believe it and I don't believe it." She empathized with clients who found it hard to believe their own abuse. Memory may well be related to family dynamic (Draijer, 1996). Nell thought that clients who had continuous memory had fewer problems. She fully empathized with the self-doubt of those who had later recall, their fear of being crazy and harming their possibly innocent family. Van der Hart and Brom (1999) have pointed out what has frequently been overlooked: Holocaust survivors, too, might not have had continuous memory of everything they were made to endure.

For Dana, who had learned so well to hide all personal distress (Chapter 6), it was "essential" to believe her clients: "Otherwise it's an additional injury.…All of them experienced additional trauma because they weren't believed, or the police treated them atrociously." However, when not actually facing a client, believing content might be harder which perhaps goes some way to explaining societal denial (Chapters 3, 5 and 11). When Dana listened to colleagues speak of their clients in supervision, she occasionally had a hard time believing the stories. She felt bad about this and sounded much like a child of survivors sensitive to what might trigger traumatic memories in their parents:

> Not to believe at all. ... It's so hard to be the aggressor again. I so do not want to be in a position of, God forbid, hurting someone again, that really, you don't allow yourself that space of 'hey' wait a minute, perhaps I do have some doubts?

Joseph was the only one who spoke quite freely of occasionally doubting facts, and mentioned "stories of ritual abuse … It does happen that I'm not always convinced that certain details were precisely described. But as far as the essence of the injuries, I have no doubt." He has never disbelieved stories of incest. "I see the injuries."

While discussing the question of whether or not to believe their clients, no one brought up matters such as therapeutic alliance, empathy or lawsuits. All the therapists expressed principles, decisions, a sense of obligation or a fear of causing damage that imply a sense of commitment to their clients that might well stem from their personal experiences as either victims or children thereof. These attitudes too, are examples of *a priori* countertransference.

Boundaries in Trauma Work

A major area in which therapists' attitudes to clients, to themselves and the work of therapy come to the fore is the setting of therapeutic boundaries. When working with interpersonal traumatization, maintaining boundaries can be particularly challenging (Dalenberg, 2000; Tauber, 1998; Pearlman and Saakvitne, 1995; Van der Hart, Defares, & Mittendorff, 1995). The interviewed therapists experienced many instances of boundary invasions in their own trauma histories and were aware of such in their family's histories. It would therefore be pertinent to explore whether these formed a source of *a priori* countertransference, and whether they expressed any specific difficulties or unique perspectives on boundaries in their clinical work with traumatized clients.

All the therapists took the need for boundaries as a matter of course in order to protect the safety of the clients and respect professional and ethical standards. But boundaries were drawn according to the demands of the setting. For instance, David considered it a matter of professional and human obligation to spend at least some part of the religious and national holidays in the hospital with his patients, and to join them on outings. This is not generally an integral part of a psychiatrist's job, but seems to reflect his family's values of being there when you're needed. On the other hand, for Ruth, the very profession of psychotherapist served as a boundary as it offers "protection against emotional involvement and being emotionally overwhelmed."

Two issues seemed most problematic for the therapists: One is the delineation between "them," the clients, and "me," the therapist. This is significant in the light of the therapists' own trauma histories. The second issue is more concrete; demanding a reasonable fee for their professional services, thereby also owning their status as a professional in relation to the traumatized client seeking their help. It is not always easy to consider someone who has had a similar fate, in this case, suffered similar trauma, as sufficiently "other" to preserve the necessary therapeutic distance (Tauber, 1998). What it may mean for the individual therapist to take on the role of therapist versus a particular client is definitely a topic for self-monitoring of *a priori* countertransference. Charging a fee is a concretization of the differential roles of therapist and client.

Fees

Nearly all the therapists felt conflicted about charging reasonable fees for their work, and perhaps clearly setting a professional boundary. The only one who had solved the issue to his own satisfaction was David. He charged high fees in his after-hours private practice to pay for the luxuries he enjoyed, as opposed to his work at the hospital which he considered public service, which to him meant total dedication for little money. Joseph, on the other hand, felt uncomfortable setting a price for his work although he was aware that inadequate payment might lead to resentment. He offered clients a sliding scale

> There are some clients whom I basically see for almost nothing … It's my choice, so that's OK. I think that in this profession and this specialty, the gaps are sharp. That is, the gap between what I invest, emotionally, what I give, and the financial compensation.

He was very aware of being underpaid and of the fact that physicians and lawyers "also" earn their income from people's distress. But "guilt feelings" prevented him from charging more especially as he worked with a "posttraumatic" population. This made so much sense to me, possibly out of a shared second generation guilt along the lines of "who am I to complain compared to what my parents endured," as well as an unquestioning readiness to offer help and support, that I did not explore Joseph's guilt feelings any further.

Commitment and a sense of obligation towards clients were additional factors that encouraged therapists to keep their fees low. Thinking back over her long career, Dora acknowledged the impact of her countertransference:

> When I worked with the second generation and felt I could help, that something could be done and they had no money to pay, I would reduce the fee a lot. But as a matter of principle, I never worked without them paying something, except for one case.

She did not say so, but it appears that this approach may stem from her desire to free second generation clients from the burdens of the Holocaust as a way to ease her own traumatization (Chapter 7).

Nell and Hanna both worked at centers set up for women clients, which paid so badly that Nell called it "practically volunteer work." Nell considered fees an essential topic when exploring the experience of being a therapist. "No one else goes to work and, you know, is willing that at the end of the month, their boss says to them…we're only going to pay some of the hours." Nell, who had been through her share of financial hardship slowly learned how to charge private clients but was aware that she charged "less than most people." She reduced her fees even further

when people just could not pay because, as Joseph and Hanna also pointed out, sexually abused people who are just beginning to work through their issues, often truly cannot afford full fees.

Hanna was deeply conflicted about the whole issue of money and asking for payment which seemed to clash with her family's pioneering values of offering practical aid whenever needed. She immediately gave examples of clients who could barely afford to buy food. "So, can I take money from her? … I won't send a client home because he can't pay." She did gradually teach herself to discuss fees prior to accepting clients and opening the topic up for discussion rather than automatically adjusting to her clients' situation. She added an interesting countertransferential perspective, of dependence on clients, to themes of obligation, reparation and familial, cultural values that seemed to motivate the therapists:

> I really don't want to feel that I'm working for the money. As stupid or crazy as this may sound, it makes me angry. I can't stand it that I might need my clients. It's problematic, I know, but I can't stand it.

Such difficulties might not be unique to therapy, but shared by low fee lawyers, and teachers or physicians who serve disadvantaged populations. In psychotherapy--and in this case, with people whose earning capacity might have been compromised as a direct result of their traumatization--possible conflicts around fees must be fully acknowledged and resolved in order to protect clients and the therapy process in its entirety, from unresolved *a priori* countertransference.

Ruth, too, used to find it hard to demand payment for her work. Influenced, perhaps, by the socialist culture (Chapter 10) of sharing and volunteering within which she was raised, she "used to think money was something dirty. It was hard for me to take any." She still charged below the going rate. Fees were a complicated issue for Dana as well. She felt uncomfortable asking clients for money but was glad to pay her own therapist to ensure some mutuality. At the same time, the actual act of paying embarrassed her. It's possible to detect a replay of her family dynamics. Like so many of the other therapists, she did her caretaking and nurturing, in her case of her sibling, "for free" while growing up. This, in addition to possible lack of confidence as a beginning therapist, might make it hard to demand a professional fee. As a child, she did not really feel there were adult figures to turn to for emotional support, so it would make sense that she felt she needed to ensure her therapists were well compensated for doing something that was beyond the emotional capacity of her parents.

Sara was concerned that fees might "cause the therapist to lose his basic sense of humanity." She felt that at least some patients ought to be seen for free or for very little money, though she acknowledged she might think differently were

she to start a private practice of her own. Clearly, none of the interviewed therapists would evoke psychoanalyst Robertiello's (1994) wrath. He felt patients' needs ought to take priority in the sessions rather than "the analyst's narcissistic or financial needs…" (p. 37).

One might expect the fee issue to be a gendered one, especially in Israel, where women tend to earn significantly less than men. But this does not necessarily seem to be the case here. The older therapists still struggled with the socialist values by which they were raised, as opposed to the highly capitalist values that prevailed in Israeli society at the time of the interviews (Chapters 10 and 11). The fact that two of the therapists resorted to comparisons with other "helping" professionals perhaps also reflects the social standing of mental health professionals in Israel as significantly lower than that of lawyers and physicians.

The therapists expressed some incompletely resolved *a priori* countertransference perhaps related to guilt feelings reflecting the child's sense of obligation to ease the parents' suffering from a trauma that he or she was spared, as in the case of Joseph, Ruth and Dana. Dana's desire to pay her own therapist--at the time of the interview, she regretfully could not afford therapy--in order to maintain her own sense of boundaries is an important double standard that might be shared by others. Many of the interviewed therapists had to struggle as children with perhaps even the moral issue of how much they could "take" from traumatically damaged, emotionally exhausted and depleted parents; whether they were entitled, able to claim their "dues" as a child. Such experiences might make it rather complicated to find a balance between giving and receiving as a therapist.

The therapists expressed genuine empathy with the huge survival struggle with which so many of the more severely traumatized clients had to contend and a wish to be of help without burdening them further with fees that were more than they could afford. The impact of fees on therapy and the sense of shame that may be engendered by making a living from people's trauma and suffering have likely received and continue to receive insufficient attention in clinical training (Barth, 2004).

The Need to Differentiate.

Another form of boundary--especially with traumatized people--is a delineation between "them and us" to protect against the vulnerability of sameness. Slater (1996) courageously and poetically challenges this wish for separateness in the story of her own traumatization and recovery:

> But I think I set aspects of my own life down not so much to revel in their gothic qualities, but to tell you this: that with many of my patients I feel intimacy, I feel love. To say I believe time is fluid, and so are the boundaries between human beings, the border

> separating helper from the one who hurts always blurry. Wounds, I think, are never confined to a single skin but reach out to rasp us all. (p. 179)

More than any of the other therapists, Ruth seemed to take an opposite approach to Slater's: She thought of the professional relationship as:

> …very limited. It's very clear. It's got boundaries. So as far as intimacy is concerned, you know there's a beginning, middle and an end. You don't get lost in it. …And the separation is set in advance....You know there's going to be a separation which is then no problem.

It is as if Ruth, as a therapist, needed to be safe from the horror of an emotional reenactment of death, of the massive loss of life in the Holocaust, which so often included complete extended families. Her role of therapist is protective in that it offers her control over the duration and structure of the relationship, and most importantly, of course, of the termination.

The therapists' life stories also echo in their decisions regarding which clients to accept. Nell had initially excluded populations that might bring up aspects of her personal history that was too painful. But she gradually shifted her "red line" as she resolved personal issues. She still felt unable to work with traumatized children, as their psychological injuries felt too immediate and close to her own.

It can be very hard to allow oneself to choose whom to accept as clients -- and therefore, whom to refuse -- especially if the therapist has a history of abuse and neglect, like Nell (Chapter 6), or, like Dora, feels an obligation to help those less fortunate than herself.

> You didn't ask this, but from the moment I…started working privately, I allowed myself, I think colleagues also do that, to choose a bit more who I really accept for therapy. The 'excuse' was always that the therapy would be more successful, efficient and promising if I felt that there was a problem here that I wanted to work on and felt able to … It's a luxury.

Like Dora, Nell was only beginning to give herself permission not to accept clients she doesn't want, who are "belligerent, negative … why should I take that sort of abuse?"

Boundaries between therapist and client can also be shaken when a threatening reality is shared (Kretsch, Benyakar, Baruch & Roth, 1997; Somer & Saadon, 1997; 2002a, 2003, Vezmar, 2002; Chapter 4) and the delineation between "them" and "me" gets blurred. In their description of therapists called up to work

with soldiers after the sudden outbreak of the Yom Kippur War in 1973, Ben Yakar, Dasberg, and Plotkin (1978) identified with the soldiers and so the "usual therapeutic distance was *not* maintained" (p. 185). Shared or similar past traumatizing events can catch therapists off guard as well and shake their personal, if not professional boundaries. After a molestation experience as a young child, Dana nearly had an accident on her bicycle as she rushed along without paying attention to the outside world. Similarly, after one of her first professional experiences with a sexually abused client, she "nearly had a car accident.… I had completely merged and felt such turmoil….I brought it to my own therapy, which was the right place for it."

As the therapists' experiences illustrate, the issue of boundaries remains an ongoing active challenge in trauma work; family and personal history can interfere when, for instance dynamics in the therapy setting echo those "at home;" when traumatizing events are shared (Chapter 4); when a sense of obligation is not sufficiently processed and acknowledged; when therapists feel an absence of choice as to whom they want to work with. The difficulties and solutions are highly individual to each therapist and provide further illustration of the importance of taking into account the person, and the extended family history. In general, boundary related issues provide excellent starting points for exploration of *a priori* countertransference, that left unmonitored, might interfere with the therapy work.

Life as a Trauma Therapist

It has becoming increasingly clear, in the analysis so far, how personal and familial history and societal context--such as social values or perceptions of (certain) trauma- can impact upon becoming and being a trauma therapist. It would make sense for an ongoing interplay to exist between personal and professional life. The following section focuses on different aspects of the interviewed therapists' lives at potential junctures between the professional and private arena. Issues that will be explored specifically are the impact of work on the therapists themselves including whether or not the risk of vicarious traumatization was relevant to them, and the impact of their work on their family and social life. The therapists also discussed their professional satisfaction.

Impact on Self

The impact of trauma tends to reverberate in the environment of the traumatized person, especially for a witness, which is one of the roles trauma therapists inevitably assume. I did not ask specifically about self care or about vicarious (McCann & Pearlman, 1990) or secondary traumatization (Figley, 1995),

i.e. traumatization as a result of exposure to their clients' accounts of their traumatic experiences. The information the interviewed therapists shared, however, about how their work affected them, their families and their social lives offered some insight into the importance of the therapists' personal background in this context as well.

Self Care/Vicarious Traumatization.

It was only mid-way through the analysis of the interviews that it struck me that none of the therapists had complained about the impact of their work on their personal lives. They did all acknowledge that they were not necessarily positively affected by their work but, with the exception of Joseph who on occasion experienced "secondary traumatization" as a result of some of his clients' stories, they seemed very accepting of the impact of their work on their lives and said nothing regarding a need for special self-care to prevent or minimize vicarious traumatization. Lonergan, O'Halloran, and Crane (2004), on the other hand, noted in their study of the development of trauma therapists, that awareness for the need of self-care was a common theme, especially among therapists working with children.

Pearlman and Saakvitne (1995) considered vicarious traumatization an inevitable consequence of trauma work. “It is unique to trauma work … Because it changes the self of the therapist, it will inevitably affect all of our relationships – therapeutic, collegial, and personal” (p. 281). Schauben and Frazier (1995) studied the impact of working with “sexual violence survivors” on female mental health professionals and found a direct link between the percentage of such clients in their case loads, and the increase of symptoms of vicarious traumatization. Therapists who had been sexually abused and worked with clients who were sexually abused were not necessarily more at risk for secondary traumatization than therapists without such history, however (Benatar, 2000). In fact, Rothschild (2006), who offered a psycho-physiological perspective based on neurobiology, suggested that vicarious traumatization might be the result of therapists' lack of awareness of their somatic empathy. Kadami and Ennis (2004) reviewed the literature on vicarious trauma and concluded that the concept needed further clarification and could not be assumed to be widespread among clinicians working with traumatized clients.

This raises the question whether in the presence of a certain mix of personal and societal influences, vicarious traumatization, like trauma, is a matter of perception and expectation on the part of the therapists (Chapter 8). They might consider a degree of social withdrawal and fatigue, or symptoms of intrusive experiences of content related to the traumatic histories of their clients, “normal” with trauma work and thus cope without special acknowledgement. Hafkenscheid (2005), on the other hand, suggested that therapists might simply experience

"confusing, disturbing and burdensome feelings that the victimized patient might invoke" (p.164), rather than become vicariously traumatized.

Furthermore, the interviewed therapists had their own trauma histories (Chapter 6), which is not untypical for trauma therapists (e.g., Van Gael, 1998). Therefore, it might not always be easy to distinguish between the ongoing confrontation with old, personal traumatic experiences, reactivation, or the development of vicarious traumatization. Sara, for instance, described what sounded like vicarious traumatization, "I'm simply a less vital person….lack of vitality in the sense of guilt feelings about being alive, lots of times." But those feelings did not start with her work with Holocaust survivors, though it might have reinforced them. Ruth was aware that her work affected her "personal life…on a cognitive level" and she always felt relieved that her own life was not as bad as that of some of her clients. In fact, she had always told herself that "things could have been very much worse; like it was there, during the Shoah." And Nell felt so drenched in awareness of sexual abuse that she was amazed whenever she learned that a client had not been sexually abused. She considered herself a trauma therapist, not necessarily limited to sexual abuse, "even though it sometimes gets so overwhelming to think how much sexual abuse there is." David's work with a geriatric population provided an additional challenge. He had to frequently cope with patients dying and made it "a point" to attend all funerals. "It's personal and professional and complex." Asked whether he allowed himself to get attached to his patients, David says: "Yes, yes, very much so! That can't be helped. You can't do it otherwise. I can't do it otherwise."

When therapists and clients live under conditions of ongoing danger and existential insecurity and economic stress, as is so often the case in Israel (Chapters 4 and 5), it might also be hard to attribute causes for fatigue, decrease in sociability and other symptoms specifically to vicarious traumatization. Joseph, for instance, dreamt of going abroad. "This is a difficult country to live in. … Many places remind me of wars, of terrorist attacks, or distress." He also referred to the effects on the population as a whole which, "because it is suffering, can be unpleasant at times. On the roads, in queues, in interactions, in offices …" To balance some of the pressures inherent in their trauma work, most therapists have expanded into additional areas of work, such as teaching and research. For Joseph, teaching was a kind of unwinding "Working with healthy people with shining eyes… It's lovely."

Nell summarized the burden of expectations on trauma therapists to help people recover from dreadful traumatic experiences and life circumstances. The normative advice to someone suffering the after effects of traumatic experiences is, 'You should see a therapist." The expectation seems to be that therapists restore traumatized people to their previous selves. As Nell said, "Now, I'm the person

they come to! You know, this is where it's supposed to be happening? That's a terribly responsible thing!"

The material that arose in the interviews thus demonstrated that vicarious traumatization might depend more on the therapists' perception and interpretation of their experience than on their actual contact with their traumatized clients. This, in turn, comes back to who they are as people and what attitudes, resources, values, histories they draw on.

Impact on Relationships with Family and Friends

An additional perspective to learning about the experience of being trauma therapists is by exploring if the interviewed therapists' professional life affects their non-clinical relationships. They all stated that their family life has been affected by their work. This impact is worth exploring for possible sources of *a priori* countertransference in case the quality of their relationships in turn impacts their attitudes towards their clients.

Sara said she was hard to live with, and spoke at length of the lack of resonance from her family of origin. "There isn't anyone in my whole family who would really listen…They're all busy with their own lives and survival…There wasn't anyone that listened ever, so why should anyone listen today?" She made no mention of her husband in this context, but dwelt at length about the responses of her family of origin, as if she were stuck in trauma time

The others related to their current family life. Sometimes, the impact was positive. Dora found that her work with Holocaust survivors and the second generation helped to create greater openness about the Shoah and about how it has affected the members of her family. Dana learned from her clients what damage lack of communication could cause in families. She realized she had related to her children with the same lack of openness that was characteristic of her family of origin (Chapter 6) "in order to protect them, as it were. And then I see the damage this does to others, that kind of behavior, and I try very hard to behave differently."

David acknowledged the fact that his family life was compromised occasionally, but seemed to consider it part of his work:

> You can't be a psychiatrist in a nut house, on a locked ward with old people who're dying and are insane, without that coming at a price…There is no time out. What, the patients stop being ill? Time out is at 65 when you retire!

Joseph worried sometimes whether he was behaving "like an abuser" in his family; at other times, he may suddenly experience himself as a victim, though "I never thought of myself as a victim… it never occurred to me in those terms."

He pointed out that he did not know what happened to those echoes that had reverberated in his personal life from sessions with clients when he went back to work, but he treasured the support and "refuge" his family afforded him. It was difficult to care for his mother after work but "the family that I built is healthy and pleasant."

Ruth sometimes lashed out in anger at her family as a result of stored up feelings from work with patients. Work with sexual abuse has also made her more alert to dangers to her daughters of possible sexual molestation. She laughed when she said that her daughters had become more alert as well. Nell too was concerned about the impact on her daughters, not just of her work, but of her response to the widespread sexual abuse, including her own as a child. Hanna mentioned that her youngest child complained she was a different mom to her than to the older kids: "Your work is making you nuts!" Hanna agreed she might have become more aware but she felt that on the whole, she had "a rather mature, adult and balanced outlook on life." Still, she realized that her family felt "jealousy and anger" regarding the time and energy she invested in her clients.

Work significantly defined the therapists' lives and except perhaps for Dana who enjoyed socializing, they tended to have little energy left over for anyone else but clients, family and perhaps close friends. Hanna felt "first and foremost invested" in her work, but did maintain her relationships with her women friends. "I'm fortunate that some of my work is with people I'm close to." David, who could display infinite patience with his patients, had very little patience for 'problems' of anyone outside his immediate circle. Joseph described an ongoing process of social withdrawal:

> It really has isolated me even more. I have introvert tendencies. On the one hand, I have no patience for small talk, and on the other hand I have no desire to talk about deep things after a whole day of sessions like that. So what's most comfortable is to write, read, go for a walk, and not maintain social relationships. I do think I'm a sociable creature, but it's being consumed by my clients. That's a price to pay.

The interviewed therapists' social life seemed to take the brunt because of reduced time and energy. Nell and Hanna considered themselves fortunate that some of their closest friends were colleagues. Perhaps helped by the remnants of pioneering spirit, David and Hanna seemed most matter of fact about their limited time resources, considering that a natural consequence of their work. Sara, who was generally at a vulnerable point in her life, soon after giving birth and before moving to another town, focused on memories of loneliness in her family of origin that were evoked by her work, and their continuing lack of support. Dora and Dana,

who each in her own way found their work helpful in coping with their own stories, became more communicative and open whereas Ruth noted that she occasionally vented pent-up anger from work on her family. Joseph was concerned about possible reenactment of clients' material in his family by taking on roles of perpetrator and victim, though on the whole he felt supported and comforted by his family. Neither Ruth nor Joseph had been in any significant psychotherapy (Chapter 8), and both had mothers who had been young girls in Auschwitz. Still, the others might have similar responses but did not think to mention them. It was noteworthy that Ruth, Hanna and Nell all emphasized increasing concern about the safety of their children against the risk of sexual assault, while neither Dana nor Joseph mentioned similar worries.

What stood out then, was the therapists' general attitude towards the 'side-effects' of their trauma work; their willingness to adapt their boundaries between work hours and private time, by accepting that the emotional and physical impact of their trauma work continued after-hours. Such acceptance of limited energy for family and friends often characterizes (families of) trauma survivors. In the case of the interviewed therapists, they might have just accepted the spill-over of trauma work into personal life, much as a press photographer has to accept disruptions in his or her private life. Therapists need to be alert to the possibility that negative repercussions may affect their *a priori* countertransference. For example, they might limit their expectations of their clients' lives to similar constrictions.

Professional Satisfaction.

The interviewed therapists easily articulated the difficulties that inevitably affected them as a result of their work with traumatized clients. Professional satisfaction can provide a necessary balance to such difficulties and might also impact therapists' *a priori* countertransference. Radeke and Mahoney (2000) compared personal lives of psychotherapists who did not necessarily work with traumatized clients and research psychologists. They found that that the psychotherapists were more likely to feel depleted by their work than researchers, but "that it also increased their capacity to enjoy life. Therapists were three times more likely than researchers to experience their work as a form of spiritual service" (p. 83).

When keeping in mind the stress as well as the satisfaction of being a trauma therapist, it is useful to also remember that clients and therapists generally impact each other's physiology (Adler, 2002). They could do so in a "negative sociophysiologic feedback loop" which might be experienced as vicarious traumatization, or positively, by causing "satisfying feelings" (Adler, 2002, pp. 886-

887). Hilton (1997) suggested that the intimacy essential to good psychotherapy places both clients and therapists at risk:

> The 'role' of the therapist functions as a form of self organization and beneath this role lie all of the unmet needs and emotions of a frightened and disorganized child. Yet the therapist is responsible for having worked enough with these unmet needs to be able to invite the client where he needs to go (p. 85).

Trauma work specifically, as Pearlman and Saakvitne (1995) noted, for all its risks and difficulties, can also be transformative on both a personal and professional level. According to Herman (1992) the positive reward of trauma therapy may be “an enriched life” and a “deepening of … integrity” (p. 153). Benatar (2004) noted that trauma work could lead to what she called "positive self transformation" which, in itself, "does not exclude some secondary traumatic stress effects” (p. 6).

The interviewed therapists appear to concur with those views. Dora, for example, credited her work with helping her realize that what she had suffered was actual trauma. She was then able to work through that. “I get a lot of satisfaction out of coping with it, and helping whoever is tainted to cope with it, tremendous satisfaction.” Dana had to learn to change her behavior and express herself more directly. “I just didn’t dare to open my mouth!” Sara felt she had gained a deepened sense of her own Jewishness in addition to a new sensitivity to, and appreciation of, Holocaust survivors.

Joseph addressed the issue of mutuality:

> It's not just that we influence our clients, they also influence us. They force us to look at ourselves as perpetrators and also as victims. And we have to look back at our lives to re-evaluate events from the past, in the light of what we experience with them in the clinic.

He found great fulfillment in the “privilege” of doing his work and was very aware of his "blessings" compared to the quantity of massive traumatization he encountered.

Hanna saw herself somewhat like "a writer or an artist who has a talent that she has to fulfill and is basically stuck with.” Still, she delighted in her ability to continue learning new things, “one of the reasons I chose this profession.” She felt a sense of achievement in the professional status she has gained. And she enjoyed the varied aspects of her career of clinical and educational work, such as "setting up new projects, so I’m in the whole possible continuum, professionally. “The

opportunity to be in an intellectual and clinical dialogue, and to pass on what I have learned in supervision and teaching" was very meaningful to her. Hanna could have dedicated herself exclusively to training other professionals at this stage of her career, but chose not to do so. She preferred living by her own values:

> I feel that ideologically and ethically, I can't just teach and not do therapy. This is a field that needs people who understand what they are doing, people who are willing to not only think of their finances and how they can have an easy work life and nice clients. I don't think that's right. It's part of my commitment. I've received a lot and I have to give back.

Hanna's extensive experience with trauma has taught her that "our control over our life and reality is very limited…we can only do our best…assuming we don't get blown up tomorrow or today when we leave our front door."

Nell found great satisfaction in helping people turn their lives around, much like she had been able to do herself. Tongue in cheek, she added, "You get to be in this intimate relationship--for the most part, you only get to show your good side, so people think you only have good sides.…for me, it's just the perfect profession." After two decades of work in a variety of settings, she also actively enjoyed the "privilege" of the quiet and independence of private practice.

David emphasized his love for his work. "I wouldn't do it for another minute if it wasn't the big love story of my life…I think it's so 'unique', so special, that combination of old age and insanity." He was aware that not all colleagues shared his attraction. "It may be the ugly part of psychiatry on the outside. But there's something, something that's a bit 'magical' in working with old people." Ruth expressed her satisfaction very succinctly: "I don't think there's a more interesting profession than mine…it's interesting and very fulfilling. You are actually doing something!"

The therapists had a variety of responses reflecting their histories and personality. Some appreciated how their work had deepened their understanding of their own trauma history and provided the opportunity to use their traumatic experiences to help others. Some therapists emphasized a sense of satisfaction and privilege in helping their traumatized clients, and in their own ability to meet the challenges of this work. Some thoroughly enjoyed their work and others felt rewarded by the results of their work. What seemed true for all were feelings of satisfaction in being effective, which is perhaps one of the strongest remedies against the sense of helplessness inherent in traumatization. Of course, this then calls for particular caution when the client's rate of progress is not satisfactory: there might be a burden of expectation on the client which is reminiscent of the experience of many children of survivors who had to be "happy and successful" in

order to provide their parents with an ever inadequate antidote for their own experiences of persecution and the deaths of so many of their loved ones.

Personal History and Professional Life

My focus in this study has been the interconnection between the personal and the professional lives of the interviewed trauma therapists and the sources for *a priori* countertransference to which this may give rise. And indeed, as has been shown, regardless of which aspect of trauma work was discussed, there were always undertones of the therapist's personal history. In order to gage the extent to which the therapists were aware of this, I asked each one at the end of the interview, whether they saw any connections between their own histories and their professional work. They all did.

For Dora, the connection between her life story and professional choice and development was an ongoing one. She spoke of the aging process both she and her survivor clients were going through:

> Just think, survivors are already my age and older. It's a very different time in one's life… Now it's the survivors' turn. This is what I say to myself! The kids are already out of the home and that's fine. They've left only physically, but they [continue to] exist. And this is the time for us to take care of ourselves, to allow ourselves to live now… To take more from life, despite all the horrendous things that happened. And despite years of helplessness. There is no helplessness now, despite the fact that the *Matsav* is not exactly encouraging, but to take permission for the third age. Even though many of us, I can't say that about myself, but many of us never saw their relatives even in the "second age"! They really don't know what it means to grow old. That is our job now, at this time with the survivors, not to get scared by every surgery. That's not the end of the world yet. You can recover or you can get used to it and get on with it. We are no longer helpless.

Ruth was perhaps the most unequivocal of all in seeing an immediate connection between her life story and all professional choices she has made, and felt children of survivors are frequently assigned the role of therapist by the family (Chapter 7). Joseph thought that the personal questions in the interview were professionally appropriate because the "results of my childhood clearly sit in the therapy room." Dana had no doubt either about the professional relevance of her personal story. What stood out for her was the risk of over-identification. She

stressed that she needed to be able to easily and fully access and resolve her own material in order to safeguard both her clients and herself.

For Hanna and David the emphasis of the connections between their personal and professional lives was less on trauma histories than on values and attitudes to life within their families and society around them. David noted his father's hard work and dedication in his own profession as a model for himself as a psychiatrist without focusing on the actual clinical work. Hanna carried on the tradition of caretaking in the female family line and pioneering of generations of family members. "So I can say that from that point of view, I initiated social changes or was part of social changes, like a pioneer, as it were."

Nell always remained aware of her own traumatic history while working with her clients. There were times it was hard for her to think just how many of their traumatic experiences she herself had suffered. But she felt that a therapist's personal traumatic experiences, once sufficiently resolved, can only contribute to sensitivity and understanding. But “sometimes I feel this is a little bit ridiculous! I mean, there’s a limit!” In fact, she realized that she sometimes needed to remind herself to be fully respectful and empathic with clients whose stories were very much milder than her own. Sara linked her current uncertainty about her career development to personal issues and to the fact that she still frequently felt “weak and very vulnerable.”

The implications of the links between the personal and the profession, what led them to trauma work, and what issues, needs, and expectations awaken in the course of their work, form the very foundation upon which *a priori* countertransference can flourish. If the link with one's personal life is taken for granted, there is a risk that this will not be sufficiently explored--beyond perhaps more pathological issues that might be resolved in personal psychotherapy--and hence, therapist might unwittingly act out their *a priori* countertransference.

Future Plans

The therapists were all committed to their work and clients. Some sought some more variety in their work and prepared new challenges for themselves by initiating projects, such as establishing new therapeutic centers, engaging in public activities to serve traumatized clients' interests in non-clinical settings (Chapter 11), and teaching. Hanna, Ruth and Joseph spoke rather wistfully of retirement, though this was neither financially feasible, nor were they really ready for this at the time of the interviews. The thought of it scared Hanna as "no one would need me and I would be forgotten.” Dana, who was still in the beginning stages of her career as a therapist, considered specializing in working with “older adolescents, like myself… that are in crisis. That can also include trauma.” She was willing to work in any setting where she could be “part of a team. Thinking together is very meaningful to

me." Nell wanted to continue as a trauma therapist despite the fact "it sometimes gets so overwhelming to think how much sexual abuse there is…" She had made a decision, however, to find a better balance between work-time and 'off'- time.

Sara was at a professional crossroads; she had experienced genuine satisfaction in her work but at times felt a lack of self-confidence and doubted whether she was "worthy of being a therapist." She worried about her "lack of ambition" and wondered whether her real destiny was being "a housewife, and all the rest a lie…that's a very difficult question I'm facing now."

A lot of the themes that have come up throughout this chapter were concentrated in this section. While the therapists remained realistic and honest about their feelings and experiences and acknowledged that trauma work was not easy, most felt committed to continue. Possible *a priori* countertransference issues emerged in Hanna's fear of not being needed, some of the others' toying with the idea of retirement without that being a realistic option, and a sense of family history defining one's destiny, which in Sara's case might preclude her continuing to take on a professional identity. These situations might reflect some underlying feelings of being stuck or overwhelmed; this does not contradict their commitment to their work, but such ideas had not been as clearly expressed earlier on in the interviews as when they were when asked to sum up their thoughts.

Summary and Discussion

The interviewed therapists experienced their work as trauma therapists intensely and in highly individual ways. This reinforces my conviction that while general areas of *a priori* countertransference can be mapped out, individual therapists need to be alert for their own specific triggers.

Their choice of work setting and their responses to conditions there seemed to echo their family dynamics. Dora, always among the first to reach out to those she perceived as vulnerable, was one of the founders of a center for Holocaust survivors. Already in her seventies by the time of the interviews, she still saw some clients and supervisees. Ruth and Joseph seemed to have taken their childhood lessons into their professional lives and created their own work conditions rather than try to adjust to an existing setting. Dana who found herself dramatically, and perhaps traumatically, let down at her place of work, exhibited resilience similar to her experiences in her family and carried on undeterred. Sara had apparently found some healing of old wounds in her positive experiences of belonging and support but was unsure whether or not she had the strength to carry that over to a future place of work. After Nell and Hanna were ejected from trauma centers working with Holocaust survivors, which for Nell might have been a

traumatic replay of abandonment and for Hanna an ironic reversal of her family culture of downplaying the Holocaust, they both found their place in centers working with sexually abused women.

The feminist culture at their places of work seemed to enable a merging of professional and personal boundaries in collegial relationships. Such relationships appeared to be of limited importance to the other therapists. Colleagues may be appreciated but it is quite possible that having been raised in a traumatized family meant that the therapists did not develop templates for expectation of mutual support and constructive sharing.

The therapists' attitudes towards supervision similarly reflected their personal narratives. For instance Hanna, who had absorbed values of doing the best work possible combined with a sense of social responsibility as well as the reliable availability of a nurturing grandmother, considered supervision integral to trauma work. Joseph, on the other hand, was raised not only to be self-reliant but also to be the caretaker of his severely traumatized mother. He could see the usefulness of supervision, but had no real expectation of finding a suitable person or framework.

The interviewed therapists were all deeply committed to be the best possible therapists for their traumatized clients. They remained in a process of developing professional skills and ways to meet their clients' needs. They volunteered no comparisons of the ways they experienced psychotherapy with traumatized clients versus clients without a history of traumatization, nor did I think to ask. This is but one of the examples throughout the interviews that highlight the *a priori* countertransference risks of any shared conceptual world in that the focus might be taken for granted and what lies outside it, ignored. Trauma might have colored our perception and the way we responded is no different, in principle, to the discourse of clinicians for whom trauma tends to be outside their perceptual field and who therefore ignore it. Thus one way in which *a priori* countertransference might manifest is in therapists' blindness to what lies just beyond the boundary of their particular professional interests and awareness, i.e. as an absence of curiosity or a need for the security of the familiar and known.

The interviewed therapists accepted the possible existence of multiple trauma in their clients' histories as a matter of course, but never referred to their own or their family's histories in this context. Very few of the therapists were professionally preoccupied by the phenomenon of dissociation, which is increasingly seen as an automatic (peri- and/or post)traumatic response, though to different degrees. They had little difficulty believing what their clients tell them, or, more importantly, they did not see themselves as arbiters of truth and felt respectful and accepting of their clients' experiences as they spoke of them in the sessions.

All the therapists easily acknowledged the importance of boundaries in clinical work in general and trauma work specifically, but a particularly rich vein of autobiographical engagement, and hence *a priori* countertransference, was hit with questions around fees. Perhaps it was the fact that fees are related to the therapists' physical, concrete existence, as well as social acknowledgement and self-assertion that made this such a fruitful discussion point. In addition, fees symbolize a separation from being called on to understand and help in a private, familial context, and professional parameters.

The therapists seemed rather matter of fact about the impact of their work on their personal, social and family lives. They did notice fatigue and reduced energy but took these phenomena in their stride as part of their job. Such acceptance might, for some, also be a replay of their coping with trauma as they were growing up, i.e. just going on and getting on with things; a copying of their families' resilience in the face of severe trauma and repeated adversity; or a lack of experience in labeling their own experiences as traumatic, and hence not necessitating specific response. Some of the therapists were also mindful of their increased concern for the well being of their own children and alert to their vulnerability.

At the same time, the therapists were well aware of the satisfaction and fulfillment their work brought them and their ongoing motivation to continue in this field. Whereas no one articulated this fulfillment as the result of somehow "curing" trauma per se, many enjoyed their ability to make a difference, to be effective in ways they could not be with their families of origin. Two therapists, children of survivors, were aware of a sense of privilege that, compared to some of their clients, particularly, but not only, Holocaust survivors, they had such good lives. And, of course, there was the pleasure of success, as Hanna experienced it and sheer love of the work, as David put it. The individual differences in attitudes, emotions and values that they absorbed in their personal lives come into play both in the frustrations as well as the satisfactions resulting from their work.

The interviewed therapists all considered their personal histories and professional lives connected as a matter of course. None thought the personal questions in the interviews superfluous or overly intrusive. However, they all related to the ways the personal and professional were linked in their own styles reflecting their family legacies. This was also the case regarding their future plans. Retirement was beckoning some as a time to rest and catch up with other aspects of their lives; Sara was struggling to resolve questions of professional identity; but on the whole they were committed to continue working with traumatized clients and searching for a balance between clinical and academic--teaching and research--work.

The therapists' positive responses to their work, such as, for example, the need to be needed, to be effective, as well as to the work setting and relationships there, are all entry points for further exploration of *a priori* countertransference. A therapist who thrives on being effective, for instance, needs to be very aware of this as possibly shaping *a priori* countertransference and, if not monitored, it may interfere with what might then be perceived as a "difficult" client with whom the therapist has a long, difficult therapeutic journey ahead.

What always has to be taken into account is the attitude, the perspective and interpretation of the individual therapist. Sara's dilemma, whether to give in to her perceived sense of destiny or fight to retain and strengthen her professional identity illustrates this. Her dilemma also raises vital questions about personal, social and professional roles. Whereas all the other interviewed women therapists had children, none spoke of having wanted to, or having felt pressured, to stay at home to raise them. Sara had fairly recently given birth, but that too is often part of a therapist's life and provides an example of how therapists confront ongoing changes and possible crises in their own lives. Another question is just how acutely wounded a healer can be and still function well as a trauma therapist. The path to finding answers to these questions that are right for the individual therapist are by further exploring the related *a priori* countertransference.

Analysis of the interviews has shown both explicit and implicit links between the therapists' personal and professional lives, many of which they have acknowledged themselves. Exploration of specific junctures, such as attitudes to therapeutic approaches, to boundaries, or to their personal quality of life as trauma therapists revealed rich territory for *a priori* countertransference. Fodor (2001) summarized perhaps most concisely the link between personal and professional development and, as will be the focus in the following chapters, the societal context:

> The changes in my work as a therapist occurred in the context of changes in the culture in general and in psychology in particular as well as of the changing nature of the clients and the issues they brought to therapy. In addition, growing older, listening to myself rather than others, luck, fate, and the challenges of my personal life and my responses to them also have been most influential in motivating me to change and shape the directions of my therapeutic work. (p. 125)

CHAPTER 10

Trauma Therapy and Societal Context

The previous chapters have concentrated on the interviewed therapists' personal and professional histories and experiences; the spotlight in chapters 10 and 11 will be on the societal context framing those experiences. In this chapter, I want to focus on the interviewed therapists' contribution to their society as well as their responses to that society's demands and possible sources of *a priori* countertransference all that may give rise to.

I present this exploration of the societal setting in three major sections: The first section (1) is a discussion of the social mosaic in which the personal and family stories of the interviewed therapists serve as examples of sectors of the population comprising Israel's human fabric. These stories provide insight into the complexity of Israeli society and the traumatic burdens affecting both clients and their therapists, whether or not these are acknowledged as directly relevant to the trauma history the client presents. Therapists and their families not only contribute to this mosaic but are keenly affected by it themselves, which serves as fertile ground for *a priori* countertransference.

The next section (2) focuses on identity issues and Israeli society. Traumatized clients often grapple with the challenge of rebuilding their sense of identity and a sense of belonging to a community (Herman, 1992). The Israeli setting with its internal divisions, ongoing conflicts and demands for complex loyalties might evoke many triggers for *a priori* countertransference. In order to establish whether there are *a priori* countertransference issues here, the interviews addressed societally relevant factors that may influence therapists' identities, such as country of origin and ethnicity.

The final section (3) focuses on the effect of living and working in a society in turmoil, a nation that is in a state of perpetual change in which daily life is tumultuous. The impact on the therapists of their army and reserve service, wars, and terrorism might also provide both aids and obstacles to understanding clients, communication and trauma processing.

Social Mosaic

Israeli society is made up of Druze, Bedouin, Israeli Palestinians, and a large majority of Jews. Some of the Jews have lived in Israel for many generations, but most of them immigrated in the last sixty years from different parts of the world for idealistic and/or trauma-related reasons. There is an ongoing cultural exchange within the population, whereby the individual contributes to the mosaic which continues to change, for example as a result of the recent influx of immigrants from the former USSR and Ethiopia (Chapter 5). At the same time, society contributes to the individual. The interaction between the therapist's

personal and family history and the impact of society may provide a rich source for *a priori* countertransference. The eight interviewed therapists represent major groups within Israel's population. Their personal and family histories are not merely their own, therefore, but are also part of the fabric of Israeli society as a whole.

Early Zionist Settlers

There has always been a core Jewish population in the Holy Land, and the ability to trace back family history over as many as 10 generations is often a source of pride. None of the interviewed therapists stem from families that have lived in Israel for that long, but David's, and on her mother's side, Hanna's families belonged to the wave of immigrants that fled the *pogroms* in Eastern Europe around the turn of the 19th century. Their parents had already become an integral part of the structure and values of the developing Israeli society before the War of Independence in 1948. In fact, they belonged to the "old-timers" who received the Holocaust survivors, the refugees from the Arab countries, and subsequent waves of immigrants. Having been born into what was already "naturally" their country, Hanna and David seemed to share a sense of solid Israeli identity and social values despite individual differences between their families. They were also aware of their roots both in idealism and trauma. However, they might also carry a legacy of the traumatic experiences that to this day remain unspoken (Davoine & Gaudielliere, 2004), that prompted their families' flight from Eastern Europe around the turn of the last century as well as the hardships they may have endured in then Turkish, and later British ruled, Palestine.

Holocaust Survivors and Their Children

In the first decades of Israel's existence, there was not much understanding of Holocaust survivors and little acknowledgement of what they had suffered in the Holocaust (Chapter 3) nor of their significant contributions to the State of Israel (Segev, 1994). Dora belonged to those who made a vital contribution to building the state. Feeling unable to remain in Europe after World War II, she became involved with Zionist emissaries who smuggled her back with them into what was then still British-ruled Palestine. She joined a kibbutz where she experienced a double culture clash because she was asked to join a group of Yiddish speaking new immigrants from Eastern Europe. Like many assimilated Jews, Dora's family of origin did not speak Yiddish and she did not understand the language. Her husband-to-be was one of that group. He had fought in the Red Army and been seriously injured. After the war, he discovered that his entire family had been killed, and led a group of Holocaust survivors on a tortuous journey to Palestine. Such histories were not uncommon, and it was people like them who,

after horrendous Holocaust experiences, found the strength to significantly contribute to building the country**.**

Ruth, Dana and Joseph represent the children of survivors in the mosaic. Ruth's father, an adolescent survivor of Auschwitz, had managed to find his way onto a boat with illegal immigrants to Palestine that was intercepted by the British. He was interned in a camp on Cyprus, as was Ruth's mother, also an Auschwitz survivor, who had been brought over by emissaries gathering orphaned children (Chapter 6). By the time Ruth's father was allowed into the country, he was "nearly seventeen and immediately drafted into the War [of Independence]". Many survivors were drafted upon arrival without their even knowing Hebrew. Many were injured or killed (Segev, 1994; Yablonka, 1999). The emotional impact of this aspect of their immigration, both positive -- being finally in a position to fight for the independence and safety of Jews -- and negative as a result of cumulative traumatization, has barely been touched upon, neither in public discussion in Israel nor in the professional literature.

Dana's and Joseph's parents also survived the Holocaust as children and arrived in Israel around the time of its independence. Neither of them mentioned their father's army service at that time, however. To further understand their background, it is important to point out that the Holocaust survivors that came to Israel and raised "Israeli" families carried not only their different trauma histories, but also the languages and cultural legacies from their countries of origin. These could be as diverse as, for instance, The Netherlands, Hungary, Greece, Poland, Germany, and (the former) Yugoslavia. This, too, can influence a therapist's perception of clients' responses, let alone a child's perception of its parents' responses. It was only when Dana visited her parents' country of origin as an adult, that she more fully understood their style of communication (Chapter 6). I find it equally significant that Joseph and Ruth did not touch upon this issue. Perhaps they had internalized the *Tsabre* ideology of being like everyone else.

North African Immigrants and their Children

The largest wave of North African immigrants arrived in Israel around 1950 when the State was just a few years old and doubling and redoubling its entire population, yearly. Israel received the new immigrants under very poor, improvised conditions. On the whole, the North African Jews had lived a religious and traditional life style and were very different from the predominantly socialist, secular Israelis that were running the country at the time. Sara is a child of such immigrants. Her family has remained resentful about their immigration experiences (Chapter 6). The feelings of being disenfranchised, that Sara's family shared with the larger North African population, gave birth to several political parties that specifically represent this sector of the population.

To a large degree, Sara internalized both the bitterness and damaged self-image. She also expressed distress at having insufficient role models from her "ethnic group." Segev (1994) pointed out that there has been little discussion in Israel about the fact that *all* immigrants in the late forties and early fifties, not just those from North Africa, endured great hardship and that different ethnic groups have passed on their different narratives to the following generations:

> In 1949 the composition of the incoming immigrants began to change. Instead of Holocaust survivors, Jews from Asia and North Africa arrived. The result was that the Holocaust survivors experienced what past immigrants had; they suddenly became "old-timers." Like the Holocaust survivors before them, the immigrants from the Islamic world had to deal not only with practical difficulties but also with a hostile atmosphere…Many of them were abandoned upon their arrival in miserable conditions, without proper housing, without education for their children, without medical care, without work…Their distress lasted for years, passing on to their children and even grandchildren, and has become a central, painful issue in Israeli history. Yet at base their experience was very similar to that of the Holocaust survivors. (p. 185)

Anglo-Saxon Immigrants

The native English speakers, generally referred to as the "Anglo-Saxons," are the only other immigrant group represented by the interviewed therapists. Nell belonged to the large wave of Anglo-Saxon immigrants that arrived in the late sixties and seventies. Many of these immigrants from the Unites States, Canada, South-Africa, Australia, New Zealand and Britain, maintained strong cultural ties with their countries of origin. At the same time, they infused Israeli society with many of their values, including feminism and western style capitalism which came to replace the existing social-democratic system. Over the past few decades, the United States seemed to have increasingly replaced Europe as the main external cultural influence on Israeli society.

Nell was very aware of being considered somewhat of a foreigner, of being treated as if she were "just off the boat" because of her strong accent: "And I sit with clients and they say, you know, I don't know if you "understand the Israeli atmosphere." And I want to say, how old are you! You're 27? Well, I've been in the country more than you!" Being immediately typecast as an outsider was perhaps the hardest aspect of being an immigrant for Nell. "In my next life, I want to live my whole life in the same country as my mother tongue."

This combination of very private history with the societal context can give rise to significant *a priori* countertransference in the shape of, for instance,

expectations regarding how others might see one, and how to see others; of emotions, such as those expressed by Sara or Nell; and a lack of sensitivity as to culture of origin perhaps in therapists who, like Ruth and Joseph, were raised in an atmosphere that encouraged denial and rejection of any personal Israel history and customs that predated arrival in Israel.

Identity Issues and Israeli Society

The societal setting can have a significant impact on therapists working with traumatized clients (Agger & Jensen, 1994: Lindy & Lifton, 2001). Because Israel is such a young state, personal histories still represent the history and creation of the state, its political development and the traumatic roots of its society. The interviewed therapists' biographies (Chapter 6) have shown a wide range of trauma-based motivation that they or their families had for coming to Israel as a personal refuge. Questions of social identity and belonging therefore may provide a fertile source for *a priori* countertransference. A lack of awareness of potential implications of these issues for individual therapists and clients might restrict the therapist's listening abilities. For instance, clients' views and attitudes might surprise a therapist into discovering that these threaten his or her own sense of identity, or even actual safety, with regard to Israel (Chapter 4).

I have chosen three major areas through which to explore the therapists' identities as Israelis: their experience and perception of (their) Jewishness -- Israel was created to be both a refuge for Jews and a revival of Jewish culture; their ethnicity--in this case, *Ashkenazi* or *Sephardi* -- which is cause for much political division, personal resentment, and actual and perceived discrimination; and third, that key to survival in the Diaspora, one's identity papers, the passport.

Jewishness

Whereas in most Western societies, religion is considered a rather private choice and experience, being a Jew entails belonging both to a people and a religion, as well as automatic entitlement to Israeli citizenship if so desired. Furthermore, Israeli therapists' and clients' histories often include (family) trauma against the background of their Jewishness, though they do not always consciously acknowledge this (Tauber, 1998). Spiritual values, as discussed in Chapter 6, are therefore but one aspect of being a Jew.

The topic of Jewishness evokes strong feelings reflecting the cultural and political struggle between religious and secular Jews in Israel. As Greenberg and Witztum pointed out (2001), this is part of a historic process:

> The secularization of Jewish society has proceeded in waves over the past two hundred years. In most cases, the parents, grandparents, or great-grandparents of today's secular Jews were ultra-orthodox. This means that the values of the ultra-orthodox community are part of the cultural heritage and background of virtually all members of the Jewish population in Israel. (p. 18)

David, who was proud of his rabbinical roots (Chapter 6), expressed carefully thought-out views about the meaning of Israel to the Jewish people. In his view, it is Israel's job to protect the Ultra-Orthodox. This is very different from the prevailing attitude of anger, among secular Israelis, against this sector that generally does not serve in the army, nor make significant contributions to Israel's economy:

> We're here to give them a home. It's not the other way around …They are the kinds of Jews who most need the protection of this place, even if they think they don't. Who will tolerate them if they go back to the Diaspora or if we have an Arab state here? It will take two and a half minutes and uh, there will be an apocalyptic finale of one kind or another. So this is the only place that can be tolerant and contain Jewish 'insanity' or fanaticism. But that's the point! It's a Jewish state, so you're allowed to be a fanatic Jew here. If not here, then where?…That's their wonderful privilege, to come to a Jewish state and say, I'm a Jew, and that's why I'm here. And all the rest, you can do, whatever you want: pay taxes, go to the army, build roads, do whatever you like. I'm here, just because I'm a Jew. That's it. That's the essence of the creation of this state.

Perhaps David wanted to protect the vanished world of his rabbinical roots. He did make very clear that he felt a deep affinity with Jews everywhere.

The other therapists had rather different views. Most spoke of the ultra-orthodox and the orthodox that live in the territories, the settlers, in one breath. As Nell put it, "I'm not real tolerant about people that live over the green line." In fact, such negativity can make settler colleagues feel very isolated especially when confronted with personal danger (Chapter 4). Hanna rejected "the extremist religious" and the settlers, as she is "not willing to accept fanaticism." The only religiously observant therapist, Sara expressed concern and anger about the recent rise in anti-Semitism world-wide. She did not link this concern to the reason why her parents had to flee North Africa. The others focused on more ethnic, cultural aspects of their Jewishness. Dora spoke of Judaism in general as something “very meaningful… but in a very secular version." Joseph considered himself an atheist, and "ethnic Jew," and attached great importance to "that ethnic existence." Nell

similarly perceived herself as "culturally Jewish" and belonging to the Jewish people.

Ruth was deeply aware of being "defined" as a Jew by others, and of the history of persecution of Jews. In addition to her parents' Holocaust experiences, her reading from an early age about the Inquisition leading up to the expulsion of the Jews from Spain and Portugal in the 1490's, and about the Holocaust deeply affected her. For Hanna, like Ruth, "Judaism isn't something I define. The environment defines it for me. Just as I can't be not-Israeli today, I can't be not-Jewish either. And after the Shoah, it's totally irrelevant if I define myself as Jewish or not, because, wherever I'll be, I'll be defined as an Israeli and a Jew."

The therapists' different responses highlight how individual, how personal, specific *a priori* countertransference can be. Ruth and Joseph, for instance shared a distancing from their Jewishness, but Joseph perceived it as a "cultural" identity and Ruth as something imposed by others. And whereas Hanna tended to identify with the pioneer side of the family on most issues, on this subject she referred to the Holocaust, perhaps resonating with the experiences of her father and his family (Chapter 6). It is precisely such personal associations that can signal *a priori* countertransference and thus invite further exploration of attitudes, emotions or values that might affect how therapists listen to their traumatized clients and what they can actually hear.

Sephardi or Ashkenazi

Israel was created as a refuge for Jews and as a cultural haven where Jewish culture can flourish. However, the Diaspora has left its mark by creating cultural distinctions between Jews from different countries and continents. Jews are roughly divided in two groups, *Sephardi* and *Ashkenazi*, as a result of the exile after the destructions of the First and Second Temple in 587 BC and 70 AD respectively, after which the majority was exiled to Iraq. Many eventually returned but were forced into exile again by the Romans. The minority remained in Judea, a part of the Holy Land. What followed were nearly 2000 years of exile with the Jews from Iraq following one path of migrations due to wars and expulsions, and the Jews from Judea another. Thus the Diaspora was created. However, a small minority of Jews always remained in the Holy Land. There are slight differences in the *Ashkenazi* and *Sephardi* liturgy and traditions and each have their own chief rabbi in Israel, institutions that are a left-over from the Turkish and subsequent British rule.*

In Israel, these distinctions have become socio-political: Jews from European origin, considered '*Ashkenazim*' regardless of whether they might actually

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* My thanks to Shlomo Avayou for information about these historic developments.

be of *Sephardi* origin, were perceived as the ruling elite, especially if they have been in the country for several generations. It is generally Jews who fled Arab countries that are thought of as *Sephardim* and have felt discriminated against, especially in the early decades after their arrival in Israel.

Of the interviewed therapists, Sara was most sensitive to these divisions and their negative influence. When I expressed surprise that she did not speak with a guttural, North African pronunciation, she admitted to being “very ashamed of it.” For Dana and Dora, on the other hand, the distinction between *Ashkenazi* and *Sephardi* held little significance. Dora told me that her grandmother, who was killed in the Holocaust, was "from a *Sephardi* family." Dana was amused when, as an adult, she discovered that her family’s *Sephardi* origins meant that they had belonged to the "elite" which had looked down on the local *Ashkenaz*i Jews who had been less exposed to Westernized education and less assimilated.

Ruth had never been much preoccupied with *Ashkenazi* or *Sephardi* identities, but had come to feel *Ashkenazi* because she was marked as such by sectarian *Sephardi* political parties. David "knows" he's *Ashkenazi* and his current partner *Sephardi,* but issue was “meaningless” to him beyond specific interests like “food and music.” Joseph attached no importance to the question of *Ashkenaz*i or *Sephardi* as such, but did habitually ask his clients about “the origin of their names" in order to learn more about their history, perspectives and attitudes.

Hanna was conscious of her *Ashkenazi* roots but attached more significance to “belonging to the top layer of Israeli society” and the social contributions and position of her family. Nell utterly disliked the preoccupation with *Ashkenazi* or *Sephard*i. She jokingly said that as a native English speaker she could somehow bypass this division as people seem to consider Anglo-Saxons as "another classification.”

Though treated “lightly” in the interviews, the various ethnic distinctions and beliefs about the status they carry are far from trivial; such *a priori* countertransference as preconceived ideas about people's origins and intergenerational animosity or prejudice can impact the mutual perceptions of clients and therapists. For instance, a therapist who might share Ruth's annoyance at being "labeled" a discriminating *Ashkenazi* and is told a new client was a member of one of the sectarian *Sephardi* parties, would need to carefully monitor the responses such information might trigger. If therapists are not sufficiently conscious of their own thoughts and feelings on this subject, they might not only unwittingly silence their clients but leave them feeling misunderstood as had happened to Sara (Chapter 8).

Passports

It might not seem immediately obvious why, in an exploration of the societal context of trauma therapists, there is a whole section on passports. But it is

worth noting that Jews have a long history of fleeing persecution and *pogroms* towards places of, at least apparent or temporary, refuge. The Freud family history and Sigmund Freud himself are a case in point (Freud, Freud, & Grubrich-Simitis, 1985). The "right papers," prior to the Second World War in particular, enabled Jews to flee the threat of Nazism before all borders were closed to them. During the War too, these could save lives, as was the case with Dora's family (Chapter 6).

Over the past decade or so, there has been a great interest by Israelis in acquiring a second citizenship. This became possible as countries like Poland and Hungary enabled Jews who had been deprived of their citizenship during or after the Second World War, to reapply. Many have started to do so in order to enable their children access to a "European" passport. This was no minor matter when anti-Semitism in Europe seemed to be on the rise and the sense of safety and refuge that Israel provided had somewhat eroded.

I asked the therapists about their passports to gauge their Israeli identity because a sense of belonging, of connection, is integral to stability without which no responsible trauma work can take place. Five of the eight interviewed therapists had spent considerable time abroad but felt drawn back to Israel. Some of the therapists, like Dora, had no conflicts about their national identity. For her, coming to Israel meant that she finally belonged somewhere. "I don't have a sense of being an outsider. That was over when I came to Israel, and especially after I entered the profession." She had given away her passport to help smuggle in other illegal immigrants during the British Mandate, and the fact that she had not been allowed to reclaim her original citizenship never disturbed her. David and Hanna, most of whose families had come to Israel around a century ago (Chapter 6), also seemed to have left the refugee mentality behind them. As Hanna put it, "What's wrong with an Israeli passport? I'm not trying to become someone else, so it makes no difference to me."

Others had encountered sufficient unpleasantness upon presenting their Israeli passports abroad, to happily accept an additional nationality for the purpose of travel. Joseph would have liked to have an additional passport in order to have "options to be less hated, rejected, arouse less suspicion. Options! Not so much to escape from here. It's not that I suffer as a result of being an Israeli. But it's pleasant to have options." The bi-national therapists stressed that they enjoyed the freedom of their foreign passport.

Ruth expressed perhaps most clearly the emotional significance passports may have for some Israelis regarding underlying feelings of lack of personal safety. When she was younger, she thought no other nationality besides her Israeli one was necessary or even desirable, and passed up an opportunity for a foreign passport. She now wished she were able to give her children the protection of an additional citizenship. Yet she rejected her parents' offer to apply for their original citizenship

which they could then pass on to their children and grandchildren. Ruth was afraid of her children having European passports, as "that's where it happened."

The echoes of persecution were clearly audible in the apparent existential need to be able to move to safer territory at short notice. The therapists' responses illustrated how alive the historic tensions of identity, belonging, threat and temporariness were to them, especially the children of Holocaust survivors. Such issues might all manifest as *a priori* countertransference. A lack of a sense of basic safety, and national or cultural self-acceptance might also interfere in the therapeutic process if therapists do not remain alert to these potential sources of *a priori* countertransference.

A Society in Turmoil

Israeli society barely provides the safety and stability which are optimal for the processing of trauma (Herman, 1992). In 1988, even before the assassination of Prime Minister Yitzhak Rabin (1995), two Gulf Wars (1990-1991; 2003-) and the ever-escalating violence that started on Rosh Hashana 2000, Rosenberg (1988) characterized Israeli society as having created "a culture of stress" (p. 152). What, then, constitutes "ordinary" life in Israel? People obviously follow the normal life cycle, including (conflicts around) family, professional and social lives. But at the same time, they face recurrent challenges such as army and reserve service, wars, and terrorism. In this section, I will explore aspects of this reality, shared by therapists and clients, which might give rise to *a priori* countertransference.

Army and Reserve Service

At age 18, most Israelis are drafted into the army for several years of service, and subsequent yearly reserve duty. Exemptions are given to the ultra-orthodox, women who are married or declare that they are religious, and people who are considered mentally or physically unfit. Nell, as an "older" new immigrant, received an exemption. Sara chose the alternative open to religious girls, which is volunteering for national service for one or two years. Ruth returned from abroad on her own, in order to do her army service even though she could have stayed on and studied overseas. Joseph had a difficult time in the army socially, but functioned well when he was confronted with combat situations. Dana's position in the army required her to work with people, which she liked well enough to change her career plans from the natural to the social sciences. Hanna initially had a hard time because she was "a spoilt girl" but eventually was transferred to a base where she was happier. David had a "difficult" but "not traumatic" army service. He rejected the option of studying medicine before joining the army, and served as a

regular soldier. Women are exempt from reserve duty when they marry, but Joseph and David were drafted for annual reserve duty and participated in actual war, Joseph in active combat, and David as a doctor.

The army service, around three years for men and two for women, is a major interruption in the average Western youngsters', ideally carefree and future-oriented path to adulthood which many Israelis try to emulate. Parents spend those years in a state of constant anxiety that only slightly abates at times. Family members and work colleagues of men called up for annual reserve duty also need to go about their business as usual. The interviewed therapists all seemed to take their own and their children's service for granted and expressed no great conflict. Still Hanna and Dana worried a great deal about their children. Dana's son was in the army during the *El Aqsa* Intifada. "I suppose that it is always hard for a mother, but especially at a time of tension and war. And this war is morally very problematic for me."

Israelis, clients and therapists alike, must live with constant disruptions of life and existential anxiety. While these experiences are not necessarily traumatizing, they include at the very least the possibility of participating in or witnessing disturbing events and activities after which one is meant to seamlessly take up one's normal routine. Therapists, therefore, need to monitor their own sensitivities at any given moment and remain aware that clients might have traumatic memories triggered either directly or vicariously.

Wars

Life in Israel has been regularly punctuated by wars and other outbreaks of violence ever since the establishment of the state (Chapter 5). This has created, what Waintrater (1993) has called, "a double rhythm" (p. 117). One rhythm regulates private, civilian professional, personal and social life. "Permanently superimposed on that rhythm is the other, public rhythm, composed of periods of reserve duty or mobilization, military exercises or false alerts" (p. 117). Noting the focus on family life in Israel, Waintrater acknowledged those without families, such as single women and (secret) lovers who suffer a particular isolation as they have no official status, support or even ongoing information about their loved one.

These outbreaks of war have created a "radioactive effect of social violence" (Gampel, 2000, p. 49), which its victims may unconsciously transmit to the next generation. The frequent recurrence of violence has also created a society with many psychologically scarred individuals. Solomon and Kleinhauz (1996) found that "[F]for many individuals, war-time traumatic experiences seem to serve as pathogenic agents that leave marks in the form of war-induced psychopathology for many years" (p. 157).

The interviewed therapists had very different memories of Israel's wars. Dora had been in Israel for all of them, but the War of Independence (1948) was perhaps the most dramatic in that the kibbutz where she was living was in acute danger. Dora, who was pregnant at the time, vividly remembered how they had to stealthily evacuate all the children one night. There were precarious times during other wars, but she was never particularly afraid (Chapter 6).

Ruth spoke of her anxiety and awareness of the very real danger, especially during the Yom Kippur War (1973) and of people she knew who were killed. Her experience shows how socio-political changes might impact the willingness to risk one's own or one's children's lives:

> Today, I find myself saying that I'm not prepared for my children to be sent to a War of Peace for the Settlements! And I'm not willing for my children to be stuck in Lebanon for eighteen years, for no reason at all…In short, with my children, I say, I'm prepared, if this country had normal borders, to fight to death for what is ours.

Joseph had some difficult combat experiences. But he was abroad during the Lebanon War (1982). He tried to speak for Israel on his college campus but the "Arab hatred" against Israel was nearly overwhelming. Back in Israel during the first Gulf War (1990-1991), he continued working as he felt safe enough in his home to be able to host relatives. "It was a romantic war in the sense that the family is all together."

Dana lost a relative in the Yom Kippur War but spoke mainly about the stresses related to the Lebanon War: "That was my generation." The *Intifada* that was raging at the time of the interviews was a source of anxiety for her soldier son. Like Ruth, she struggled with the dilemmas that accompany non-consensual wars.

Hanna recalled that the Six Day War (1967), and the tense weeks preceding it, passed very quickly because kids like herself were given tasks. "We knitted hats for the soldiers and dug ditches." She remembered a school teacher explaining "with a map, what might happen in case of invasion, if the Arab countries were to win….But because it was such a short time and we were busy with the ditches and that, it just passed." The Yom Kippur War (1973) was very hard as its sudden outbreak interrupted plans and left her to care for a new baby while her husband was in extended reserve service. Quite a number of friends and acquaintances were killed. She had less to say about the other wars, other than that she had not been frightened.

David was a young boy during the Six Day War (1967) and recalled no fear. During the Yom Kippur War, he was in high school and, as was normative at the time, volunteered at a factory with other classmates. That war was "a little more

frightening." He served during the Lebanon War (1981), which he described as "difficult." During the first Gulf War, he was a reserve soldier. Given the fact that Israel was not involved in actual combat, there was no particular stress associated with this time.

Nell had been a student in Israel on a special program for foreign students during the Six Day War but did not remember it as a difficult time. Israel's other wars somehow got left out of our interview.

Sara was very young during the Yom Kippur War but she had vivid memories of the Lebanon War. Her brother was traumatized in that war, though he perceived himself as "fine." Sara explained that "I am the one who's not OK, because I think he's not OK." Sara was very glad that she happened to be abroad during the first Gulf War.

The societal trauma background, the cultural and personal backgrounds of both therapists and clients in Israel, are defined by the tragically regular occurrences of war and terror attacks. The therapists experienced these either as children, soldiers, or as civilians worrying both about soldiers' and their own personal safety. What they all had in common, though, was that they did not define any of their war experiences as traumatic, but rather as difficult or stressful. This might be a perception that is conditional for successful coping and resumption of ordinary life. Many also stressed that they had not been afraid. Apart from that, they perceived their experiences in highly individual ways, expressing echoes from their own and their family's histories, and so marking areas for exploration of *a priori* countertransference.

None of the therapists paid much attention to the first Gulf War in the interviews. This was interesting as this was the first war in which Israel took no defensive action and the whole population sought protection from Iraqi Scud missiles in sealed rooms. For me personally, it was also one of the most frightening wars. An Israeli therapist's account, (Oz, 1991) gives some insight into the extreme stress and disruption of life at the time. Perhaps the interviewed therapists needed to put that war out of their minds at the time of the interviews, as they were again fairly defenseless potential targets, this time of suicide bombers (Chapter 4). Were they to show a similar diminishing of attention or discounting of importance in relation to a client's experience, this would be an example of *a priori* countertransference.

The interview with Nell is particularly interesting in this respect. Although we started talking about wars, we soon got sidetracked. I only became aware of this during the analysis of the interview. There are several possible explanations: we might have somehow created a "foreign" atmosphere between the two of us; we spoke in English, both of us had immigrated to Israel after completing high school and we had not served in the army. We therefore missed a major developmental

stage in the lives of most Israelis who grow up and go to the army together, an experience that creates very meaningful relationships and a way of fitting into Israeli society. Though we both lived through many of its wars, we might have done so somewhat as outsiders. Another possibility is that we had spoken of so much trauma that there was no more "room" in our conversation for the wars that had passed without leaving significant psychological scars. There may have been additional reasons, but this aspect of Nell's interview serves as a perfect illustration of possible consequences of unacknowledged *a priori* countertransference as similar dynamics can easily occur within the therapeutic setting.

Terrorism

Traumatization as a result of terrorism might need specialized attention. According to Hobfoll, Canetti-Nisim, & Johnson, R.J. (2006), there are unique consequences both for victims if they become symptomatic, and for society at large. In Israel, it is not uncommon to lose relatives, friends, neighbors or classmates to war and terrorist activities. Direct questions about terrorist acts in the interview broke a kind of taboo of denial regarding personal risk, at the same time increasing awareness that this is not necessarily a problem in much of the rest of the world. Terrorism in Israel is not experienced as a rare event with tragic consequences, but rather, especially during the *Matsav*, which was still going on at the time of the interviews (Chapter 2), as a daily threat. Ruth and I instinctively both “knocked on wood” when she said that she had not been personally involved in a terrorist attack because we were aware that there was no guarantee that such luck would hold. Some of the interviewed therapists were less fortunate. One of Dora's children was badly hurt in a terrorist attack (Chapter 6) and Dana and her mother survived a major terrorist attack without physical injury (Chapter 6).

Can this aspect of reality in Israel remain outside the therapy room? Miller-Florsheim (2002) questioned whether this was possible or even desirable:

> Can such a complex reality not threaten to intrude the psychotherapy room when just a moment before we started the session, we heard horrifying, painful, infuriating or bewildering news? We become enraged, anxious and hateful, unable to sympathize with those who are, at this moment, a terrible enemy, but whose children are being killed in the hopeless poverty and cesspool of their lives…“Unthinkable thoughts” come to our mind – vengeful, murderous, unethical thoughts. (p. 79).

Miller-Florsheim wondered how, under such circumstances, therapists could help their clients cope with evil. This is a highly relevant question especially with trauma survivors. But, as has been shown, especially in Chapter 4, current

events might so preoccupy therapists that they become insufficiently available to their traumatized clients to even be able to fully listen. Furthermore, their clients' responses might trigger their own anxieties. And while it has become generally accepted in Israel to cope with traumatic circumstances by maintaining daily routine (Pat-Horenczyk, 2006) and getting on with business as usual, in psychotherapy pretending everything is normal might dull the therapists' ability to monitor *a priori* countertransference. This might, therefore, ultimately be harmful to the therapeutic process for all clients. And it seems particularly relevant for those who have been retraumatized by the lack of acknowledgement of the reality of their own traumatic experiences. The *Matsav* provided an opportunity to learn about the possible impact on the interviewed therapists of an intensive, ongoing--at the time of the interviews for close to two years already--state of terrorist attacks and other forms of violence. Unlike in the study of the experiences of the six other therapists at the start of the *El Aqsa Intifada* (Chapter 4), the *Matsav* was not the focus of the interviews, but the background against which the interviews took place, much in the way therapists were living and working at the time. Therefore, there might be further implications for *a priori* countertransference to be learned.

The Matsav

Referring to the weeks turning into months turning into years of intensive suicide bombings and other terrorist attacks aimed at civilians as the "*Matsav*", which is Hebrew for situation, rather than calling it by its international name, *Intifada El Aqsa*, the *El Aqsa* uprising, reflects a national style of coping: that's the situation, that's what you've got to get on with. Israelis have lived with terrorism for a long time. But in the years of the *Matsav*, starting in September, 2000, the sheer number of attacks had been all but overwhelming. In Bleich, Gelkopf, and Solomon's (2003) study about a year and a half into the *Matsav*, "almost half the participants in the sample were exposed to terrorism personally or through a friend or family members" (p. 618). Bleich and colleagues also found that around sixty percent had felt their own lives were in danger, and slightly more feared for the safety of friends and relatives.

Such conditions are bound to impact therapists' *a priori* counter-transference (Chapter 4). The long period of existential threat took its psychological toll on the therapists. Dana recognized only in her supervision group (Chapter 9) the extent of her own anxiety and stress which she had been able to ignore in her daily life. "When we drew it, it became very clear that it was impossible to put aside." Other interviewed therapists did not explicitly mention this kind of "not noticing," of restricted awareness which I have referred to as "adaptive dissociation" (Tauber, 2002b).

Nell and I demonstrated such adaptive dissociation when we simply 'forgot' about the security situation despite the fact that the day before, there had been a dreadful attack not too far from where we were meeting. The questionnaire provided us with a reminder. Nell explained that it had been relatively "quiet" for a while. "So we're all in complete denial. Until it comes again. And now, our denial gets bigger and bigger all the time!" Nell coped with her anxiety through humor. She told me that when she had to take out a loan, she chose a bank in an area of town where several attacks had occurred nearby. That way, should there be another attack and damage to "her" bank, she might not have to pay back her loan.

David's experience illustrated that a psychiatric hospital setting does not necessarily insulate patients or staff from external pressures and threat. When staff nurses wanted to switch T.V. channels so as not to show live reports of attacks, patients protested vigorously. David noted that violence seemed to have gone up in all hospital wards since the outbreak of the *Intifada*. Everyone was affected but:

> It gains much greater significance in a ward with survivors. The threat is experienced twice, as it were. There is reactivation of the threat on survival...and the impotence, we're locked up in a mental hospital, what are we going to do? There's very little they can do about it except feel threatened.

David thought that his own sadness and disappointment at the absence of a realistic chance of peace in the near future came through in his work.

Dana, perhaps sensitized by her experience as a child of survivors, noted the anxiety her adolescent clients felt for the safety of their parents. Such a role reversal and its implications are not generally part of public discourse on the security situation. Parental anxiety for their children's safety is more commonly acknowledged. Ruth expressed this in her hope that one of her children who was abroad at the time of the interview, would stay there to "rescue" the rest of the family should the need arise. The undertones of the Shoah history were unmistakable. We both laughed in recognition of this, perhaps to neutralize the underlying fear with self-mockery. Nell, too, was glad that her children were abroad at such a dangerous, frightening time, and that she was exempted from the heart-stopping phone checks after a terrorist attack. Israelis call family members and friends immediately upon hearing about a terrorist attack to check that they are safe and well --before the phone systems crash. Such fears and desire to have loved ones well out of range cannot but impact work with the existential anxiety of already traumatized clients.

Joseph found that the *Matsav* complicated trauma work with survivors of sexual abuse in childhood, because "the internal reality of 'unsafety' is not only internal…The 'here and now' is also dangerous." Furthermore, the childhood

difficulties of reality testing regarding who is perpetrator and who deserves what he/she gets can be played out again in the difficulty of such clients in defining "their identifications in the Israeli Arab conflict." Joseph also referred to the impact on the therapeutic process:

> It's a situation in which I am also frightened and worried and it places me in a very symmetrical position with my clients…On the one hand, it's distracting. On the other hand, it creates a good connection between the client and the therapist as it places them on a shared experiential level that does not create a disruption of boundaries the way it would if we were to go for a beer together…

When we started talking about the *Matsav*, Hanna immediately recalled an Arab client who had raged at her for being one of those conquering, occupying *Ashkenazi* Jews and accused her of not taking sufficient responsibility for the injustices perpetrated against the Arabs. This was hard for Hanna but the strength of their therapeutic relationship carried them through this confrontation. At the time of the interviews, Hanna had no clients who had been injured in terrorist attacks, but the bereaved parents she worked with were deeply affected by the *Matsav*. After stressing that the situation in her area was not the worst in the country, Hanna acknowledged the existence of tensions, atmosphere and terrorist attacks in her area as well and noted that clients came in with fears and anxiety. She adopted a fatalistic attitude:

> I know I can explode any moment, but when it happens, it will be because it's my fate and luck, nothing else. I hope I won't.…And I say the same thing to my children when they go out in the evenings. I'm not prepared, not willing to lock myself in, and I live well with that. It was very different, for example, when…I was facilitating a group of bereaved parents…That was very traumatic for me…I could see *myself* sitting in that group as a bereaved mother.

This sliding from one traumatic situation into another is so typical that it took some time while analyzing the material, for me to even notice Hanna was no longer speaking of the actual *Matsav* but of what it triggered for her. Both her response and mine offer excellent examples of how *a priori* countertransference might manifest itself.

Hanna reminded both her children and her supervisees that we have only limited control over our fate. Thinking of the death of her baby, she started crying. "I can only control what I can control. And where I can't have control, I try, as much as possible not to be in touch with whatever I can't control, because

otherwise, it would drive me insane." Hanna's responses offer a rare glimpse into a very Israeli internal world of associations, fears and strengths.

Sara experienced a "state of ongoing stress" because of the *Matsav*. At the same time, she expressed her great love for the country, her friends and her family. She felt very deeply, that despite the difficulties and dangers, "there is no other place," she could live, and this awareness gave her strength.

Dora seemed less concerned about the threat to life during the *Matsav* than about the direction Israeli society was taking. Like many Holocaust survivors, she had a deep sense of identification with Israel (Chapter 4). Much of the survivors' personal identity, hopes and projections were invested in this society that they built with so much personal sacrifice and which was meant serve as kind of substitute or continuation of their lost families:

> That was not at all that we intended. …Where is the common sense, where is everything that we learned, where has the *humanity* gone? We were victims, what are we doing now? Some of it is self-defense and that is justified, but it is accompanied by so much else.

The existential dangers of the *Matsav* did not induce in Dora the sense of panic she encountered in many of her second generation clients: "We need to distinguish between when we were really totally helpless and defenseless, and now. But the fact that we don't really know what will happen, also has an impact."

The century old struggle between the Jewish, and the local and surrounding Arab populations, has been a major cause for interpersonal and intra-psychic conflict and traumatization in Israel--within the personal histories of many of the therapists' families and quite likely of those of their traumatized clients. Both peoples, the Israelis and the Palestinians, seem still locked in blaming each other (Bar-On, 1999b; Mendelsohn, 2006), unable, as of yet, to acknowledge the pain and losses of the 'other' and take responsibility for their share in this. With the exception of Hanna and Joseph, the therapists did not speak directly of this conflict.

Almost everyone expressed discomfort with the current political situation and most referred to the socio-political direction Israel has taken over the past decade(s) as heart-breaking and frightening. They said little, however, about any psychological conflict about the existence of Israel itself beyond personal danger and suffering; about Israel's share of the responsibility for the occupation-induced suffering; or about the absence of Israeli Arab colleagues in most professional contexts. I did not ask and the interviewed therapists only volunteered an occasional comment here and there. But at the time, neither they nor I seemed to perceive this ongoing conflict as an existential issue that perhaps colors our whole existence and professional experience (Davoine & Gaudilliere, 2004). Nell did

comment on her "insulated life" and "sense of guilt" at enjoying the serenity of her clinic and enjoyable life while "you know, the whole world is burning." Such a blocking out of living history that defines daily life to such an extent might give rise to far-reaching *a priori* countertransference.

Additional areas came to light that might point to *a priori* countertransference. The *Matsav* was the only trauma-related context concerning which therapists, Dana, David, Hanna, Joseph and Nell, talked about their clients. This suggests a changed level of preoccupation and perhaps identification with clients. A variety of responses such as fear, distancing, denial, flooding with previous trauma, such as traumatic loss or the Holocaust, would all demand a close monitoring of *a priori* countertransference.

Summary and Discussion

At first glance, the topic addressed in this chapter might have seemed irrelevant to psychotherapists and to trauma therapists in particular. Do the history and social components of a society really impact trauma therapists and thus create potential *a priori* countertransference? The answer that emerges from the interviews is clearly affirmative. The different factors explored in this chapter, such as the therapists' socio-cultural status in Israeli society, different aspects of their Israeli identity and the impact of the ongoing (threat of) violence in Israel, have uncovered many areas for potential *a priori* countertransference.

The eight interviewed therapists represent significant sectors of the Israeli social mosaic. They have both personal and shared trauma histories and different personal or family immigration backgrounds. They therefore have different styles of (self) expression, coping, of communication including languages other than Hebrew, and ways of relating to Israel and its high demands on its citizens. Such cultural and language differences are not always immediately obvious. For example, four of the interviewed therapists, the survivor and three children of survivors, all come from different countries with very diverse cultures in addition to their Holocaust histories. Not acknowledging such differences and their possible impact on perception could give rise to *a priori* countertransference such as "we're all the same," i.e., Israelis. This might prevent the traumatized client from expressing or even identifying the specific meaning of his or her own traumatization, and how life in Israel might impact upon that experience. The therapists also clearly indicated differences in values, in expectations and interpretations of events, all fertile ground for *a priori* countertransference.

The ongoing external threat to Israel's security and the lives of its citizens does not guarantee a sense of internal cohesion. In fact, social divisions, groups of

the population that oppose each other with great emotionality, have become increasingly sharp. The interviewed therapists gave examples of their, occasionally negative, perceptions of members of other "groups." For instance, Sara had internalized her family's resentment towards *Ashkenazim*. Quite a few therapists came across as very intolerant of the ultra-orthodox and of the settlers. David, on the other hand, seemed particularly empathic towards the ultra-orthodox. Therefore, therapists need to be aware too, of possible *a priori* countertransference towards clients who belong to socio-cultural strata that are not their own. And of course, those who belong to the same strata as the therapists may invoke *a priori* countertransference of assumed similarities and perhaps misjudged understanding.

Perhaps the most exciting finding in this chapter is the sheer wealth of information the interviewed therapists volunteered on identity issues related to their family's and their own part in the social mosaic, their views and feelings related to Jewishness, *Sephardi* or *Ashkenazi* origin or country of origin, and their responses to questions related to their passport. This led me to wonder what additional issues in therapists' personal lives, in relation to the societies in which they live, might unknowingly affect their professional work.

All the therapists responded to the question about their Jewishness in their own ways, raising specific *a priori* countertransference issues. Some related with a sense of distance and conflict; some focused on the aspect of religion, whereas others emphasized the cultural aspect. Undercurrents of the Shoah and anti-Semitism were clearly present though not always specifically named. The topic of *Sephardi* or *Ashkenazi* background evoked rather surprisingly involved responses. I had expected a more general, theoretical attitude, but the subject aroused quite some energy for most of the therapists. Preconceived ideas, perceived negative attitudes from the "other" group and intergenerationally transmitted resentments are all forms *a priori* countertransference that therapists need to be aware of and monitor.

Passports are a formal expression of national identity and for me personally, as a child of Holocaust survivors who instilled in me a deep awareness that that document can have the power of life or death it is a meaningful topic for exploration. The interviewed therapists demonstrated in their responses that for them too, echoes of the tenuousness of social belonging, and safety persist. They expressed awareness of how the right kind of passport could provide safety or at least, choice and freedom of movement and respect, and that the Israeli passport might not provide that. Only three therapists felt comfortable having only their Israeli nationality. Unacknowledged *a priori* countertransference in this area could cause difficulties on the part of therapists who only have an Israeli passport; feelings of lack of safety, of being caught without alternatives could arouse

emotions and attitudes towards clients who might have dual citizenship, for instance, that could disturb the course of therapy.

The fact that neither personal nor national safety can reasonably be taken for granted in the therapists' experience of their life in Israel is also highly relevant when working with traumatized clients for whom a sense of safety is a vital first condition towards recovery (Herman, 1992). The therapists' responses to the turmoil in Israeli society, army service, the history of wars, and coping with terrorism, exemplified by the *Matsav*, yielded valuable information as to the degree of all the therapists' personal involvement in the daily confrontations with genuine danger.

One of the reminders of the precariousness of normal life in Israel is the army service for almost all eighteen year olds and the annual reserve service for men. The therapists did not question the necessity of serving in the army, but expressed quite a lot of concern for their children. Therapists need to monitor *a priori* countertransference around this issue as well since they might have clients who might be too traumatized to want to serve, or simply too afraid (Chapter 4).

The therapists responded in their own unique ways to the subject of Israel's wars, which ones they remembered and why. They all found it necessary to state that although some of the wars had been very stressful and difficult for them, they had not been traumatic. Another thing they had in common was not mentioning the first Gulf War, with the exception of Joseph who had felt relatively safe. Perhaps the sense of helplessness, in addition to fear, was too much to recall during the *Matsav* during which no one could really defend themselves against being blown up on a bus or other terrorist attacks. This omission might well be an illustration of *a priori* countertransference.

Acts of terrorism have been an unfortunate fact of life in Israel, with periods of greater or lesser frequency. Two therapists had been either personally involved in a terrorist attack or had a close relative that had been injured. The interviewed therapists, like most Israelis, coped with a mixture of increased alertness and going about life as usual. The act of setting aside awareness of threat and personal vulnerability needs to be monitored for possible *a priori* countertransference such as lowered tolerance to clients who do express anxiety (Chapter 4).

The *Matsav* was an exceptional period of years of intense terrorist attacks such as suicide bombers exploding buses and café's, and shootings and throwing of rocks on the roads. When discussing the *Matsav*, the therapists gave examples from their clinical practice. Apparently, their reasons for doing this made so much sense to me during the interviews that I did not raise the issue with them. Such an assumed understanding, or lack of awareness of something with which the therapist resonates deeply, is further illustration of *a priori* countertransference. It is very

likely that therapists spoke of their clients, because of the additional, current strain of sharing this dangerous reality with them. In their actual work, the therapists' anxiety might be triggered by opposing political views and preferred solutions or differences in coping styles. An additional complication might arise when clients and therapists also share the burden of defending their country whether as soldiers or as civilians. These are clearly issues that need to be kept in awareness, especially since traumatized clients likely have a more fragile sense of trust and stability than others who seek professional help.

The therapists' responses in the interviews also revealed tensions between control and helplessness. For instance, Hanna's tears while she articulated her need to avoid awareness of the absolute lack of control over her own life and her inability to protect those she loved were an eruption through the surface of apparent normality. It is vital, therefore, for therapists to be aware of their own "no-entry" zones in their psyches as demanded by their own coping styles (Chapter 8), as these might significantly impact their ability to be present for their clients.

In the earlier study (Chapters 4), the therapists interviewed at the start of the *Matsav* illustrated clearly that the therapeutic relationship was affected by their own changed perceptions of their clients. All fourteen therapists, in both studies, expressed the need for some form of supervision and support for themselves, and in the earlier study, some therapists remarked that the interview itself served that purpose and had deepened their listening abilities. I understand that to be the result of having become aware of instances of blocking *a priori* countertransference.

The exploration of the interviewed therapists' experience of the *Matsav* in this chapter served as an example of the existential crisis that Israel has had to face every few years in one form or another. Most of the therapists did not speak directly of the near-century long conflict with the Palestinians or about Israel's share in this. Many did express regret and concern over the changes in Israeli society in recent years but no one had any doubts about the continuing need for Israel to exist. I can only speculate how such bypassing of a vital aspect of Israel's history and present might manifest in *a priori* countertransference. There is a risk of an unconscious colluding silence, reminiscent of silence surrounding traumatization, including Holocaust and sexual traumas.

This chapter focused on the impact upon the interviewed therapists of the contemporary societal context in which they actually worked with their traumatized clients and which they themselves and their families have helped to shape. Societal context, historically, has had a major impact on the way traumatization itself has been perceived and defined, if at all. This will be the focus of the next chapter as reflected in the experiences of the interviewed therapists.

CHAPTER 11

Trauma Therapists and Society

As has been seen in the previous chapter, Israeli society offers the interviewed therapists a rich variety of sources for *a priori* countertransference. In this chapter I hope to show, with the help of the experiences of these therapists and two additional experts (Chapter 2), how attitudes to therapy, and to trauma in particular, have changed over the years in Israel. Dora recalled an anecdote which shed some light on the climate in which psychotherapy developed when the State of Israel was still very young. At a social gathering with Israel's second president, Ben Zvi and his wife, Dora told them she was a psychologist. Mrs. Ben Zvi's immediate dismissive response was typical for the time: "We don't need that in Israel… We don't need that here at all!"

In addition to the socio-cultural influences on the degree of mental health professionals' awareness of Holocaust and sexual abuse trauma in general and in Israel specifically, I will explore how the interviewed therapists may have contributed to these changes with the intention of uncovering further sources for *a priori* countertransference. This chapter is divided into two main sections. In the largest section, history of awareness of trauma, I reviewed attitudes to trauma, and specifically, Holocaust and sexual traumas, both abroad and in Israel. In addition to the changes the interviewed therapists perceived during their careers, first-hand accounts of societal and professional developments in Israel have been provided by Dr. Haim Dasberg with regard to Holocaust survivors, and by Karen Shachar, with regard to sexual abuse. In the second section, beyond the therapy room, the focus is on the interviewed therapists' views whether or not active socio-political involvement is--or needs to be--integral to being a trauma therapist. The underlying question throughout this chapter is what possible implications there might be for further awareness of aspects of *a priori* countertransference.

History of Awareness of Trauma

Culture can influence what form symptoms and suffering take (Fernandez, 1994). The question arises whether the culture and socio-political setting might not similarly influence therapists' perception and interpretation of suffering and symptoms. It has been customary to think of psychotherapy as an intimate process between client and therapist within the confines of the therapist's room, but this might be an incomplete perception. Ellenberger (1970) commented that "Curing the sick is not enough: one must cure them with methods accepted by the community" (p. 57). Such "methods" are linked to the values and beliefs held by that community at a given time. Fleck (1979), a Polish Jewish physician, micro-biologist and Auschwitz survivor, presented a thought-provoking thesis, first published in his 1935 monogram, about the link between scientific discovery and

the socio-cultural setting, the impact of societal and socio-historical context on what can be perceived and accepted as true or as fact within a given professional community.

After tracing the literature regarding trauma, starting with Pierre Janet and William James, Walker (1999) outlined a clear picture of the impact of socio-political forces on the perception of trauma and its impact on the personality, and the philosophical assumptions of the task of the therapist. There have been extreme fluctuations in awareness of trauma over the past century (Chapter 1). Bloom (1998) noted that the socio-political developments of the 1960's and 1970's "all play a role in the background of the people who founded the ISTSS [The International Society for Traumatic Stress Studies] and in the evolution of the organization itself" (p. 3). Caplan (1995) uncovered an additional aspect of societal influence. Her descriptions of the processes involved in putting together the Diagnostic and Statistical Manual (DSM-IV) suggest that politics and personalities play a major part in determining diagnostic procedures and societal perception of suffering.

The acknowledgement of traumatization and its consequences involves far more than a diagnostic exercise. Regarding war trauma, for instance, Op den Velde, Koerselman, and Aarts (1994) suggested that, except for some who were themselves survivors, therapists were afraid to acknowledge the psychic damage the Second World War had inflicted; doing so might threaten their own premise of the linear progress of their civilization. Weisaeth (2000) confirmed this observation: "To an unusual degree in Europe, research on traumatic stress has been pioneered by professionals who were themselves war participants or victims. The conclusion seems obvious: They could identify with the unbearable situation" (p.450).

Even after the formulation of PTSD, and its inclusion in the DSM-III (APA, 1980), some mental health professionals did not accept it as a legitimate diagnosis. Van der Kolk et al. (1996) traced the rise and fall of awareness of trauma and explored how the diagnosis of PTSD might impact the perception of traumatized clients' experience. They noted that even significant symptom reduction of PTSD might not necessarily stop the suffering of these clients. They thus drew attention to the existential reality of people who have been traumatized.

Mental health professionals have increasingly become aware of the existence and consequences of traumatization. Fensterheim's (2001) account of psychoanalytic blindness to trauma in a report written in the early 1950's now reads more like a parody: "based mainly on the Rorschach, [it] stressed the patient's masturbation guilt and nowhere mentioned that the person had just had both legs amputated" (p. 110). Yehuda and McFarlane (1995) noted that, from both clinical and socio-political perspectives, victims of trauma have become more visible and less stigmatized. Other authors have pointed out that a trauma diagnosis has

become sought after as it may evoke greater empathy and willingness to offer support than other diagnoses (Gael, 1996). It can even lend an identity which offers a worldview and sometimes, entitlement to financial support (Withuis, 2001a). In fact, in her analysis of Dutch society's changing attitudes to trauma, Withuis (2001b) warned that the current (over)use of the concept of trauma might erode sensitivity to genuine trauma victims.

The greater awareness of possible repercussions of traumatic events does seem to have led to increasing openness to trauma victims in general clinical practice (Fodor, 2001; Gold, 2004). And the diagnosis of PTSD is already sufficiently anchored for researchers (Mol et al., 2005) to want to explore whether the symptoms could occur as a result of non-traumatic events. At the same time, studies are also beginning to point out positive responses to trauma, such as resilience and growth (e.g., Bonnano, 2004). The fact that the American Psychological Association added a Division on Trauma in early 2006 would seem to be further acknowledgment that trauma work is becoming more mainstream.

However, important books, such as the recently published exploration of different aspects of the therapist's share in the therapeutic relationship (Norcross, 2002b), may still neglect to list trauma or dissociation in the index. And in a study inquiring whether or not mental health staff in New Zealand ask about sexual abuse and/or whether or not clients disclose, (Read, McGregor, Coggan, &Thomas, 2006) "between 63% and 78% (15% were unsure) of women who had contact with mental health services had not been asked about CSA by mental health services" (p. 41). Read and colleagues noted this was consistent with international findings. On the other hand, Follette, Polusny, and Milbech (1994) found that "nearly all of the mental health professionals (96.9%) surveyed indicated that it is important to address abuse issues in treatment" (p. 279). Thus, while there has been progress, the issue remains very unbalanced and Shapiro (1997) pointed to the profession's tendency to neglect the perpetrators of abuse. "Where are the conferences on abusers? On their failures of memory…Why is there no entry in DSM-IV for sexual abusers?" (p. 104).

Indeed, while the prevalence of sexual abuse and incest has become harder to deny in the past two decades, the fight to dim awareness and contest the numbers has shifted to questioning the reliability of the memories of the victims (Dalenberg, 2006). In the interviews, the subject of memory barely came up. Still, the closely related subject of believing clients' accounts of their traumatic experiences can cause therapists conflict between their desire to believe them and the difficulty in doing so (Chapter 9).

Kirmayer (1996) emphasized the need to acknowledge the societal impact on the very formation of trauma memory: "Narratives of trauma may be understood then as cultural constructions of personal and historical memory" (p.

175). He contrasted memories and narratives of Holocaust survivors with those who survived childhood abuse:

> The fundamental difference lies in the social context of retelling. In the case of Holocaust testimony, the enormity of the event always precedes the individual story, so that every detail becomes portentous. In the case of the victim of childhood abuse, the retelling involves an idiosyncratic personal history whose moral implications attack our complacent image of family life. (1996, p. 192)

Holocaust Trauma

It has taken decades for society at large as well as for mental health professionals to start a genuine process of learning the extent, depth and forms of the consequences of Holocaust traumas for the adult and child survivors, and for their children (Tauber, 1998; Chapter 3). The difficulties in acknowledging the (extent of the) traumatization of Holocaust survivors were world wide. De Wind (1984) mourned that psychoanalysts retained so little of their Second World War knowledge from their encounters with the survivors after 1945. Durst (2003) noted that the literature about child-survivors "as a subgroup and as a new term in Holocaust literature and research" began only to be published in the 1980's (p. 502). De Swaan (1982) pointed out how, in the case of Holocaust survivors, mental health professionals turned political problems into psychological ones similar to a process feminist writers had described in relation to sexual abuse and other violence against women. Still, as De Swaan noted, while mental health professionals had to think up new names and diagnoses for those survivors who could not function, they did also listen. The testimony of the political history of genocide was thus transformed into complaints within the therapy room. Professional awareness of Holocaust traumas and the ability of survivors to dare to seek psychological for help are therefore clearly interlinked with societal developments.

Holocaust Trauma in Israel

As has been noted in previous chapters, attitudes to Holocaust survivors in Israeli society at large, have been ambivalent at best. This might be partly due to guilt feelings (Segev, 1994). During the Nazi era, Palestine was ruled by the British who issued only a limited number of immigration certificates to Jews. Each recipient knew that another Jew had inevitably been denied a certificate and this likely meant their death. One of the ways of coping with the intolerable emotions aroused by the Holocaust and its aftermath was to blame the victims, though this was rarely actually voiced aloud. "Zionist political orthodoxy was that the Jew's place is in Israel. The unspoken accusation was that having chosen to remain in

Europe, the Holocaust victims brought their sufferings on themselves" (Solomon, 1995, p. 221). Such emotions and thoughts can certainly create *a priori* counter-transference.

Haim Dasberg, a child survivor of the Holocaust, arrived in Israel in 1949 in his late teens, and subsequently became one of Israel's leading psychiatrists, prominent in work with Holocaust survivors and the second generation. In 1999, he gave a 'participant-observer' account of attitudes in Israel towards survivors, especially in the early years after the founding of the State of Israel. He spoke of the political and cultural climate of socialist Zionism at that time. Dasberg greatly admired Israel's first Prime Minister, David Ben Gurion:

> He was like a messiah for me, but he was a Bolshevik. He thought in terms of masses and revolutions and manipulations. He didn't hide that. So you have to look at everything against that background. And I'm not saying this as something negative. It was like that, then.

Dasberg spoke of the *ma'abarot*, the tent camps erected by the newly created state in order to house the floods of new immigrants,"both Holocaust survivors and refugees from Arab countries. There was a lot of help from volunteers at the time, but no awareness of trauma." After his arrival from Holland, where he had survived the Holocaust in hiding and had managed to complete an accelerated version of high school studies after the War, he went directly to a kibbutz. People were kind, but preoccupied with what they had endured during the War of Independence. Dasberg became friends with a young man who had suffered severe sexual abuse while in hiding -- he later also became a psychiatrist. The kibbutz members had no understanding for his rebellious behavior.

Dasberg left for Jerusalem in 1950 where he was drafted into the army. The following memory gives an idea of the chaos of a state that was then not yet two years old, absorbing immigrants at a frenetic rate, and having to cope with ongoing threat to its existence. "Well, it was early December 1950. I had already discovered that I had to go to the army because there were posters everywhere. There were no individual draft notices yet." Dasberg's Hebrew was good enough for him to have understood those posters. But he told me a rather shocking story--considering this was five years after the Shoah and many survivors had horrible trauma histories--how others, who might not have seen or understood the draft posters, were drafted. The center of Jerusalem was suddenly closed off and:

> people were detained by police, the military police, in order to find those who were trying to get out of being drafted. Because the army had to keep functioning…and then I just stood there near a

> shop, innocently looking at books, or shoes, shoes, as if the whole thing had nothing to do with me. Well, we knew about *those* kinds of defenses! Those kind of "*razzias*." It's incredible that this took place. The papers were full of it later, that this could never happen again, and it didn't.

Dasberg was twenty when he joined the army. The following anecdote gives a flavor of his experience there and the social atmosphere in the country at the time:

> Some of the fellow soldiers were two boys from Belgium who had been in hiding. We only guessed that about each other, it wasn't talked about. And there was a guy from Yemen in my tent, 37 years old, and a family man. He was also drafted. And there was a guy, a very young, blond guy who hardly spoke any Hebrew. He spoke German. He simply was a *Wehrmacht* (German army) soldier who had got to the Middle East and volunteered into an army…We told the officers about him and they took this guy away. He hadn't done anything, but they took him away. He was actually a nice guy, but it was shocking! There were a lot of people from the Shoah.

Dasberg's first officer was a Jewish lieutenant of German origin who had blue eyes and blond hair. "I always imagined, now I'm also in the *Wehrmacht*. And I have a German officer. That's a strange fantasy isn't it? But I became very depressed." Only years later did he understand how many Shoah-related triggers he had had to deal with during his army service.

When Israel's first faculty of medicine opened, in the early 1950's, Dasberg enrolled. Many of the students were Holocaust survivors from different countries and ages. Nobody spoke of "the past. You just didn't do that. I don't know why…No, no one, no one at all spoke of it. It just wasn't done….it was not "politically correct" as you'd call it today." The oral historian, Leydesdorff (2004) noted that victims can only truly express themselves regarding their traumatic experiences once a society becomes open to hearing the stories, often as a result of ideological struggles. Dasberg's descriptions of his experiences in the first decades of Israel's existence give a vivid impression of the Zeitgeist, the socio-cultural and perhaps intellectual climate at the time and a possible societally influenced foundation of *a priori* countertransference on the part of therapists regarding Holocaust survivors. Examples of such sources of *a priori* countertransference might be anger at, or impatience with Holocaust survivors resulting from unacknowledged guilt on the part of David and Hanna's parents' generation and their offspring; or anger and defensiveness on the part of Holocaust survivors and

their offspring at 'veteran' Israelis for their insensitivity towards survivors in the first decades of the nation.

The Therapists' Professional Awareness of Holocaust Trauma in Israel

The career span of the therapists at the time of the interviews ranged from about four to forty years. It was my intention to trace via their experiences, the degree to which they had or had not been aware of Holocaust traumas over the years, and whether their attitudes reflected the rest of Israeli society in this regard.

Dora, the most veteran of the interviewed therapists, started her professional career working with children in a psychiatric setting in the 1950's. She recalled very little awareness of trauma in those days even though at least some of those children must have been Holocaust survivors, sexually abused or otherwise traumatized. But the first focused attention on trauma she experienced pertained to Shoah survivors through Hillel Klein. He pioneered therapeutic work with Holocaust survivors in Israel when the Eichmann trial in the early sixties finally paved the way for public interest in the experience of Holocaust survivors. Klein, a psychiatrist and a Holocaust survivor himself, gathered a small group of fellow mental health professionals, most of whom, like Dora, had been directly impacted by the Shoah in some way (Chapter 7). They became the first therapists in Israel to explore therapeutic work with survivors and their children. At the time when Dora and her colleagues started recognizing the survivors and second generation among their clients, only survivors who exhibited psychiatric symptoms received professional attention. This was also reflected in the literature published at the time (Chapter 5). Some of these survivors still lived on David's hospital ward.

While Klein, Dora and the other members of their group explored ways of doing psychotherapy with survivors and enabling them to talk about their experiences, other colleagues were concerned that “those people aren’t suited for therapy!” However, Dora's group became “increasingly convinced that what we were doing was right." In the seventies, Dora also became one of the pioneers in Israel working with children of survivors.

By the mid-eighties plans were under way to set up an organization devoted to work with survivors and their children. Some members of Klein's original group, including Dora, were involved and new therapists were attracted to the project in order to increase its chances of success. Dora remembered encountering concern and skepticism from colleagues about the feasibility of such a center which started modestly but grew very rapidly. Around the late eighties, early nineties, Dora belonged to a small group of professionals who offered seminars and academic courses on therapy with survivors and second generation. Her work and academic experience reflects the widening circles of awareness and professional acknowledgement of the unique needs of survivors and their children.

By the time David started his psychiatry training in the late eighties, there was already some awareness of trauma. He interned at a hospital that was sensitive towards Holocaust survivors given that the hospital director himself had a personal connection to the Holocaust. The interest in trauma among his colleagues varied. "I think that the dialogue in psychiatry with "life events" in general and with trauma in particular, waxes and wanes…I suppose it's personal and also environmental."

David's career reflects much of the attitudes towards Holocaust survivors in Israeli psychiatry. He started paying attention to his patients' Holocaust history in the early 1990's. He noted that at that time, it was still not uncommon for patients who had lived in Europe during the Second World War to be referred by the emergency room, or a clinic, "without any mention of the Holocaust." Bachar, Dasberg, and Ben-Shakhar (1995) found in their study, comparing attitudes to survivors versus controls, that hospital staff did not know that twelve of their patients were concentration camp survivors.

David's direct colleagues have come to understand that "something as complex and dreadful as the Shoah is very, very relevant also to the illness, to the progression of the illness, to the treatment and to the family, and also to what we can offer." But such awareness, according to David, was not yet widespread in Israel. He thought this was a matter of historical development:

> You couldn't fight the War of Independence, establish a state, set up agricultural settlements, do "whatever" and at the same time, do any kind of containment of all those people who got here from "there" with those horrendous things that some knew about and some didn't. I do not think that was possible. It's true that, as professionals, we should have opened ourselves up to that world much quicker.

In David's understanding, Israeli psychiatry ignored the plight of Holocaust survivors as a result of the historical context of the "generation" of Israel's psychiatrists at the time. The first ones, mostly psychoanalysts and often survivors themselves, maintained silence. The next generation, the "giants" of the seventies and eighties modeled themselves on North American psychiatry. "The introduction of medication and criteria and the Americanization of medicine in general, and also of psychiatry, didn't enable a dialogue either." David felt that only his generation who already took the existence of the State of Israel for granted and were able to read articles published in English, could become more open. He gave as a further reason that they had grown up without trauma. David seemed to skip over national traumatizing events such as the wars and terrorism:

> I think it's a process. It was not possible. Israeli psychiatry was not mature enough. On an individual level, there were *wonderful* doctors who did terrific things. But as a profession, it wasn't possible at the stage of the "life cycle" of Israeli psychiatry, it couldn't happen earlier.

Tragically, not all the patients on David's ward needed chronic hospitalization from the start. “But there was no social network to receive them back into the community, no family, no money, nothing!" This was a serious indictment of Israel's difficulty in providing for the needs of these severely traumatized citizens. His hospital ward turned into a kind of hostel or "old age home or home for life, whatever you want to call it. In that sense, not all of them were ill, not now either.” But David pointed out that there were indeed severely mentally ill patients among the hospitalized Holocaust survivors.

David felt that Israel owed the survivors "the best service, just like army invalids" for whom Israel has created a support system over the years. Of course he was aware that quite a number of survivors were also army “invalids," in the sense that they carried either physical and/or psychological scars from active combat:

> Many arrived and straight away, in '48, were given a gun and told to go and fight. That was totally crazy! And there were those who later fought in the Six Day War [1967]! Some of them were in the Sinai Campaign [1956] and again in the Six Day War. There were a lot of people, those who came here in '50, let's say, between the ages of twenty and thirty, let's say, who served during the Sinai Campaign and then in the Six Day War.

The experience of Joseph's mother could serve as an example of David's analysis of the development of attitudes in psychiatry. A child survivor, she did receive outpatient help well before Holocaust survivors became a recognized client population because she had psychiatric symptoms. Still, Joseph remembered that there “was a lot of stigma, a lot of secrecy” and he made no mention whether her traumatic history received any attention, or whether the treatment consisted only of medication.

By the time Sara, who has only been working with Holocaust survivors for a few years, was finishing her studies, trauma work had already become sufficiently accepted for her to have been offered an internship with Holocaust survivors. At the same time, the prejudiced attitudes she had internalized towards survivors and the second generation (Chapter 6) in her family and neighborhood, were still very much alive in Israeli society. Working with survivors was therefore uniquely complicated for Sara. One way in which she expressed her *a priori*

countertransference was that it took her several years before she could fully acknowledge that the people she was working with had truly been hurt in the Holocaust. She spoke heatedly of the hatred she had absorbed for the Yiddish language which would surface when some of the survivors would sing Yiddish songs. She also spoke of her feelings of shame about her family of origin and how she imagined an *Ashkenaz*i child would never have felt ashamed. She assumed that all the Holocaust survivors she would be working with "are rich inside. They play the piano and read books." I could not stop myself from asking whether she really thought that was true. Sara agreed that this could not be so, but then repeated that they would be perceived as such because they were *Ashkenazim*, "at least in my parents' eyes."

Sara's account demonstrates how hard it is to neutralize deeply ingrained prejudice, projections and old interpretations of one's emotional wounds, even if these appear to no longer fit a therapist's current narrative. Perhaps it is more difficult for some who have felt victimized--in the case of Sara's family by those they perceived to be the *Ashkenazi* elite--to be empathic to the pain of others, especially if they have a sense that there might not be sufficient empathy, attention or funding for everyone.

What can be gleaned from the interviews with Dora, David and Sara is that even in the early 2000's, Israeli society and its mental health professionals were still working through their different socio-historical and personal issues that could prevent optimal care of Holocaust survivors who want or need help with their traumatic experiences and memories.

All three therapists were exceptional, whether as pathfinders like Dora, innovators like David, or like Sara, gifted with the courage and integrity to confront deeply ingrained stereotypes and intergenerational wounds. All three seemed to have found a balance between their personal histories and motivation and what was becoming possible socially. It needs to be kept in mind, for instance, that Klein, Dora and their colleagues pioneered therapy with survivors only when they sensed this might stand a change of becoming accepted. The personal and societal hurdles they have struggled with and might still be confronting could certainly be considered part of their *a prior*i countertransference and unless acknowledged, monitored and resolved, find adverse expression in their clinical work.

The Therapists' Professional Awareness of the Second Generation in Israel

The existence of the children of Holocaust survivors and their characteristics as a distinct population entered Israel's consciousness more or less parallel to developments in the rest of the world (Tauber, 1998, Chapters 3 and 5). This is not yet the case regarding children of other refugee immigrant groups to Israel, who shared part of the continuum that had culminated in the Holocaust:

persecution, loss, inability to return, the parents' idealization of what was lost and the 'children' can never know for themselves. As Sara put it: "I am second generation to frustration, to transition; to transition because of anti-Semitism; to a reality of life in fear, as it were, that whole environment of Moslems and persecution."

Children of Holocaust survivors pose a challenge to mental health professionals since their family's Holocaust history and its possible influence on them can so easily be ignored. They often present, at least initially, with the same issues as contemporaries. Even Joseph, a child of survivors himself, did not relate specifically to possible intergenerationally transmitted Shoah traumatization in his second generation clients (Chapter 7). However, when, in the early nineties, Van der Hal, Tauber, and Gottesfeld (1996) offered open groups specifically for the second generation, the response was impressive and participants immediately experienced a sense of familiarity and kinship with each other. Brom, Kfir, and Dasberg (2001) showed clearly that the second generation do indeed have distinct characteristics. The fact that the Holocaust can still so negatively impact even the post-war generation can be quite challenge for therapists to acknowledge.

Some aspects of the dynamics in Holocaust survivor families still remain under-acknowledged. David suggested "cautiously" that there might be more "proneness" to trauma in the families of survivors. Personally, he had no interest in working with second generation clients, as he only felt drawn to old people. Dora was among the first in Israel to offer groups for Second Generation and Ruth was one of the first and few people in Israel to openly acknowledge sexual and physical abuse can also occur in Holocaust families. She felt that the second generation had started to speak out more. "Some of the parents died, and they [the children] permitted themselves to speak out. But I think that to this day, the second generation has not really been asked direct questions to talk about the private Shoah they experienced at home." Freyd (1996) wrote how sexual abuse of a child can create "information blockage." To know is to put oneself in danger. Not to know is to align oneself with the caregiver and ensure survival" (p. 4). In the case of children of Holocaust survivors, "not to know" might have meant protecting the emotionally wounded caregiver from knowing s/he had been a perpetrator too. Both client and therapist might (unconsciously) collude to protect the Holocaust survivor by non-exploration of possible sexual abuse. The *a priori* countertransference issues can be quite complex, then, including not only attitudes and feelings towards the Holocaust, but also towards survivor parents, towards acknowledging areas of possible (intergenerational) traumatization that clients might not bring up themselves--which might include distress and anxiety in response to frequent acts of terrorism (Chapter 4); towards the implications of intergenerational traumatization, i.e. that the suffering does not necessarily stop

with the direct victims; towards daring to break a taboo by perceiving Holocaust survivors not only as people who have endured inhuman suffering, but also as people, who just like other parents, might have hurt their children; and towards focusing on issues and difficulties most of their colleagues, and the rest of society might prefer to ignore.

Sexual Abuse

The process of recognizing societal impact on clinical perceptions and sensitivities regarding sexual abuse is not a simple one. Walker (1999) acknowledged this outlining the process of working with victims of abuse and incest and the need to navigate among different social messages, ranging from discouragement of believing clients through to suggesting to clients that their presentation implies that they might have been sexually abused. Herman (1992), Brown (1997) and Amstrong (1996), among others, have pointed out the impact of societal demands and mores on the perception of sexual abuse. According to DeMause (1992), incest has been a universal behavior in human history rather than a universal taboo.

It has been widely accepted that there has been little awareness of sexual abuse in psychoanalytic circles. This may have been because of Freud's interpretation of his patients' accounts of sexual abuse as fantasy-based expressions of intra-psychic conflicts. Historically, however, this is not entirely correct as Freud (1925[1924]) never denied the actual existence of sexual abuse and incest, did acknowledge sibling incest, and even seemed to prophecy accusations of implantation of memories.

While highlighting Freud's interpretation of sexual abuse as fantasy, Wolff (1995) set this in the context of descriptions of child abuse from the contemporary Viennese press which subsequently faded from public awareness. "At the same time that Freud revealed that children dream of the deaths of their parents, anyone who read the newspapers knew that parents both tortured and murdered their children" (p. 242).

It was not till the late nineteen sixties and seventies that women in the Western world, especially the USA, became able to demand respect for their stories and experiences; feminist therapists listened with greater openness to their clients. Burgess and Holstrom (1974) were the first ones to describe the traumatic consequences of rape and the needs of the survivors. Issues such as sexual abuse, including incest, began to enter general professional awareness. However, in their textbook, Freedman, Kaplan, and Sadock (1976) noted regarding incest, that "[i]n Sweden … the yearly incidence has been estimated at 0.73 cases per million population. Comparable figures from United States sources range from 1.1 to 1.9 cases per million" (p, 770). In a vein more commonly heard by perpetrators, they

then reassured their readers that "[t]here is often found little deleterious influence on the subsequent personality of the incestuous daughter…one study found that the vast majority of them were none the worse for the experience" (p. 770). And though great strides have been made, Hartman and Jackson (1994) pointed out that in North America decades later, medical staff, including in emergency rooms, or representatives of the legal system might still not believe rape victims. Sexual harassment has only recently become a topic of study by PTSD researchers, despite the potentially severe consequences for its victims (Street, Stafford, & Bruce, 2003). Furthermore, sexual abuse is not yet universally acknowledged. As of 1994, it was still unmentionable in professional circles in Japan, for instance (Lionells, 1997).

A major consequence of accepting the existence and common occurrence of sexual abuse is the necessity to confront the existence of the perpetrators. Price (1997) wondered how it was that "the memory of incest victims is being challenged as potentially false, but the memories of the accused perpetuators are rarely, if ever, the object of analysis. Theirs are accurate and left out of this current discourse." This is a clear reflection of societal values and perceptions. Herman (1995), too, questioned the narrow focus on the victims in the field of trauma and noted that the "dynamics of human sadism have almost entirely escaped our professional attention. Our diagnostic categories do not comprehend the perpetrators; they present an appearance of normality, not only to their children, but also to us" (p. 7). In fact, as Hilton (1997) pointed out, therapists working with victims of incest and other sexual abuse in the 90's found themselves on the defensive and many have started to "stay away from issues of childhood abuse and trauma. It's not uncommon for therapists to ask themselves when interviewing a prospective client, Is this the kind of person who would one day take me to court" (p. 5)? This indicates that societal and professional acknowledgement of sexual traumatization can still be controversial.

Even as awareness of sexual abuse grows, therapists can still impose silence on their clients by their own inability to hear. In their interviews with Chilean therapists who worked with fellow Chileans tortured by the authorities, Agger and Jensen (1994) carefully observed their own responses and noted that not everything was discussed. "We know about sexual torture…We nearly "forget" about this theme in Chile" (p. 270). They thought it might have been just to be too difficult to ask about this or to hear the answers. "The sexual undertones are still part of the 'conspiracy of silence,' part of the unspoken--maybe words can never express it" (p. 270).

Personally, I realized that I could not remember ever asking or hearing explicit details of sexual abuse in the concentration camps. And although sexual abuse of child survivors in hiding during the Second World War, for example, was far from rare, unfortunately, one would not learn much about this from the

relevant professional literature. And unless one specifically asks, survivors do not often volunteer to speak of these horrors. Therapists, therefore, do not only need to monitor their *a priori* countertransference originating from their personal histories; they also have to monitor the impact of perhaps doing work that goes against majority views and that can have professional, and even legal repercussions on the therapist.

Sexual Abuse in Israel

Anglo-Saxon female immigrants were significantly responsible for the increased awareness of sexual and other abuses of women, and the establishment of appropriate services. In some ways their influence on the mental health profession in Israel could be compared to that of Hitler's refugees and later, the survivors of the Holocaust who had introduced psychoanalysis and psychodynamic psychotherapy decades earlier. Hanna laughed as she remembered that her job interview at a woman's therapy center had been conducted in English, rather than Hebrew. Swirsky (1993) noted the contribution of the English speaking immigrants to the women's movement:

> The nurturing ground this time was not a socialist Zionist movement, but rather middle-class; University-educated, mostly Ashkenazi young women who, like the rest of the middle and upper classes of Israeli society, had become identified with American culture…The beginnings of the movement can be traced to 1970… (p. 294).

Karen Shachar, who worked as the coordinator at the Rape Crisis Center between 1989 and 1996 and was one of those immigrants, told me in an interview we held in 1999, how awareness had grown and services been set up. The creation of the first Rape Crisis Center by a group of Feminist women in the late 1970's had been spurred on by the suicide note of a woman stating that there had been no one for her to talk to after she had been raped. Whereas initially, a hundred calls a year had been considered a huge number, by 1999 the Center received an average of 4500 calls a year.

Shachar told me that a change in the name of the center from Rape Crisis Center to Center for Sexual Assault Victims brought in calls from women who had suffered sexual harassment, (gang) rape and incest. This is a poignant illustration of how the appropriate use of language can convey openness, inclusiveness and acknowledgement, and so provide the necessary encouragement to trauma victims to ask for help. By the same token, the language used can also reduce awareness of sexual abuse (Amstrong, 1996).

The rise in the number of calls for help by incest victims in Israel also reflected the social climate. According to Shachar, by 1990, "7 percent of our calls were about incest. Today, [1999], over thirty percent of the calls are about incest." She also noted increasing openness to male victims. If a man called in the early eighties, he would "be perceived as someone who wanted to hassle the staff." However, a growing number of calls from men signaled a reality that could not be ignored so "volunteers were trained for a special phone service for men. And on the men's helpline, over ninety percent are incest." This is a clear illustration how societal changes can affect *a priori* countertransference, and therefore perception.

Shachar also worked at a feminist center for psychotherapy which was set up in the late eighties. A significant percentage of the women who turn to this center are incest survivors. The needs that are being recognized by the Centers for Sexual Assault Victims and the feminist centers for psychotherapy raise challenging issues of perspective and response. A study of the Israeli Journal of Psychiatry (Tauber, Brom, Brinkgreve, & Van der Hart, 2004 [Chapter 5]), might give the impression that over the past four decades or so, there has been no problem with incest, sexual abuse or assault in Israel, as almost nothing was published there on these topics. The growing numbers of, women and later of men, who called, in distress, to finally talk about the horrors of the incest they endured, and the clients seeking psychotherapy for sexual assault seem to represent a hitherto invisible and mute, section of the population. Professional awareness unfortunately, remains insufficiently widespread.

The Therapists' Professional Awareness of Sexual Abuse

The interviewed therapists reflected some of the societal and professional changes in perception of sexually abused clients in Israel, and some had helped to steer those changes. Over the decades of her professional life, Dora had not consciously encountered much evidence of sexual abuse. She did remember a client she had seen nearly forty years earlier, who had been sexually abused by her father. "And that was at a time when that wasn't talked about at all! Today people don't stop talking about it." Dora often thought of her and "how I would have treated her differently today." Unfortunately, I did not explore with her what it was that kept the memory of this particular client alive for her. Dora also recalled two women she had worked with in the seventies who had been sexually abused by their previous therapists. She had felt troubled by this but some of the colleagues she discussed it with at the time had not been surprised about the phenomenon nor about the particular perpetrators. "It was clear that it was not allowed, but not that it was so traumatic. And there really was some denial because colleagues were involved."

Joseph started doing therapy about a quarter of a century ago. He did not recall whether he had clients then, who had been sexually abused. He thought that he might not have noticed because of the lack of awareness of sexual abuse within the profession at the time. He gave a wonderful analogy of *a priori* countertransference; when his wife became pregnant, he suddenly noticed pregnant women everywhere.

When Joseph did become sensitized to sexually abused clients, it was not easy for him to find like-minded colleagues. In his experience, many of the therapists that specialize in working with sexual abuse in Israel were female feminists; and some of the more radical feminists did not want to collaborate with men. He regretted that it had not been possible to maintain good professional contact with all the professionals involved. Without minimizing his own contribution to the positive change that had occurred in Israel, he thought that "the main thing is the Zeitgeist, the spirit of the times. The excellent work of the feminist organizations and the Centers for Sexual Assault Victims raised awareness. The press deals with it. It's no longer possible to ignore such problems." He credited his colleagues' and his own "stubborn" work which enabled others to discover that it is not destructive to acknowledge the existence of sexual abuse and work with abuse victims. Joseph also felt that recent developments in the field of psychoanalysis had significant and positive consequences for sexually abused clients:

> Psychoanalysis is moving away from the arrogant psychoanalyst who announces to the client what his reality is and interprets it. That was what had made it possible to deny the experiences of incest and say it was wish fulfillment…How many victims have sat there on those sofas being told that they had imagined it! But that's changing. Today there is more space for relational work and not everything is carved in rock. There's space for the client's perspective as well. Psychoanalysis has become more human, and in that sense, less dogmatic. And if the therapist is capable of being there, as a human being, not as a blank screen, then there is space for a human response to the pain of the client.

Ruth felt rather isolated when, as a young social worker in the early seventies, she became alert to victims of sexual abuse (Chapter 7). "That was a terribly hard struggle because there really was no one. Psychiatrists were not willing to back me up either…" She has noticed a significant change in attitude towards sexual abuse over the past twenty years, especially the past five years. "People are willing to talk about the subject. And second, social workers are increasingly willing to ask direct questions." She thought this was partly the result of the huge influx of

immigrants from the former USSR, that because, as an immigrant group they had intensive contact with social services, problems around sexual abuse were more easily discerned among them. "I think that made a real contribution to the subject." Ruth has also noted more interest in children's rights and in child abuse "not just in Israel; it's world-wide."

Nell has had personal experience with professional deafness to clients' experiences of sexual abuse (Chapters 6, 8). It has also been hard for her to insist on attention for the emotional scars of her own sexual abuse. She had always remembered her abuse, but only plucked up the courage to really pay attention to it when there was a societal OK in the eighties. That was when some books on the subject started coming into the shops (Chapter 7). Nell then bought one. "It was the first time I was willing to touch something like that. And it then sat on my shelf for another two years." She sounded shocked at how very difficult it had been for her to actually read it.

Nell participated in an academic psychotherapy training program in the early nineties which, to her distress, did not teach the participants to explicitly check with clients whether or not they had suffered sexual abuse. There was no specific focus on trauma in the training but, in case presentations, there was occasional mention of sexual abuse and the Holocaust. In her clinical practice, Nell also witnessed the suffering of clients who were hospitalized; their sexual abuse was not only ignored but they were retraumatized by some of their hospital experiences. Still, over the past twenty years, she has found that sexual abuse and trauma have become more often discussed "and more understood." Like Joseph, she was aware of her own contribution to this social and professional change.

When Hanna started clinical work in the early nineties, there was some awareness of battered women, but sexual assault was still rarely discussed. She thought that work with sexual abuse victims and the training of therapists began to gain momentum around the mid-nineties. This was in line with Israel being "about twenty years behind the States in those things." She also noted changing attitudes to men and "a start of a man's movement...I imagine that will be the next topic of sexual assault, of men. And I'm starting to learn, to read, to hear and supervise group facilitators in that field. I'm already getting clients as well."

Hanna perceived herself and a small group of female colleagues as having had a major part in creating professional awareness and training professionals to work with sexually abused clients. She has been involved in a course for mental health professionals intended to sensitize them to physical and sexual abuse of women since the late eighties, and more intensively, since the mid nineties. Brown's comment (1995) seems apt here, i.e., that feminist analysis of trauma and the societal causes of traumatization make "our profession revolutionary; we challenge the status quo and participate in the process of social change" (p. 111).

Dana's situation as a relatively new therapist was already different. Like Sara, she was offered the option of working with a traumatized population as an intern, in her case, victims of sexual abuse. This in itself reflects the significant changes in attitudes that have taken place. Still, Dana felt it was important to tell as many people as she could what work she was doing in order to raise awareness in case they needed encouragement to seek help resolving their own abuse issues. Occasionally, men would ask her if she could be certain that her clients did not just make up the stories. She understood this to be not only "male chauvinism," but an expression of fear that "women have found the weapon to get at men."

The interviewed therapists all seemed to have been affected differently by their colleagues and the societal context. Joseph and Nell, for instance, most directly credited societal changes for their own ability to confront sexual abuse. The therapists also provided different explanations for the changes in awareness of sexual abuse that have taken place, some acknowledging the influence of feminist immigrants and others the presence of a large immigrant population that was in close contact with social services. Perhaps it is easier, initially, to distinguish sexual abuse in the group of the "other" than in one's most familiar and intimate surroundings.

The interviewed therapists also found ways to contribute to societal awareness. Work with sexually abused clients seems to evoke the need to clarify one's own attitudes as well as awareness of the mutual impact of society and colleagues, which can all be considered aspects of *a priori* countertransference.

Beyond the Therapy Room

Psychotherapy with traumatized clients can raise many philosophical and ethical questions as to whether it is morally justified to just listen to clients' accounts of injustice and traumatization rather than also try to actually change traumatogenic social conditions. Hopper (2003b) advocated social awareness. "One does not have to be a political activist to believe that psychotherapists ought to learn something about the nature of social processes, and to try to understand how our patients are constrained by social events" (p. 122). Noting the relatively recent interest of historians in trauma and life stories, Leydesdorff, Dawson, Burchardt, and Ashplant (1999) pointed out that the various protest and liberation movements "demonstrated that trauma has social roots in structural oppression, persecution, devaluation, and official indifference to the sufferings of socially subordinated and powerless groups" (p. 8). Cushman (1990) described the conflict inherent in psychotherapy:

> Psychology cannot fully alleviate the symptoms unless it can treat the cause (i.e., the political and historical constellations that shape the era) and yet that cause is the exact subject psychology is not allowed to address. Psychological ideology ignores it, and job descriptions exclude it. (p. 606).

In the field of traumatology this traditional job description seems no longer adequate. For Herman (2006), for example, the very "study of psychological trauma is and always will be an inherently political project, because it calls attention to the consequences of oppression" (p. 83). Because of the complexity, it seems vital to explore the interviewed therapists' attitudes regarding direct societal involvement to increase the protection of vulnerable population groups, in addition to their clinical work, and so uncover further sources of *a priori* counter-transference.

Socio-political Activism

In the context of interpersonal traumatization, it can be difficult to separate clinical work with clients from societal involvement. "Work with trauma victims confronts us with questions of social involvement that are inescapable, even if we are not always aware of them" (Brom & Witztum, 1995, p. 247). Even traumatization that is carried out in relative secrecy, such as incest, occurs in a societal context within which it is perpetrated, and either (silently) condoned, or condemned and treated. Gold (2000) states uncompromisingly that "[S]society as a whole is to blame" (p.79) for insufficiently supporting families and individuals to resolve their difficulties and thus limit both perpetration of abuse and the suffering of its victims. Brown (1995) wondered what might happen "if we admit that our culture is a factory for the production of so many walking wounded?" (p. 103) Brown (1997) also disputed the view that psychologists should not activate towards social justice because this would affect their objectivity.

Societal context can exert an extreme influence. Sluzki (1990) drew attention to the "imprinting of fear and self-censorship" that was the lot of both therapists and clients in Argentina under the military regime (p. 132). Bar-On (1992) noted that, as history has shown, societally accepted values are not consistently moral:

> In certain instances reality can be deviant and 'immoral' even if accepted as normative by many of the people involved in it, and who may have developed the ability to suppress it. Such a reality can be designated as moral' and 'just' in certain circumstances, and yet be interpreted in a completely different way under later, different circumstances. (p. 298)

The founding fathers of psychotherapy had differing views on socio-political activism (Stanton, 1990). Janet and Ferenczi advocated social involvement, whereas Freud tended to shy away from explicit action. The more trauma-focused Janet pushed for legal reform against the persecution of homosexuals, and Ferenczi headed the Budapest Psychoanalytical Society which was considered "quite subversive, as it contains vociferous and renowned advocates of world communism, gay rights, anti-militarism and the imminent collapse of the Habsburg Empire" (Stanton, 1990, p. 22).

Haaken (1990) gave a thought-provoking review of the influence of socio-political events in Germany on psychoanalysis as a field and clinical practice before, during and after the Nazi era. Op den Velde (1996) noted that it might be even harder to realize that there had not been sufficient professional resistance and opposition to Nazi ideology *before* the outbreak of the war, than it is to judge Nazi-psychiatrists for collaborating in genocide.

Pearlman and Saakvitne (1995) took a clear stand in favor of the social responsibility of mental health professionals. They warned that societal awareness of sexual abuse could not be taken for granted and that it was up to therapists to keep such awareness alive. "When we do not recognize the social and political context for our work, we unwittingly participate in this return to silence, denial and neglect" (p. 2). Van der Kolk (1994) highlighted the "deeply political nature of traumatization and the need for social action to prevent trauma, or at least to alert the world to the psychological cost of traumatic experiences" (p. xii). Pope and Garcia-Peltoniemi (1991) considered it unethical for mental health professionals to ignore torture and its victims. Segal (2002) pointed to the danger of remaining silent:

> How is it, that terrorism of whatever kind can get such massive support? I think that part of the problem is that we submit to the tyranny of our own groups…We are all members of some group or other and share responsibility for what 'our group' does."(p. 284)

Fischman (1991) considered socio-political involvement integral to therapeutic work. She, in fact, described a source of *a priori* countertransference when she suggested that many therapists "have chosen to work with survivors of human-induced trauma out of a sense of social responsibility or from an ethical commitment to help heal those whose lives have been shattered by the psychopathology of repressive societies" (p. 183). Herman (1992) gave an excellent example of societal engagement and its consequences:

> In 1975, in response to feminist pressure, a center for research on rape was created within the National Institute of Mental Health.

> For the first time the doors were opened to women as the agents rather than the objects of inquiry…" (p. 30).

Herman noted that "[R]rape was the feminist movement's initial paradigm for violence against women in the sphere of personal life…And the initial focus on the rape of adults led inevitably to a rediscovery of the sexual abuse of children" (p. 31). By stating that therapists working with trauma need not only be witnesses but also allies, Gael (1996) concisely made the case for some form of involvement outside the therapy room.

Such an alliance between therapists and clients could be considered a threat to social stability. In a sense, trauma therapists deal with society's secrets: every act of recognition of trauma and acknowledgement of post-traumatic symptoms is, in the case of man-made trauma, an act of accusation of the perpetrator(s) as well as their enablers. Herman (1995) pointed out that taking sides is unavoidable. "When we bear witness to what victims remember, we are inevitably drawn into the conflict between victim and perpetrator. Although we strive for therapeutic neutrality, it is impossible to maintain moral neutrality" (p. 12). The manner in which each individual trauma therapist resolves this challenge has obvious implications for *a priori* countertransference.

The Therapists' Views on Social Activism

The question arises whether trauma therapists have, or feel, an actual obligation to be involved on a socio-political level in order to make certain that interpersonal traumatization and abuse are recognized, and to demand preventative measures. The individual therapist's response to this question might yield important sources of *a priori* countertransference regarding the boundaries of professional preoccupation and a sense of responsibility regarding clients' suffering. While the professional literature does seem to support some form of societal engagement on the part of therapists as integral to their work, the interviewed therapists did not have a uniform response to the combined challenges of life in Israel and work with their traumatized clients.

Some of the therapists, perhaps reflecting the highly politicized Israeli society, understood my question about societal involvement to be about party politics. Sara, for instance, worried that clients might experience conflict if they knew their therapists' political views. She said nothing about societal involvement on behalf of traumatized clients or to prevent further traumatization. David was not certain whether being a therapist was a particular advantage or disadvantage as far as politics was concerned. He felt that therapists ought to be socially involved, but quietly so. He did this by volunteering psychiatric services to a socially vulnerable population. Joseph said that he did not like to participate in political

demonstrations but “I'm active for social change in ways that suit me." He regularly and freely gave of his time to societal and professional causes close to his heart. Dora had clear political views, but did not discuss any connection between trauma work and political involvement.

Other therapists, too, were in favor of societal involvement: Dana firmly believed in active social engagement through speaking out and taking social action. “We have an important tool, and must use it.” Nell was mostly in favor of therapists acting publicly in the field of mental health to increase awareness and try to prevent further trauma. Her current focus was sibling sexual abuse, which she feared was too often overlooked. Ruth did not really address socio-political aspects of being a trauma therapist in the interview. This might be because, by the time we were discussing this subject, we were already rushing to wrap up (Chapter 2). She did speak of a lack of a sense of personal safety as a result of political reality at the time of interview.

Most of the interviewed therapists did not speak in political terms about the trauma and suffering of their clients. This does not mean, however, that such perceptions are not implicit in work with Holocaust survivors, for instance, where both the perpetrators and the bystanders are so unequivocal. Staub (1989) stated clearly that bystanders to maltreatment of others have an obligation to act regardless of personal risk. “It may be the courage to oppose the group and endanger one's status or career…" (p. 239). Freud seemed to have preferred observing to acting even in the face of the rise of Nazism. This attitude might well have served as a precedent for later psychoanalysts, which is relevant here in view of the dominance of psychoanalysis in Israel for so many decades. As Moses (1992), one of Israel's senior and respected psychoanalysts, put it:

> Freud was, of course, shocked by the proposed changes removing Jews from all positions of authority in the society, and soon from the Society altogether but he could not bring himself to take an unequivocal stand against them. He hoped that psychoanalysis in Germany could somehow be saved. (p. 229).

For Hanna, social and political involvement was integral to working with sexually abused clients. “I deeply believe that social and political matters enter the therapy. And in my specialty, I don't think you can be a good therapist if you're not aware of the political and value-related parts of yourself." She felt committed to her clients and their suffering as well as to Israeli society as a whole. Working towards social change also provided Hanna with an important way to process the impact of her clinical work:

> I consider it part of my Zionist work to try to educate generations of therapists that will be able to listen better to people who endured sexual assault. I've done the same regarding battered women…I find it hard to understand how you can work with people who have suffered incest and not be involved in building more supportive social networks for them.

It is perhaps appropriate to end this section with Hanna's response to political developments in Israel. She did not respond with her usual attitude of active engagement but, with honest self-reflection, she summed up many of the issues explored in chapters 6, 7, 8 and 9 and gave some further insight into some of the wealth of sources for her *a priori* countertransference responses.

> I really feel we live in the middle of a tragedy…We live with that personal sense of not knowing what will be tomorrow, politically. And you don't know whether or not there will be a country tomorrow. I have often wondered over the past years, when, considering what happened in Europe, I would say to myself, I'm in danger and I'll gather my things and run away? And where to? That is a question I ask myself! …It comes up on the level of fantasy. That is, my father escaped from Germany in 1933. What did he see that I don't see now? Or what did he see, that I'll later say, 'too bad I didn't do that'? That has to be done? But that's a hypothetical, philosophical question…. Politically, I don't feel I contribute anything at all. I don't have the have the energy for that…. Socially, I feel I contribute a lot.

As the interviewed therapists' responses have shown, conflicts, as well as solutions, regarding personal engagement to improve conditions for their traumatized clients and society as a whole vary with each individual. No comments were made about whether societal responsibility perhaps needs to be integral to the profession as a whole. The degree to which the therapists feel social responsibility in general, and regarding their clients in particular, reflects much of their personal and family histories. It would be reasonable to expect, therefore, that in this area too, self-exploration for *a priori* countertransference, which might, for example take the form of guilt, or a desire to overcompensate, will prove fruitful and ensure that clients have a better chance to be fully and correctly heard.

Summary and Discussion

The focus in this chapter has been on the link between societal and professional awareness of trauma, particularly when caused by the Holocaust or

incest and sexual assault, and a possible redefinition of professional preoccupations and boundaries as a consequence. The professional literature, as cited in this chapter, reflects the changing perceptions of trauma and its consequences in general--from ignoring and denial to acknowledgement. This was also the case with the Holocaust and sexual abuse. Such shifts in perceptions are not merely the result of scientific evolution of knowledge, but are clearly linked to ongoing societal developments.

The experiences of the interviewed therapists present a clear picture of societal shifts in perception of trauma as well as their own contributions to these developments. Dora, Ruth, Joseph and David, for example, all spoke of times when trauma, including Holocaust-related trauma or sexual abuse, was not named nor were the sequellae of trauma directly explored in psychotherapy. While trauma was outside the therapeutic focus--as mirrored in the interviewed therapists' personal experience (Chapter 8)--the clients were left to deal with their traumatic experiences as best they could without external acknowledgement and support. During the careers of the interviewed therapists significant changes have taken place in the way society at large, Israeli society and fellow professionals have regarded trauma, in particular Holocaust and sexual traumas.

The interviewed therapists' experiences seemed to confirm the extent to which a therapist's ability to acknowledge trauma and explore its impact may be connected to the socio-political climate at the time. For instance, Klein, Dora and the rest of their group were among the first to consider that Holocaust survivors could be helped therapeutically by attending directly to the traumatic memories rather than only treating those survivors with psychiatric symptoms. They started their work at a time when Israeli society first gave public space to Holocaust testimonials during the Eichmann trial. Still, it took much time and effort to persuade fellow professionals to consider therapeutic work with Holocaust survivors as possibly beneficial.

Rape and incest only began to receive serious professional and societal acknowledgment when the influence of feminism and feminist immigrants created a base of sufficient support that gradually enabled increasing numbers of professionals to expand their field of perception and develop clinical skills. Nell's personal experience of finding in the appearance of books, the support she needed to start addressing her own abuse experiences that had not received real attention in her years of psychotherapy illustrates just how far societal influence can reach into the psyche of both victim and therapist.

The interviewed therapists pointed to different factors to explain the changes in societal and professional trauma awareness in Israel: from the influence of the feminist movement (Joseph, Hanna), through an analysis of the personalities and socio-political realities of previous generations of mental professionals (David)

through to the presence of an "other," the large group of immigrants from the former USSR, that enabled closer and more accurate observation (Ruth). These differences in perspective might well be linked to the personal and familial histories of the individual therapists.

The more veteran therapists have all made significant contributions towards greater societal awareness of Holocaust and sexual traumatization and are continuing to deepen the understanding of the field (see also Chapters 7, 8 and 9). They have done so by allowing themselves to carefully listen to their clients, teach themselves about trauma and then train colleagues. This demanded a capacity for autonomy and personal integrity versus generally held beliefs and truths--or strong societal conventions--as well as societal attunement as to what changes they could realistically aim towards. Many of the therapists also felt a need to extend their commitment to traumatized clients beyond their therapy rooms by teaching colleagues, working towards societal and legal changes and raising awareness of the public at large.

The interviews have brought to light many of the issues involving societal influences that the therapists have had to come to terms with: whether or not to open themselves up to noticing and hearing about traumatized clients' experiences; whether to lead or be led within the profession, i.e. whether to trust their own perceptions and listen to their clients, or stay within the frame of currently accepted interpretations of clients' stories and symptoms; and how to cope in a specialization that is in such a state of flux. Not only does the field of trauma continue to change, but so do the ways potential clients might define themselves, and therefore the expectations they might have of their therapists. Absorbing and accepting societally accepted values and perceptions become part of therapists' *a priori* countertransference. The interviewed therapists have all, because of who they are, struggled with those accepted values and perceptions and found their own ways. Both the struggle and their resolution at any given time can also be expressed as *a priori* countertransference.

Analysis of the interviewed therapists' experiences has helped to outline areas to monitor beliefs, emotions and thinking. In order to raise awareness of their *a priori* countertransference, therapists working with traumatized clients need to find ongoing answers to questions such as, what the effect might be on them—personally and as therapists--of belonging to a professional minority; how they are affected by the fact that there can be such contradictory views about their clients' traumatization; how they might be affected by the fact that their discrete, clinical work can be interpreted as a form of political activism; how they might be affected--i.e. their ability to hear, see and respond clinically—by the fact that they might have to, or want to be more vocal about their clients' needs and rights; how they might be affected by the fact that they might have a share in the responsibility for

their clients' well being, for example by (not) educating the public at large, or colleagues in mental hospitals who might not be sufficiently aware of what might cause retraumatization for sexually abused clients, for instance. These are all guiding questions to explore *a priori* countertransference as impacted by society, which, if left unexplored, might lead (again) to traumatized clients not being heard or being misunderstood.

There have always been clinicians, including among the interviewed therapists, who have been able to do groundbreaking work. It would appear, therefore, that some therapists might have *a priori* countertransference that helps them to neutralize societal impact, i.e. an attitude of independence, of reliance on one's own sense of values, or trust in one's own perceptions. Others, and perhaps also these same therapists for different aspects of the traumatic events, or for traumatic events of different origins, might need to explore their *a priori* countertransference as shaped by internalized societal values, so that they will be better able to listen to their clients. It would be worthwhile, in my view, to go beyond the realm of the individual therapist and include exploration of societal influences, political mores, professional norms and awareness of *a priori* counter-transference within the mandate of the profession as a whole. Once discussion of values and encouragement of professional normalization within a specific society, including social responsibility become integral to being a proficient professional, individual therapists will be able to engage in exploration of their *a priori* countertransference as part of his or her professional commitment and ongoing learning processes in a more straightforward manner.

It certainly seems possible to state that "society" is actively present in the clinical work with clients traumatized in the Holocaust or by sexual abuse. The therapists' professional contributions, however pioneering and courageous, were not totally independent of socio-cultural changes, of the Zeitgeist. The fact that the field of traumatology and the societal context are continuing to evolve, obliges therapists to remain alert to developments, their own contributions to those developments and how this might impact their *a priori* countertransference.

CHAPTER 12

Summary and Discussion

A priori countertransference has proved to be a far richer and more complex concept than I could have imagined when I started the work for this dissertation. As has been shown in the previous chapters, all aspects of the therapists' life, including family history and societal context, may provide sources for *a priori* countertransference that, in turn, may affect their work with interpersonally traumatized clients.

Examination of specific factors that might influence therapists before they engage in a specific therapy is not a new idea. Prior influences have, for instance, been considered to result from social learning (Luhrman, 2000). Another example is "writing countertransference" (Seritan, Gabbard & Benjamin, 2006, p. 1708), the risk which, as Gabbard noted, may result from selective focus when a therapist anticipates writing up a case of a particular client.

However, the lack of systematic inquiry into the personal, individual contribution of the therapist to the therapeutic dyad, to the therapeutic relationship, troubled me. I had already conceptualized as *a priori* counter-transference (Tauber 1998), the attitudes, beliefs, values, prejudices, a variety of conscious and unconscious cognitive and emotional responses that therapists who themselves were Holocaust survivors or second generation brought with them to the therapeutic encounter with clients belonging to this population without having previously met them. I now wanted to deepen and widen the scope of my exploration.

Therefore, I set out to uncover and map, as it were, sources of *a priori* countertransference with the help of therapists who worked with Holocaust survivors, second generation and people who suffered sexual abuse, without necessarily having a similar background themselves. Furthermore, as the awareness of trauma, both within the international mental health community and in society at large, has fluctuated so much (Chapters 3, 5 and 11), I was interested in learning whether the societal context provided potential sources of *a priori* counter - transference.

The purpose of optimal awareness of *a priori* countertransference is to enable therapists to reduce interference in their listening ability to their traumatized clients and to create a climate in which clients can feel safe to talk about their traumatic experiences and their current suffering. In my understanding, therapists' prior attitudes, such as world views, values, prejudices, are not *incidental risks* to unintended influence on psychotherapy with traumatized clients, but an *inevitable phenomenon*. In this dissertation I have found sufficient indication of this inevitability to justify further systematic research.

Research Methods

Potential sources of *a priori* countertransference may be factual, such as country of origin, religion, being a child of Holocaust survivors. But the two main studies in this dissertation, (Chapter 4; Chapters 6-11) have shown that the experience and interpretation of those facts, and the possible expression of *a priori* countertransference are specific to each therapist. The qualitative research methods I chose to explore this (Chapter 2) were highly conducive to eliciting not just fascinating information about the therapists' personal and family histories, but to evoking discussion, exploration and the emergence of new thought, emotions and recollection of seemingly forgotten events. The in-depth interviews have proved most appropriate for the exploration of multiple levels of the individual experience.

Qualitative research has occasionally come under criticism for not being sufficiently scientific and in fact, being "journalistic." The Dutch sociologist Goudsblom (1974) stated however, that to qualify as scientific, the study had to be precise, systematic, relevant, and have depth of scope. A quarter of a decade later, Seale (1999) acknowledged similarities with journalism but stated that the differences are "generally based in a commitment to greater depth of thought, more sustained periods of investigation and a more rigorously self-critical approach" (p. 15). I have done my utmost to meet these authors' requirements for scientific work by adherence to qualitative research methods (Baarda, De Goede, & Teunissen, 2001; Guba & Lincoln, 1994; Janesick, 1994; Maso & Smaling, 1998; Moustakas, 1990; Reinharz, 1992; 1997; Taylor & Bogdan, 1998), incorporating extant literature on various aspects of trauma and trauma therapy, and bringing to the process of analyzing the interviews my extensive experience as a psychotherapist specializing in work with traumatized clients (Chapter 2).

My interest in the 'person' behind the therapist is not restricted to collecting information such as country of birth, immigrant status, professional qualifications, specific characteristics of personality or years of prior experience as a mental health professional before specializing in this work, even though this information was part of the "raw" material. What I wanted to learn more about was what the influence of the therapist's personal and family history might be on his or her *a priori* countertransference (Chapter 6); how conditions of socio-political crisis and danger might affect therapists' *a priori* countertransference (Chapter 4 and 5); what might motivate a person to work with interpersonally traumatized clients, in this case, Holocaust survivors, the second generation and people who were sexually abused (Chapters 7 and 8); what it is like to be a trauma therapist, and how the work itself might impact the therapist's *a priori* countertransference (Chapter 9); what might be the impact of the socio-political context in which the therapist was raised and has chosen to live and build a career (Chapters 3, 10 and 11). I have

done this with the help of 14 therapists who have specialized in working with Holocaust survivors and the second generation, and/or people who have endured sexual abuse. And in order to get a better historical sense of attitudes to trauma in Israel, I have also surveyed the first, nearly forty years of publications of the Israel Journal of Psychiatry and Related Sciences for trauma related articles (Chapter 5). In addition to surprising findings about which traumas did or did not receive attention within a specific period, this study also provided a societal background to the interviews analyzed in Chapters 6-11.

The Interviews

The interviewed therapists for the second study (chapters 6-11), engaged in probing interviews with me (for the questionnaire see Appendix II) with extraordinary professionalism, candor and integrity. The interviewing process proved to be both similar and different from psychotherapy in challenging ways. The therapists were well aware that the interviews were an integral part of my research. Still, an atmosphere of trust and intent listening enabled them to narrate and explore deeply personal and professional experiences.

The format of the interviews shed some light on, for instance, the complexity of eliciting trauma-related material. Even though all the interviewed therapists specialized in trauma and knew of my general interest, they did not speak of their own traumatic histories unless specifically invited to do so further into the interview. My openness and willingness to hear about traumatic experiences, allowed for attuned listening and questioning that enabled the therapists to speak of, and even remember, traumatic experiences (Chapter 6). Thus, for instance, the therapists helped to uncover a significant dilemma, particularly for a trauma therapist, regarding what to acknowledge as traumatic (Chapter 8).

The interviews related as much as possible to the whole person within their temporal and cultural context, to their personal and family histories, and to the events and experiences that have formed them as people and as professionals. And, similar to the therapeutic setting, the therapists told their stories to me specifically, with all my sensitivities and blind spots. They may well have adjusted their stories accordingly (Leydesdorff, 2004). My awareness of my own *a priori* countertransference may have contributed to the depth and openness of the interviews. However, despite my best intentions, it may also have contributed to silences and topics being left unaddressed, as I will discuss a little further in this chapter. The fact that I also served as a research instrument allowed for a great measure of flexibility at each stage of the research, not just in the interviews themselves but in the actual structure of this dissertation (Chapter 2).

The therapists were generally very positive after reading their transcripts. One therapist, with whom I had occasional contact at professional venues,

expressed concern about privacy, which made me struggle even harder to find a balance between genuine representation and the effort to protect identity. But there were no systematic discussions with the interviewed therapists about the findings, not individually with me, nor as a group.

The research presented in this dissertation has uncovered a map of different sources of *a priori* countertransference, which, if unattended and unresolved, may manifest in the actual session. One source that has emerged as worthy of particular attention was the societal context.

Societal Context

One of the major findings of this research was the pervasiveness of the societal context, in this case Israel, in providing potential sources of *a priori* countertransference. Israel is the country in which I live and work and hence the most logical and natural place for me to carry out research. But in many ways, because of its complexity, it would be a place of choice as it also provides a kind of microcosm for many of the world's challenges. Therapists, regardless of place of residence, need to be aware of their *a priori* countertransference as they are likely to be confronted with some of these challenges through the traumatic histories of their clients.

Israel as Societal Context

Though thankfully, humanity has been spared a World War for the past six decades or so, throughout this time local wars have been raging on many continents. Among the horrors of war are traumatization and psychological scarring of civilians and soldiers. Israel is still in a state of existential insecurity and has endured wars and periods of particularly intense terrorism with frightening frequency and regularity (Chapter 5).

Wars often cause massive refugee problems--there are currently millions of refugees from The Democratic Republic of Congo, Chad, Somalia, Afghanistan, to mention but a few countries. The plight of the Palestinian refugees and their offspring, and Israel's share in the creation of this problem, is generally well known. The population in Israel too, is to a large extent made up of refugees and their offspring. When refugees immigrate or seek asylum, this poses serious challenges for them as well as for the absorbing countries--as is currently being experienced in Europe, for instance--that might provide sources of *a priori* countertransference to local therapists.

There is growing awareness of the horrendous physical and psychological consequences of torture and the need for particular sensitivity in the treatment of

torture survivors. In Israel, there are, unfortunately, victims of torture among the Holocaust survivors, among Israeli prisoners of war freed from captivity in Egypt and Syria and -- though this is not discussed openly -- possibly among immigrants from Latin America.

Traumatic loss and death are, of course, often very much part of the traumatic experiences that cause great suffering. Ongoing acts of terrorism and frequent wars have made traumatic death an integral part of life in Israel. There are additional aspects of life in Israel that provide sources for *a priori* counter-transference, such as tensions between the very religious and the secular sections of the population, and occasional tensions between the Sephardi and Ashkenazi Jews in Israel. Religious and inter-ethnic conflicts may be found in many societies and countries the world over.

This is the societal context within which the therapists interviewed for this dissertation, our clients and myself have been living and working. The trauma specializations I have chosen are, of course, not unique to Israel. Holocaust survivors and their children live in many countries, and sexual abuse is, tragically, rampant everywhere.

Therapists' Societal Involvement

In Israel, the link between personal stories and the development of the State and its society are particularly interwoven, as illustrated by the narratives of these therapists (Chapter 6 and 10). Two of the therapists were grandchildren of East European Jews who fled *pogroms* and were among those who laid the foundations for what was to become the State of Israel. Their parents fought in the war of Independence as did the fathers of two additional therapists, teenagers who had just survived the Holocaust. The family of another therapist uprooted itself in order to flee virulent anti-Semitism in North Africa, and arrived in Israel, then a socialist, secular society that was shockingly different from their expectations. I learned that the familial and personal link with Israel was very much alive for all the therapists (Chapters 4 and 6). And they all absorbed, or rebelled against, the different values, customs, philosophies, traditions, languages, prejudices from their families and countries of origin, which in turn, formed sources for *a priori* countertransference.

The analysis of the interviews uncovered the degree to which Israeli society, with its diverse populations, including immigrants--refugees and immigrants by choice--from a multitude of countries, and the ongoing state of conflict can give rise to unique sources of *a priori* countertransference. Every facet of both personal and professional life is closely intertwined within the social context. The different population groups have a history of complex relationships, such as between the *Ashkenazim* and *Sephardim*, religious versus secular; settlers

beyond the Green Line versus left wingers, to just give a few examples (Chapter 10). Therapists may do well to be aware of their *a priori* countertransference to members of any of these and other groups to which clients may belong.

Many of the interviewed therapists felt very socially involved and were active either politically or socially, volunteering mental health services or consulting legislators regarding the needs of victims of interpersonal trauma, for instance (Chapter 11). Every such interest or activity can shape *a priori* countertransference and hence needs to be monitored. The fact that, in Israel, therapist and client may affect each other's lives so dramatically by the way they vote, or whether or not they serve in the army and provide defense for the other, only increases the need for alertness.

Many of the therapists remained conflicted as to their identity as Jews, Israelis, Ashkenazi, Sephardi, and the implications of being a veteran or new immigrant Israeli. This became very clear when I asked about their attitudes to their passports (Chapter 10). The issue of the right "papers" and nationality was ever current in my own family of origin, as if the Holocaust had only paused, rather than ended. I was amazed to learn that for many of the therapists, the kind of passport they owned continued to be a matter of concern, or at least consideration, and many of them would like to have additional passports. Living in Israel has not yet created sufficient safety and security to make the lessons of so many centuries of persecution obsolete. Many of the therapists remain alert to developments of anti-Semitism in Europe and elsewhere. On the map of sources for *a priori* counter-transference, this question of belonging, identity and security as expressed in the feelings and attitudes evoked by the discussion about passports appeared to be a key juncture.

It is worth noting that in exploring identity issues of Israeli therapists, whole sections of the population remained outside the discussion. I noted the extreme paucity of references to minority population groups such as the Bedouin and the Druze. Although they serve in the army, they, like the Israeli Arabs who do not, often remain on the margins of Israeli society. All these population groups have their own traumatic histories and unmet needs. Leydesdorff 's (2004) experience as an oral historian taught her that in each narrative, the teller chooses what can and what cannot be said, a choice that is influenced by what narratives are currently acceptable in the sense that society, whether or not as a result of ideological struggles, is or is not yet ready to hear. One of the characteristics of trauma is the unmentionable, the unspoken, the invisible. I propose that therapists need to explore what is 'unspoken' in their own personal lives and in their social environment for possible implications for *a priori* countertransference.

Some reference to the societal setting has been inevitable in all chapters, regardless of the specific focus. The interviewed therapists have had to confront

being outside the professional consensus in their recognition of trauma and their desire to help their traumatized clients. They have done so within the confines of their clinical practice settings. Some risked their professional reputations in their efforts to change professional and societal consensus regarding Holocaust survivors and victims of sexual assault. Their individual reasons and motivation to do this may all point to sources of *a priori* countertransference.

Further Sources and Expressions of *A Priori* Countertransference

The first study, in which I interviewed six therapists who work with Holocaust survivors and the second generation (Chapter 4), explored the impact of the sudden outbreak of violence, the *Intifada*, on their work since they, at that time, shared a reality of existential danger with their Holocaust survivor clients. The larger study (Chapters 6-11), for which I did in-depth interviews with eight therapists who had specialized in work with Holocaust survivors and second generation and/or survivors of sexual abuse, had a much wider scope. Neither one of the studies focused specifically on the therapists' clinical work. Still, both studies yielded examples of expression of *a priori* countertransference. The smaller study demonstrated unequivocally the impact of societal events on *a priori* counter-transference whereas the larger study uncovered a whole road map of areas and sources that can give rise to *a priori* countertransference.

The Expression of A Priori Countertransference

As was seen in Chapter 4, external circumstances can have such a powerful impact that even experienced therapists may not necessarily be aware of their *a priori* countertransference, and therefore risk acting upon it. The interviewed therapists had become much less emotionally available to their clients due to their preoccupation with their own physical safety and changed circumstances; their listening ability was reduced and their political views colored their perceptions of their clients. At times, they even had difficulty being empathic to their survivor clients' anxiety. A particularly striking expression of *a priori* countertransference was the difference in their perception of second generation clients and colleagues. The therapists perceived their colleagues as extremely anxious and distressed by the *Matsav* (the situation, as the *Intifada* and the accompanying (threat of) violence were referred to) but not so their second generation clients. On the whole, they did not explore the possible impact of the Matsav in the therapy sessions with these clients. Whereas the second, larger study was more geared towards uncovering and exploring sources of *a priori* countertransference, the interviews also revealed

examples of the therapists' actual expression of *a priori* countertransference. One highly charged issue for most of the therapists was that of setting fees (Chapter 9). While the sources for their *a priori* countertransference could be traced to their family histories and the societal values in which they were raised, they expressed their *a priori* countertransference in their own ways. Another example was the determination of one of the therapists to literally, believe everything her sexually abused clients told her for fear of causing them further damage. This same therapist was able to adopt a more reflective attitude when listening to colleagues at supervision discussing their clients' narratives

Areas of exploration for Sources of *A Priori* Countertransference

Whereas personal, societal and professional aspects of therapists' experience are obviously intertwined, I did find it useful to explore major aspects separately, in 'close-up' as it were, in order to learn more specific details. These avenues of exploration, personal and family history (Chapter 6); motivation for, and experience of, being a trauma therapist (Chapters 7, 8 and 9); personal connection to society and the possible impact of societal attitudes to trauma (Chapters 10 and 11), proved very fruitful. In fact, this approach uncovered a kind of road map of sources, of places for further exploration of possible *a priori* countertransference.

Personal and Family Histories

Despite my years of clinical experience as a trauma therapist, I was still shocked to learn that these exceptional therapists, pioneers and leaders in their field, came from families that carried so much trauma, turmoil and tragedy, and that most of them had coped with so many traumatic experiences themselves. Still, none of the therapists had taken on an identity of trauma victim (Withuis, 2002), and, as mentioned earlier in this chapter, they did not readily speak of these trauma histories.

Furthermore, despite their (later) specialization as trauma therapists, they did not make a point of focusing on their trauma histories in their personal therapies. The possibility exists, therefore, that these therapists might have some conflicting attitudes towards acknowledging trauma and its impact. This, in turn, could give rise to trauma-related *a priori* countertransference.

The therapists varied in their emphasis on different aspects of their personal and family narratives, or even in choosing from which generation to start their story. Their narratives were not merely fascinating accounts of coping and

resilience that offered insight into both personal and societal processes. They truly presented a map of issues and areas that may serve as sources for *a priori* countertransference, as detailed in Chapter 6.

None of the interviewed therapists were surprised at the personal nature of many of the questions. They all more or less took for granted that their personal histories were somehow linked to their professional choices. It has been my assumption that these links might continue to impact their professional lives. I have tried to learn what some of the consequences of these links might be while looking to uncover sources of *a priori* countertransference.

Becoming and Being a Trauma Therapist

Analysis of the interviews revealed the extent to which therapists have been influenced by aspects of their personal histories; in their professional choice, their sensitivities to traumatized clients, in their attitudes to supervision or relationships with colleagues, to mention just a few instances. This has been described in detail in Chapters 7, 8 and 9, but perhaps one example is worth recalling here. Most psychotherapists and psychiatrists have encountered trauma survivors among their clients while not necessarily recognizing them as such. Even if they were aware of their clients' traumatic past, they might, as a result of their *a priori* countertransference, not have addressed these traumatic experiences directly. It was not too long ago that Holocaust survivors, or incest survivors, might have had therapy with genuinely caring, experienced psychotherapists who, perhaps as part of what I prefer to refer to as the "silence out of fear" culture, rather than conspiracy of silence (Chapter 3) would not acknowledge and address their clients' traumatic experiences. And, as some of the interviewed therapists told me, even when their own therapists were aware of their traumatic experiences, they did not necessarily offer appropriate treatment.

The interviewed therapists were, however, sensitive to their clients' traumatic experiences. It was most enlightening in view of their subsequent professional development, to hear their recollections of the first encounter with a traumatized client that they were aware of (Chapter 7). This encounter stimulated them to train and learn more in order to help that client and future clients like them. In fact, quite a few of the interviewed therapists were pioneers in their field in Israel and willing to risk finding themselves outside of the professional consensus at the time.

In my understanding, it is precisely because of the personal traits of the interviewed therapists and what they had experienced and absorbed, that they felt compelled to respond so differently from so many of their colleagues. In no way do I want to suggest that specific events or family constellations automatically lead a person to chose a career as a trauma therapist, nor that these will necessarily

manifest as *a priori* countertransference. What is crucial, however, is how individual therapists interpreted their (family) histories. This point, made before in this dissertation, bears repeating because the very manner in which therapists interpret their life events affects their personal and professional development. One of the therapists, for example, interpreted her experiences, first as a child refugee and later as an adolescent actively persecuted in the Holocaust, as having motivated her to study psychology with the goal of understanding and helping people. Her history might just as easily have caused her to despair of any ability to have an impact upon people or events and she may have thus chosen a life style focusing on safeguarding her personal existence.

It would be reasonable to assume, that those same experiences, values, opinions, personality styles that inform the therapists' interpretations, their individuality and subjectivity, also affect their expectations and perceptions of their clients; these may therefore serve as fertile ground for *a priori* countertransference. In Chapters 7, 8 and 9, a number of significant sources of *a priori* countertransference have come to light--such as the need to be effective, or attitudes to supervision--that may all point the way to issues and directions in which individual therapists might fruitfully explore and uncover their own *a priori* countertransference.

My Own *A Priori* Countertransference

For all my awareness of *a priori* countertransference, my motivation for doing this research, and my feelings and attitudes towards the interviewed therapists, which include a deep respect for all, I inadvertently expressed *a priori* countertransference, as indicated occasionally, in the text. One example arose in the interview with Hanna. I am always intrigued by people whose families have lived in one place for generations, perhaps because I am a daughter of Holocaust survivors who had first become refugees well before the outbreak of the Second World War, and a member of a nuclear family of four people, all of whom were born in different countries. Hanna's father was a child refugee from Europe, but her mother's family had been in Israel for several generations. Hanna's stories about that side of her family so enthralled me that I did not really notice at the time of the interview, how little she focused on her father's history. My personal fascination caused me to neglect exploring more thoroughly, the possible impact upon Hanna of being the child of refugees who had managed to escape before the outbreak of the Second World War.

At a rather late stage in the analysis of the interviews in this study, I also realized that my conflicted relationship with the Hebrew language had prevented

me from including the topic of language as a major area of exploration. Two therapists, one a new immigrant and the other, the child of immigrants, did raise issues of feeling typecast by society at large by the way they spoke and pronounced the language. However, I did not attempt to elicit further exploration from them or any of the other therapists.

Hebrew had been preserved as the language of the Jewish holy books and of prayer in the *Diaspora*, but was renewed as a secular language as part of Zionist ideology. Apart from the possible emotional associations with this language which might give rise to *a priori* countertransference, language is in itself a complicated facet of trauma work.

Training

My ultimate aim as a clinician and as a researcher is the well-being of clients. I wish for all therapists, myself included, to become more reliably able to truly listen and create a therapeutic setting in which clients feel safe to speak of their traumatic experience and subsequent suffering. One way I hope to have contributed to this is by conceptualizing the actual existence of *a priori* countertransference, and by outlining a 'roadmap' of areas in which to look for sources for *a priori* countertransference and some ways in which this can be expressed.

The next step would be to provide training to teach trauma therapists the concept and help them become aware of the sources and manifestations of their own *a priori* countertransference in their life and work. This is not to say that therapists who are not aware of their *a priori* countertransference can not do good work. The interviewed therapists expressed satisfaction with much of their experience as therapy clients, despite the fact that their therapists did not relate to their traumatic histories. I would advocate for raising optimal awareness, however, in order to further improve the quality of therapeutic work, which also implies sensitivity to trauma.

I would like to see training in awareness of sources and expressions of *a priori* countertransference including the whole range of traumatization, and techniques for self-monitoring become an integral part of clinical education and supervision. Danieli's (1994) training format regarding "event countertransference," the event being the Holocaust, could provide a possible starting point. My questionnaire and the analysis of the interviews can certainly serve as a further model for self-exploration and monitoring in order for therapists to be as aware as possible of potential obstacles they might bring to the therapeutic encounters with

their traumatized clients. The creation of training programs would be a natural follow-up to this dissertation.

An unexpected finding of the interviews, especially of the first series held at the start of the *Intifada* in 2000, was the therapists' response as to how personally and professionally helpful the interview had been. This might well point to the usefulness, or possibly even necessity, especially at times of societal crisis such as war, major acts of terrorism or natural disasters, to offer therapists a chance to explore their experience. Empathic listening might help therapists to become more aware of their personal responses and coping styles and explore how these might affect the ways they perceive and relate to clients with whom they share a traumatizing reality.

I would also hope that the concept of *a priori* countertransference, the approach I have taken in this dissertation and the wealth of knowledge and experience shared by the interviewed therapists will also encourage discussions with colleagues about values, self exploration, personal history and experience. *A priori* countertransference is not something that can be resolved and "done with." Rather, raising and maintaining awareness of *a priori* countertransference is an ongoing process and remains relevant even after decades of clinical practice. Similarly to going on a journey, the scenery is ever changing and even in familiar territory, there are always new places to discover, to explore further and deeper.

Suggestions for Further Research

The map of sources and expressions of *a priori* countertransference which I have presented here is not complete and can provide a basis for further study. Both qualitative and empirical studies could now be done to explore how *a priori* countertransference may manifest itself in different areas in clinical work. It might also be of interest to devise a study to investigate to what degree therapists' awareness actually makes a difference, clinically; whether therapists subsequently monitor their responses better and how this impacts their clinical work.

I have chosen to explore *a priori* countertransference of therapists who specialize in interpersonal traumatization, with clients traumatized by the Holocaust and/or by sexual abuse. Now that the phenomenon has been shown to exist, it might be of interest to study how it might manifest with different client populations. Furthermore, it might prove fruitful to explore how *a priori* countertransference arising from different sources might manifest in the therapeutic work.

It was beyond the scope of this dissertation to include a study on somatic responses as possible expressions of *a priori* countertransference but there remains

much to learn on this level of awareness. The first hint I had of the existence of *a priori* countertransference was in the form of the somatic responses I experienced when I joined a center specializing in work with Holocaust survivors before any clients had yet appeared. I have also found that encouraging participants in workshops in which I have taught awareness of *a priori* countertransference to monitor their somatic, in addition to emotional and cognitive responses to fictional referrals, often enabled them to uncover unexpectedly rich pathways to awareness of sources and expressions of *a priori* countertransference. These proved excellent starting points for further exploration of possible sources. A well-designed study of somatic *a priori* countertransference might, therefore, yield useful information and tools to increase awareness.

Regarding the societal context, analysis of the interviews has shown pervasive societal impact upon both sources and expression of *a priori* countertransference. I carried out the studies for this dissertation in Israel, a complex, multicultural, relatively young country that is still struggling to gain existential security. In order to further understand the range and quality of societal impact, studies should be carried out in different countries. Such studies might uncover just how clearly linked sources for *a priori* countertransference, including, of course, attitudes to traumatic experiences, might be to the socio-cultural context within which the therapist grew up and was trained professionally, as well as the context within which they do their actual clinical work.

In Summary

The work for this dissertation has been a hugely rewarding and at times emotionally painful journey for me. I had to immerse myself in the world of trauma more consistently and to greater depth than ever before in order to further raise my own awareness. I had to break through levels of denial necessary to cope with the tenuousness of daily life in Israel, and confront just how pervasively, for better and for worse, my personal and professional life too have been influenced, even shaped by this society. I have also had to learn about the limits of good intentions, and that positive beliefs and assumption of understanding can also, if not monitored, be expressed as *a priori* countertransference with counterproductive consequences.

It has been a privilege to work with the interviewed therapists. I am deeply impressed by the fact that the transcripts of the interviews have remained instructive, moving and inspiring throughout the lengthy process of analysis. One of the many things that stood out for me was that none of the interviewed therapists made use of techniques of professional distancing, by using diagnostic

language, for example, or even referring to PTSD. Instead, they remained open to the suffering and painful consequences of traumatization.

While there has hardly been any discussion in the interviews of actual clinical work, the process of psychotherapy with our traumatized clients, this dissertation is full of clinical application. I am not referring to applications in the sense of the currently much encouraged, mode two research-based protocols (e.g. Bisson & Andrew, 2007; Maxfield & Hyer, 2002; Seidler, & Wagner, 2006). I am however, referring to clinical applications in the vein of mode three research (Kunneman, 2006), of not just acknowledging the importance of the person of the therapist, but exchanging points of view, learning and understanding, of presenting a model for discussion and expansion of awareness; of raising awareness of the risk that, if unmonitored, therapists' prior held beliefs, attitudes, emotions and values may impede the therapeutic work with traumatized clients; a model of searching for ways to communicate appropriately, and sharing personal and professional narratives in a meaningful manner.

I hope to have demonstrated that *a priori* countertransference is a useful concept to describe attitudes, beliefs, values, prejudices of the therapist that are deeply rooted in personal and family history as well as in professional and personal societal context, and that it can impact upon every aspect of a therapist's professional life, including initial and ongoing motivation to work with trauma survivors. The thorough inquiry into the personal and familial backgrounds of the therapists interviewed for this study, their motivations for and experiences of professional work and their personal and professional societal contexts has, I believe, offered clear parameters within which to define sources for *a priori* countertransference

Hopefully, this dissertation has provided a broad base for discussion, exchange and exploration that can enhance awareness and clinical sensitivity of trauma therapists. In this way, it can contribute to a broadening of the definition of being a trauma therapist within the context of normative professionalization. It has been my aim to contribute to a model for professional conduct; to contribute not only to the quality of listening of individual therapists by raising awareness of *a priori* countertransference, but to encourage changes in attitude of the profession as a whole. Such a model would include a discussion about changes in perception of what is considered professional preparation and skill from the perspective of normative professionalization, incorporating values and learning through professional narratives and exchange of experiences (Van den Ende, 2007). This would hopefully lead to a professional code that includes mode three learning processes of the search for, and exploration of, sources of *a priori* countertransference in both personal biography and socio-cultural contexts, as well

as the reflection and dialogue leading to increased awareness, as integral to therapeutic work with traumatized clients,.

At the same time, it is up to the individual therapists to create his or her map of sources: We are all individuals with our own histories, backgrounds, frameworks, and idiosyncratic interpretations of our life events. Still, as the analysis of the interviews has shown, there are shared landmarks on the different maps, and further exploration always remains possible, and in fact, necessary. As in traveling, revisiting familiar sites can teach new perspectives and bring into sharp focus what was previously unnoticed. It is my hope that the concept of *a priori* countertransference will find resonance in the professional community and that increased awareness will contribute to the quality of psychotherapy with clients needing to heal from the devastating impact of trauma.

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Appendixes

APPENDIX I

The Interviewed Therapists (Chapters 6-11).

Holocaust Trauma.

Dora, in her seventies at the time of the interview, a child survivor of the Holocaust, was one of the first therapists in Israel who worked with Holocaust survivors and later with the second generation, with whom she specifically focused on Holocaust experiences and traumas. She was still seeing clients and doing supervision at the time of the interviews.

David, in his mid-forties, a grandchild of Eastern European Jews who fled *pogroms* to become pioneers in the land of Israel, is a psychiatrist whose field of interest is the aged. Over a decade ago, he set up a psychiatric hospital ward for Holocaust survivors. Some of the residents are indeed chronically ill; others simply have nowhere else to go in the community.

Sara, in her early thirties, an Israeli born child of North African immigrants, has been working as an art therapist with Holocaust survivors for a few years.

Holocaust Trauma and Sexual Abuse.

Ruth, in her early fifties, has worked for over three decades with survivors of sexual abuse, children of Holocaust survivors and their parents. In fact, she has gone out of her way to combine her specializations and raised awareness of the existence of childhood physical and sexual abuse in the lives of some second generation clients.

Sexual Abuse.

Joseph, in his early fifties, a child of Holocaust survivors, has been working with sexual abuse victims for over two decades and has achieved prominence in different aspects of trauma work.

Hanna, in her early fifties, is a grandchild of Eastern European Jews who fled *pogroms* and became pioneers in the land of Israel, and the daughter of a child refugee from the Nazi threat. She has worked with Holocaust survivors and the second generation for several years and for nearly two decades has been a well-respected specialist in therapy with sexually abused women.

Nell, in her mid-fifties, a veteran Anglo-Saxon immigrant, went through a lengthy process of clinical qualifications over a decade ago. She has since worked with Holocaust survivors and the second generation but has specialized in working with sexually abused clients.

Dana, in her late forties, daughter of Holocaust survivors, has only recently embarked on a career change to art therapy, and has been working with sexual abuse survivors for a few years.

APPENDIX II

Questionnaire that formed the basis for the interviews analyzed in Chapters 6-11

Following is a list of subjects that will be touched upon in all the interviews, though not necessarily in the order presented here. The questionnaire serves as a guide-line to elicit potential sources of *a priori* countertransference.

Name: _____
Place of residence & work: _____
Current family status: _____

BIOGRAPHICAL:
What kind of family background do you have? If the questions below are not answered, elicit the answers - immediately or after following leads in material volunteered.
- Are your parents alive/dead?
- When? How?
- Do you have any siblings?
- Sibling order? Ages? Alive? Dead?
- Are there significant members of the extended family? Alive? Dead?
- Were there any other significant people when you were growing up? Alive? Dead?

TRAUMA HISTORY:
If you look at your life-history so far, what descriptive words or adjectives, would you use to characterize it?
- Do you know of any trauma history of any family members? (Go back two generations).
- What are the formative, important events in your own history?
- If I were to ask you specifically about a trauma history of your own, what would you say?
- Single trauma? Multiple trauma?

[Warn interviewee before asking specific questions regarding personal traumatic experiences]

- Any traumatic experiences as a result of physical abuse? Assault?
- As adult? As child?
- Any trauma during war as soldier? Civilian?
- Any trauma as result of sexual abuse? As adult? As child?
- Any traumatic losses?
- Any traumatic experiences at any point in your life?
- What kind of trauma?
- What age(s)?
- Have you discussed this with others?
- How do/did you take care of yourself?
- How do/did your environment take care of you?
- Do you consider this an ongoing project?
- How do you live with your own trauma?

Do any of the questions thus far seem professionally relevant?

GENERAL PERSONAL & FAMILIAL MENTAL HEALTH:
Are/were there (other) psychiatric/clinical problems in the family? In the interviewee's own life?

- What was treated? What resolved? What is ongoing?
- What, if anything, was accepted as untreatable? Was this adjusted to?
- Did you have (a) male or female therapist(s)?
- Was that a conscious choice? Why?
- What kind of person would you choose if you were to return for some therapy?/ What kind of person did you chose when you returned for therapy?
- What qualities? What gender?

PEOPLE, GROUPS, COMMUNITIES OF BELONGING AND AFFILIATION:
What is your current family status? In committed relationship now/ever? If not, why?

- Are you a parent? If yes, why? If not, why?
- Ages of children?
- Is the parenting shared?

Do you consider yourself part of a larger group?

- Social; religious; national, etc.
- What are your attitudes towards the major groups in the last question – and towards your belonging to them?

[If not volunteered, explore relationships with friends and meaning of friendship]

Explore interest and engagement in social and political issues.
- Explore rigidity of norms;
- Sense of clear right/wrong;
- Religious truths as pertinent to others;
- Cultural superiority, etc.

PROFESSIONAL:
- What is your academic background?
- What were your prior career goals? Since when?
- Why do you think you became a therapist?
- At what age did you become a therapist?
- What is your clinical style and preference? i.e. dynamic humanistic, etc .
- Why?
- Do you remember your first encounter with serious traumatization in a client's history?
- Do you remember your personal responses?
- And the responses of colleagues? Of your supervisor?

WORK WITH INCEST AND OTHER SEXUAL ABUSE SURVIVORS/ HOLOCAUST SURVIVORS AND SECOND GENERATION:
- When did you start working more intensively with traumatized clients? Why?
- What percentage of your workload is taken up by traumatized clients?
- Is this your choice?
- What issues/difficulties, if any, does this raise?
- What kinds of traumatization do you mainly encounter?

[It's important to first elicit (attitudes to) general trauma]
- Since when have you been working with Shoah/incest?
- What drew you to that then?
- Did you train specifically to work with these traumas?
- With trauma in general?
- What training did you have?
- Who initiated the training? Why?
- Are you receiving any (ongoing) support for this work?
- From whom? What is that like for you?
- (Check for absence of support and how that's experienced)

CLIENTS:
How are your clients referred to you?
- Are there clients you refer out? Why?
- And at what point?

Elicit feelings towards other traumas than worked with - i.e. what might seem too hard, not interesting, etc. also very important if anyone mentions multiple trauma - i.e. incest survivor who was in exploding bus, survivor who was raped, etc.

- roughly how many of your clients are male? How many female?
- How do you feel about these percentages?
- Are any client's issues seen as not worth dealing with?
- Therapeutic style? Focus on attitude, motivation, rather than discipline per se.

SOCIAL IMPLICATIONS OF BEING SHOAH/INCEST THERAPIST:
When asked, at social occasions, what it is that you do, how do you answer?

- Say you're a therapist? Why & when?
- A trauma therapists? Why & when?
- Specifically what kind of trauma therapist? Why & when?

Have you ever experienced any interpersonal difficulties as a result of your trauma work?

- With colleagues at the same place of work?
- With colleagues at professional meetings?
- With colleagues who are friends?
- With friends who are not colleagues?
- With your spouse /significant other?
- With other people?
- How would you characterize/describe the difficulties with each of these categories?

PERSONAL IMPLICATIONS AND EXPERIENCES AS SHOA/SEXUAL ABUSE THERAPIST:

- Do you have any personal difficulties in connection with work?
- Elicit signs of burn-out, etc.
- If yes, check for current stressors, difficulties in personal life and/or Matsav
- Do you feel satisfaction in your work? How does this manifest itself?
- How do you feel when other therapists ask you what you do?
- Is your trauma work ever a source of pride and personal satisfaction?

In your professional life now, who, if anyone, makes your life easier?

- How? How do you understand this? (also check gender)
- Did this use to be different?
- Might you be perceived by other colleagues in such a role, i.e. supportive, mentor like, etc.? Why?

- In your professional life now, who, if anyone, makes your life hard? (explore along similar lines).
- Are there any conditions, in your professional life, that makes your trauma work easier? Or that make it harder?

CONNECTING LIFE STORY (INFLUENCES) WITH CAREER CHOICE:
If you look back into your personal history - father/mother, brothers/sisters, uncles/aunts, teachers, friends, etc., who would you say might have most influenced your professional choices?
- Why do you think that? How do you explain this?
- Is there anyone else (instead) who influenced your professional choices?
- Is there a specific event (instead) that influenced your professional choice?

CURRENT EXPERIENCE AS SHOAH/SEXUAL ABUSE THERAPIST:
- What makes you continue now as a trauma therapist?
- And specifically as Shoah/sexual abuse therapist?
- Do you have thoughts about changing specialization?
- What has it been like during this War (*Matsav*)?

IS THERE ANYTHING YOU WOULD LIKE TO ADD, OR THAT YOU WOULD LIKE ME TO HAVE ASKED YOU (MORE) ABOUT?

SAMENVATTING

Summary in Dutch

TRAUMATHERAPEUTEN IN ISRAEL:

Een kwalitatieve studie naar persoonlijke, familie- en maatschappelijke achtergronden die van invloed zijn op *a priori* tegenoverdracht

Vraagstelling

In de laatste honderd jaar valt er een golfbeweging te constateren in het bewustzijn van geestelijke volksgezondheidsdeskundigen ten aanzien van interpersoonlijke traumatisering en in onderkenning van de mogelijke gevolgen hiervan. De eerste beschrijving van de posttraumatische stress-stoornis (PTSD) in het diagnostisch handboek van de American Psychiatric Association (DSM-III) in 1980 heeft een erkenning betekend voor het lijden van slachtoffers van incest, verkrachting, huiselijk geweld, oorlog of genocide, maar dit maakte therapeuten niet automatisch tot begripvolle luisteraars. Tegenoverdracht tijdens traumatherapie is bijzonder complex en kan het luisteren van de therapeut negatief beïnvloeden.

Er zijn altijd therapeuten geweest die het hun patienten mogelijk gemaakt hebben over hun traumatische ervaringen te spreken, en die ook werkelijk naar hen hebben kunnen luisteren. Dit was ook het geval in tijden waarin een professionele consensus ontbrak voor erkenning van het bestaan en van de gevolgen van traumatiserende gebeurtenissen. De holocaust en seksueel misbruik in het gezin kunnen als voorbeelden dienen van traumatiserende gebeurtenissen die niet altijd als zodanig erkend werden, ook niet in professionele kringen. Dit proefschrift tracht de vraag te beantwoorden welke persoonlijke, professionele en maatschappelijke factoren therapeuten kunnen beïnvloeden in het kunnen en willen behandelen van getraumatiseerde mensen.

Mijn onderzoek richt zich op de opvattingen, houdingen, emoties en waarden, die therapeuten al *voor* hun eerste ontmoeting met de individuele cliënten koesteren, en die een adequate indruk van de getraumatiseerde cliënt kunnen bevorderen dan wel in de weg staan. Deze persoonlijke en beroepsmatige bagage van de therapeuten heb ik *a priori* tegenoverdracht genoemd.

Gezien de toenemende bewustwording van de invloed van de therapeut als persoon op de therapie (e.g. Garfield, 1997; Lambert & Barley, 2002; Norcross, 2002a; Pearlman & Saakvitne, 1995), stelde ik mij als taak te onderzoeken of ik mogelijke oorzaken en voorbeelden van *a priori* tegenoverdracht aan het licht kon brengen. Door middel van vraaggesprekken met in traumawerk gespecialiseerde therapeuten onderzocht ik of en hoe hun persoonlijke, familiale, sociaal-culturele en professionele achtergrond van invloed waren op hun motivatie en hoe ze hun werk ervoeren.

In deze dissertatie worden twee kwalitatieve studies en een survey beschreven. In het eerste onderzoek gaat het om de ervaringen van therapeuten die gespecialiseerd zijn in het werken met holocaust-overlevenden en hun kinderen tijdens de eerste maanden van de El Aqsa Intifada in 2000, een periode van acuut persoonlijk (levens)gevaar. Het tweede onderzoek betreft een diepgaande exploratie van de persoonlijke en professionele levensverhalen van therapeuten die zowel holocaust-overlevenden en hun kinderen behandelen als slachtoffers van seksueel misbruik. In de derde studie, bekeek ik alle aan trauma-gerelateerde artikelen in het Engelstalige *Israel Journal of Psychiatry and Related Sciences* (IJP) tussen 1963-2002 op thema, strekking en tijdstip van verschijnen, om een beeld te krijgen van de verschuivingen in aandacht voor trauma.

De sociale context voor deze dissertatie was Israël; zowel de geinterviewde therapeuten als ik wonen en werken in dit land. Israël heeft een korte, maar bewogen geschiedenis; het heeft een multiculturele bevolking, grotendeels bestaand uit emigranten en vluchtelingen. Zij ondervonden vaak grote problemen met het inburgeringsproces. Bovendien liepen zij (en hun kinderen en kleinkinderen) veelvuldig gevaar in oorlogs- en geweldtraumata betrokken te raken. Deze complexe realiteit bleek in de studies van grote invloed te zijn op het onstaan van *a priori* tegenoverdracht. Het is goed mogelijk dat traumatherapeuten in andere landen en culturen ook geconfronteerd worden met verschillende aspecten van deze problematiek.

A Priori Tegenoverdracht

In de literatuur over tegenoverdracht in het algemeen en over tegenoverdracht tijdens de behandelingssituatie van interpersoonlijke traumatisering in het bijzonder, wordt enige aandacht besteed aan stereotype opvattingen, zoals racistische vooroordelen en seksistische ideeën. Er bestond tot dusver echter geen algemeen concept voor de opvattingen, emoties en houdingen van de therapeut die geen verband houden met de geeigende reakties die de cliënt tijdens een therapie-sessie bij de therapeut opwekt, maar die reeds – mogelijk onbewust – bij de therapeut aanwezig zijn voor de aanvang van de sessie.

Ik heb het concept *a priori* tegenoverdracht voor het eerst beschreven en bestudeerd bij behandelaars van oorlogsvervolgden die zelf holocaust-overlevenden waren of tot de tweede generatie van vervolgden behoorden (Tauber, 1998). In mijn dissertatie heb ik dit veld aanzienlijk verruimd door therapeuten te interviewen die verschillende achtergronden hebben en met een verscheidenheid van getraumatiseerde populaties werken. Door onderzoek van hun persoonlijke en hun familie-geschiedenis, hun maatschappelijke en professionele referentiekaders, en de

socio-culturele context, heb ik gezocht naar mogelijke oorzaken voor en uitingen van *a priori* tegenoverdracht.

De Hoofdstukken

In Hoofdstuk 1 beschrijf ik de doelstellingen van mijn onderzoek. Het concept van *a priori* tegenoverdracht en zijn toepassingsmogelijkheden worden belicht door een bespreking van de literatuur op het gebied van tegenoverdracht, in het bijzonder waar deze in verband staat met trauma en het wisselend maatschappelijk bewustzijn ten aanzien van trauma en de gevolgen ervan. Aandacht wordt gegeven aan het belang van Israel als de sociale setting. Tevens wordt gewezen op de verhoopte bijdrage van deze studie, de interesse in en verbreiding van normatieve professionalisatie (Van den Ende, 2007) in het geestelijke gezondheidswerk met slachtoffers van interpersoonlijk trauma.

In hoofdstuk 2 beargumenteer ik de keuze voor een kwalitatieve onderzoeksmethode vanuit het perspectief van modus drie onderzoek (Kunneman, 2006). Daarnaast heb ik gebruik gemaakt van de bestaande literatuur over aspekten van trauma en traumatherapie en van mijn jarenlange ervaring als klinisch psychologe gespecialiseerd in traumatherapie.

Hoofdstukken 3 en 4 zijn gebaseerd op twee eerder gepubliceerde artikelen (Tauber 2002a; 2003). Hoofdstuk 3 behandelt een historisch overzicht van het geleidelijk erkennen van het lijden van holocaust overlevenden door de samenleving in zijn geheel en door geestelijke gezondheidswerkers in het bijzonder. Tevens wordt in dit hoofdstuk de relevantie en het nut van het concept "*conspiracy of silence*", de stilte rond de holocaust, de traumatische gevolgen ervan en het lijden van de overlevenden, kritisch onderzocht vanuit het perspektief van *a priori* tegenoverdracht.

Het onderzoek beschreven in hoofdstuk 4 bestudeert de invloed van het onberekenbaar uitbreken van vrijwel dagelijks geweld en terrorisme over een periode van maanden op de manifestatie van *a priori* tegenoverdracht. De zes interviews geanalyseerd in dit hoofdstuk belichten hoe de stress van in direct levensgevaar verkerende behandelaars het vermogen naar cliënten te luisteren beinvloedde en tot een onbewust uiten van *a priori* tegenoverdracht leidde.

Hoofdstuk 5, gebaseerd op een gepubliceerd artikel (Tauber, Brinkgreve, Brom & Van der Hart, 2004) had als doel de houding ten opzichte van trauma te onderzoeken binnen de professionele gemeenschap in Israël en van niet-Israëlische auteurs die ook in de *Israel Journal of Psychiatry and Related Sciences* publiceren. Een analyse van artikelen, gepubliceerd tussen 1963-2002, die blijkens hun titel trauma als onderwerp hadden, toont een duidelijk verband tussen de houding tegenover

trauma in deze artikelen en de ten tijde van de publicatie heersende maatschappelijke houding ten aanzien van trauma. Zo kwam het onderwerp van traumatisering van soldaten ten gevolge van hun oorlogservaringen pas echt ter sprake in de periode na de Libanon Oorlog (1982). Ook was het opvallend dat er gedurende bijna veertig jaar, geen artikelen werden gepubliceerd over seksueel geweld en de gevolgen daarvan. Dit hoofdstuk geeft ook een socio-historisch referentiekader aan hoofdstukken 6-11.

In de hoofdstukken 6-11 wordt getracht mogelijke oorzaken van *a priori* tegenoverdracht aan het licht te brengen. Deze hoofdstukken zijn gebaseerd op een diepteanalyse van interviews met acht Israëlische therapeuten gespecialiseerd in het werken met holocaust-overlevenden en/of slachtoffers van seksueel misbruik. De interviews toonden aan dat op verschillende levensterreinen het zich bewust zijn van een *a priori* tegenoverdracht van wezenlijk belang kan zijn voor een optimaal verloop van het therapieproces. Verder onderzoek op dit punt is dan ook aan de orde, en zal een bijdrage kunnen leveren in het begrijpen en hanteren van *a priori* tegenoverdracht in de therapeutische setting.

In hoofdstuk 6 worden de eigen levensverhalen en familiegeschiedenis van de geinterviewde therapeuten geanalyseerd. Door deze analyse kwam veel belangrijk en vaak ook schokkend materiaal naar voren. Het biografische materiaal in dit hoofdstuk vormt de basis voor de volgende hoofdstukken en toont zo aan hoe het de persoonlijke achtergrond van de traumatherapeut een integraal onderdeel vormt van het professionele arsenaal. In hoofdstukken 7 en 8 wordt duidelijk dat de beroepskeuze en de motivatie om traumatherapeut te worden te maken hebben met de wijze waarop de geinterviewde therapeuten hun autobiografische, hun familiegeschiedenis, en hun sociale milieu beleven en interpreteren. Hun achtergrond, hun opvattingen aangaande trauma, hun beroepskeuze, en de manier waarop zij traumatherapeut geworden zijn, bleken belangrijke faktoren voor een *a priori* tegenoverdracht.

In hoofdstuk 9 werd onderzocht hoe de geïnterviewden het beroep van traumatherapeut ervaren. Door het ter sprake brengen van specifieke onderwerpen die van belang zijn in traumatherapie, zoals hun houding tegenover methodiek, het stellen van grenzen in de therapie, de invloed van het beroep op de leefkwaliteit kwamen eveneens belangrijke gronden voor *a priori* overdracht aan het licht. In de interviews bleek de belevingswereld van de traumatherapeut veel aandacht te vergen en een tot nog toe onderbelicht aspect te zijn van traumatherapie. De gespreksanalyses toonden dan ook een duidelijk verband aan tussen het persoonlijke en professionele leven van de therapeuten. Daardoor werd het mogelijk specifieke terreinen af te bakenen, zoals de houding jegens trauma en traumatherapeuten in kliniek of centrum waar de therapeut werkzaam is, de focus van de professionele belangstelling, bijvoorbeeld de behandeling van de gevolgen

van seksueel misbruik of geriatrische psychiatrie met holocaust-overlevenden, en het omgaan met de betaling voor therapie, die *a priori* tegenoverdracht kunnen beïnvloeden.

Hoewel in alle hoofdstukken de persoonlijke ervaringen en de ervarings-aspecten op grond van sociaal milieu naar voren komen, werd in de hoofdstukken 10 en 11 de klemtoon specifiek op aspekten van sociaal milieu gelegd. In hoofdstuk 10 werd het onderzoeken van een mogelijke invloed van het sociale milieu op de *a priori* tegenoverdracht besproken. Het feit dat zowel de geïnterviewde therapeuten als de onderzoekster in Israël wonen, bood een unieke gelegenheid te onderzoeken in hoeverre de intensiteit van het leven in Israël tot uitdrukking kan komen in een *a priori* tegenoverdracht. Inderdaad bleek het mogelijk aan te tonen dat bedreiging ten gevolge van terroristenaanvallen en oorlogen, het dienen in het leger, en de veelvuldige sociaal-culturele verschuivingen door een voortdurende toevloed van immigranten – vaak met traumatische voorgeschiedenis – *a priori* tegenoverdracht beïnvloeden.

In hoofdstuk 11 werden de reacties van de geïnterviewde therapeuten geanalyseerd op mentaliteitsveranderingen in de maatschappij en in het professionele denken rondom het begrip trauma--erkenning van traumatische gebeurtenissen en hun gevolgen--alsmede hun eigen inbreng in deze veranderingen. Hier werd belicht hoe de snelle veranderingen en ontwikkelingen in de traumatologie als vakgebied, en tegelijkertijd in het milieu waarin het wordt uitgeoefend, een voortdurende waakzaamheid van therapeuten vereist ten aanzien van hun eigen reacties op die veranderingen en de manier waarop hun *a priori* tegenoverdracht daarvoor beïnvloed kan worden.

Hoofdstuk 12 geeft een samenvatting en discussie van de studies in deze dissertatie. Hier worden de oorzaken voor *a priori* tegenoverdracht zoals zij ter sprake zijn gekomen in deze dissertatie duidelijk in kaart gebracht. Vervolgens worden aanbevelingen gedaan voor training van traumatherapeuten, met het doel het bewustzijn, bij zowel individuele therapeuten als bij de professie als geheel, ten aanzien van *a priori* tegenoverdracht te versterken. Tevens worden aanbevelingen voor verder onderzoek besproken.

Tot Slot

Deze dissertatie heeft als doel verschillende bijdragen te leveren aan het gebied van traumatherapie. Ten eerste vult het concept van *a priori* tegenoverdracht een leemte in de literatuur. Ten tweede wordt door dit concept het inzicht verdiept in de complexiteit van de diade van therapeut en cliënt in traumatherapie. Het analyseren van de interviews heeft aangetoond dat *a priori* tegenoverdracht

plaatsvindt zonder dat de therapeut zich daar noodzakelijkerwijze van bewust is. Uit dit onderzoek blijkt verder dat *a priori* tegenoverdracht niet alleen voortkomt uit de interpretatie van de persoonlijke en familiegeschiedenis van de traumatherapeut maar ook in belangrijke mate wordt beïnvloed door zowel professionele als algemeen maatschappelijke opvattingen.

De onderzoeksaanpak en methoden in deze dissertatie, het verwerven van kennis via de levensgeschiedenissen, persoonlijk en professionele ervaringen van traumatherapeuten, en het onderzoeken van waarden, conflicten en inzichten komen overeen met de criteria voor modus drie onderzoek (Kunneman, 2006). Het is te wensen dat het in kaart brengen van de in deze dissertatie beschreven faktoren die een *a priori* tegenoverdracht kunnen veroorzaken, de basis zal vormen voor een gerichte training van traumatherapeuten, voor bevordering van normatieve professionalisering, en voor verder onderzoek.

Curriculum Vitae

ne Tauber

Yvonne Tauber was born on 6th January, 1950, in Amsterdam. Upon graduating from the Maimonides Lyceum in 1967, she emigrated to Israel in 1967. She spent her first year there at the Hebrew University of Jerusalem in a one-year program organized by WUJS (World Union of Jewish Students). She then completed her BA in English Literature and earned postgraduate certification as a High School English teacher, both at the Hebrew University. She taught in Jerusalem and then left for England for 3 years. In London, she taught English as a foreign language and took many theoretical and experiential courses in humanistic and analytical psychology. She subsequently returned to Jerusalem for a further 6 years, during which time she taught English at a high school. She loved her work but was more interested in her students' personal development than their skills in English. Hence she moved to San Francisco to study Psychology.

In the 4 years she lived there, she completed her MA in Clinical Psychology at Antioch University, graduated from the San Francisco Gestalt Institute and, upon completing internships with a variety of populations, worked for over a year at a residential crisis house which served as an alternative to hospitalization for acutely psychotic patients. Just before she could sit for her licensing exams and start her PhD in San Francisco, her stay was cut short due to illness in the family.

Back in Jerusalem, she worked as a school counselor while completing requirements for licensing in Israel as a clinical psychologist. In 1987, she joined AMCHA (The National Israel Center for Psychosocial Support of Holocaust Survivors and their Offspring) as it was being established. She has remained there as a senior staff member doing both group- and individual therapy. Whereas she had become aware of the impact of interpersonal traumatization--especially sexual and physical abuse—while doing her clinical work in San Francisco, joining AMCHA signified her specialization in trauma work, particularly with Holocaust survivors and children of survivors. To this end, she trained in various approaches to working with traumatized clients and became a facilitator and supervisor in EMDR. In 2000, she joined the newly established Israel Center for the Treatment of Psychotrauma where she continues to treat clients, many of whom are survivors of terrorist attacks. She also sees clients in her private practice.

Since the early 1990's, she has (co-) presented at professional conferences organized by the International Society for Studies on Traumatic Stress (ISTSS) (Washington, New Orleans, Baltimore, Jerusalem, Melbourne), the European Society for Studies on Traumatic Stress (ESTSS) (Paris and Maastricht), the International Society for the Study of Trauma and Dissociation (ISSTD, until recently ISSD) (Baltimore and New Orleans), the World Federation of Jewish

Child Holocaust Survivors (Houston) and the World Conference of Jewish Community Service (Jerusalem). She has also given workshops in Israel and abroad. Articles she has (co)authored on different aspects of trauma and trauma therapy have appeared predominantly in English language professional journals, though some also appeared in Hebrew language journals. Her book, *In the other chair*, was published in 1998.