alex - 4 28/07/2016 18:35 Page 80

CHAPTER
FIVE

Countertransference in the Treatment of Siblings of Fallen Israel Defense Forces (IDF) Soldiers

Major (Res.) Moshe Z. Abramowitz,
Col. (Res.) Haim Y. Knobler,
Lt. Col. (Res.) Yoram Ben Yehuda and
Dov R. Aleksandrowicz

Psychotherapy of bereaved family members of fallen Israeli soldiers involves complex countertransferential issues, and countertransference in the treatment of bereaved siblings of fallen soldiers is a unique example.

Since 1948, the bereaved parents and spouses of the fallen soldiers have been at the center of public attention. While they are called the "families of bereavement", the term "family" included, in fact only, some of the family, the parents, and where relevant, spouses. Consequently, the soldiers' bereaved brothers and sisters were overlooked, and were often told that their responsibility was mainly to take care of their parents – the "real" bereaving in the families of bereavement.

Over the last decades, the importance of treating the bereaved siblings was revealed, and multi-faceted countertransference issued in these treatments, which should be explored. These countertransferences may be divided into three major areas: Socially-derived countertransference, which is based on the therapists' values and opinions; Siblings-derived countertransference, based on the therapists' inner representations of their own siblings; and parents/others-derived countertransference, which may include, the therapists' attitude to the way in which the patients relate to their bereaved parents.

alex - 4 28/07/2016 18:35 Page 81

All types of countertransference may be beneficial for the therapeutic alliance, but may cause over-protection or a negative attitude towards the patients.

Another interesting topic is the part the bereaved parents take in their children's' treatment; when bereaved parents take an active role in helped their distressed children, this may be crucial to the treatment's success.

Different cases representing such types of countertransference will be presented, and the importance of understanding countertransference for the success of the treatments will be discussed.

Background: Israeli society and the concept of the "family of the bereaved"

Since Israel's War of Independence in 1948 – which took place only three years after the end of the Holocaust – the families of Israel's fallen soldiers have "have been assigned the special status of "families of the bereaved". Israel considers itself morally bound to care for such families, an imperative first articulated by David Ben-Gurion, the founding prime minister of Israel, who stated that "the welfare of IDF [Israel Defense Forces] casualties is an inseparable part of national security" (Department of Family and Commemoration publication).

More than 6,000 Israelis were killed in the 1948 war, most of them soldiers, and the first Israeli Independence Day in 1949 was also marked as a day of commemoration for the fallen. Two years later, Israel instated a separate national Memorial Day to honor the fallen, taking place annually on the day before Independence Day. The term "family of the bereaved" was coined during this period. Since that time, Israeli society has handled the families of the IDF's fallen soldiers differently than the families of civilians whose lives were tragically cut short (such as road accident fatalities), and in the young Israeli state, it was a belief taken for granted that these "families of the bereaved" deserved preferential treatment.

Until recently, the Israeli term "family of the bereaved" excluded the siblings of the fallen, and focused almost exclusively on the parents and spouses of the deceased. Thus, siblings had to bear a double injury: the loss of a brother or sister, and the fact that they were excluded from the special treatment given to grief-stricken families. Furthermore, siblings were told to be "strong" for their parents' sake. These types of attitudes created the belief that only the parents' grief was in fact true grief.

alex - 4 28/07/2016 18:35 Page 82

Over the past decade, and perhaps because of the therapy that the siblings of the fallen have undergone, Israelis' attitudes towards sibling grief have changed. In 2007, a group of bereaved siblings established an association called "Forever My Brother" ("La'nezach Achi"), to raise awareness in Israel society and among Israeli authorities regarding the existence and the plight of bereaved siblings of fallen soldiers, and to encourage action on their behalf. While the foundation does not provide counseling to its members, it encourages them to seek therapy and support, and refers grieving siblings to therapists who specialize in caring for bereaved families.

Psychotherapy of Israel's "families of the bereaved" – and bereaved siblings in particular – has given rise to unique questions involving countertransference. Examples of treatment issues that must be identified and addressed include guilt felt by therapists over the lack of recognition of sibling grief in Israeli society; and coping with the anger felt by siblings towards their parents, particularly in situations in which the therapist identifies with the bereaved parents. In some cases, the therapist must deal with a bereaved sibling who falls into a special category, such as those who are also children of Holocaust survivors, or siblings of IDF soldiers who committed suicide or did not die on the battlefield, for example, soldiers who died in training accidents, roadside fatalities (while active members of the IDF or during reserve duty), and even soldiers who died of illness, sudden or otherwise.

In what follows, we first present a clinical vignette that demonstrates the complex dynamics within the family of a fallen soldier. Next, we engage in a more detailed discussion of transference and countertransference issues that arise during psychotherapy of bereaved siblings. All names in this chapter have been changed to preserve anonymity.

Case vignette[1]

Rachel S., a twelve-year-old girl, was referred to psychiatric consultation after being admitted to the hospital because of an attempted suicide. A few hours before that, she had swallowed several tablets of a tranquilizer, used by her mother because of "nervousness". The girl was only mildly somnolent on admission, but the pediatricians realized that she had seriously intended to kill herself and requested a consultation.

Rachel, a bright, vivacious, well-developed girl, was sullen and diffident during the initial interview, but it was possible to establish a modicum of cooperation. She admitted being very angry at her mother,

alex - 4 28/07/2016 18:35 Page 83

though she preferred to complain of minor grudges, such as interfering with plans for a Bat-Mitzvah party, and was vague and evasive about the family's deeply disturbed situation.

Rachel was the youngest of four children. Her father, an uneducated, but intelligent and energetic man, was a self-made prosperous businessman, and her mother was a housewife. Jonathan, the eldest son, had always been his mother's favorite; a friendly boy, liked by his peers, a good student and a considerate son and brother, Jonathan was particularly fond of his youngest sister, Rachel, whom he used to read stories to and play with. The mother was always very anxious about Jonathan and reluctant to separate from him. When he was drafted, she begged him not to volunteer for any of the commando units; he gave in to his mother's pressure and was sent to a non-commissioned officers' (N.C.O.) training course. When the Yom Kippur War broke out in 1973, his unit was sent to an assignment on the front lines, and he was killed in action.

Rachel's mother, Ms. S., in her own words, "stopped living" when Jonathan was killed. She became indifferent to the rest of the family, refused to meet friends or relatives, and, for a while, was in psychiatric treatment after trying to commit suicide by an overdose of medication. She stopped treatment after several months, no longer suicidal, but resigned herself to merely waiting for death and for the reunion with her son. To her family's reproaches about neglect she would reply angrily: "What do you want? I cook and keep the house, our needs are provided for. Leave me alone!" She imposed a strict regime of mourning; since Jonathan (the fallen son) had loved music, no music was allowed in the house. Family members could watch television, but only with the sound turned off. Since Mr. S. refused to give up news bulletins, Ms. S. would retire to her room at that time; otherwise she made no concessions to the family.

After many futile attempts to involve Ms. S. in family life again, each member of the family coped with the loss in his or her own way. The second son essentially left home, coming to the house only to sleep and to eat. The other daughter, four years older than Rachel, spent most of her time with friends, began dating, and assumed an indifferent, defiant attitude. Mr. S. tried to hold the family together and took care of Rachel as much as his busy schedule allowed, but otherwise permitted his wife to impose her way of mourning on the family.

Rachel was a model child during the first years of mourning and appeared to show no signs of being affected by the devastating loss of her idolized brother. In the year preceding her suicide attempt, however, she had become more willful and demanding, confrontational towards her siblings, and defiant to her parents. The attempted

alex - 4 28/07/2016 18:35 Page 84

suicide followed a disappointment at school and a quarrel with her mother.

Following the initial evaluation, the psychiatrist conducted a series of family meetings with Rachel and both parents, intended as a crisis intervention. The topic that dominated these meetings was the depth of Ms. S.'s grief and her profound estrangement from the rest of the family. It appeared as if she had been carrying the pain of the entire family on her shoulders. The other family members' expressions of grief were muted, as if silenced by the mother's implied exclusiveness of suffering. The meeting revealed hints that the rest of the family felt resentment towards Ms. S.; beyond their open criticism of her emotional estrangement, it seemed they felt she belittled the others' right to suffer and to grieve the loss.

During the course of the sessions, it became apparent that Rachel's attempted suicide served several purposes:

- A conscious attempt to punish the parents, especially the mother, for ignoring her needs, and an unconscious attack on the introjected "bad object";
- A conscious wish to rejoin her beloved brother (Rachel revealed that she had been reading articles about parapsychology and reincarnation);
- A preconscious wish to regain the love of her mother by competing with her brother: "Since Mother loves the dead let me be dead, too".

In the last interview, we discussed the parents' disagreement about how to treat the girl. It became apparent that Ms. S. was overwhelmed by guilt and fear of Rachel's possible suicide to the extent that the girl now had the mother firmly under her control. Although she resented the mother's clinging and nagging, Rachel cherished her new power and used it to put an end to some of the mother's impositions: the TV was allowed now, as well as visits by friends.

From the beginning, Ms. S. was a reluctant participant in the family sessions; her resistance increased when we discussed her grief and when Rachel and her father expressed their feelings of being rejected and neglected. The therapist tried to help her to express affection towards the husband and surviving children, but that seemed to increase her hostility. The family left for a vacation (another concession to Rachel), and they later sent a message that "everything was alright" and no further treatment was needed.

The therapist discussed the case extensively with his supervisor. In retrospect, it appeared that the change that had taken place was more

a result of the girl's suicidal attempt than of psychotherapeutic intervention. The main issue the therapist expressed was his failure to engage Ms. S. in the process beyond her formal cooperation. The therapist seemed not to have realized that his intention to help Ms. S. to "terminate" her "interminable mourning" was perceived by the mother as an attempt to deprive her of her last, desperate hold onto the beloved object. The supervisor also pointed out that the therapist's empathy was "asymmetrical"; he identified with the child's feelings of rejection deeply, but the empathy he felt towards the mother's catastrophic loss seemed more in the nature of understanding rather than intuitive identification. The therapist was initially skeptical about that interpretation, but later realized that it was correct and had to do with some of his own life-experience, which made him ambivalent about the "idealization of the fallen", particularly prominent in Israeli society.

Understanding the role of the "family of the bereaved"

The characteristic bereavement of the parents of fallen soldiers has been described in several studies. Simon S. Rubin, for example, compared parents who had lost young children to parents who had lost sons to war (Rubin, 1990). Although all parents demonstrated pronounced mourning, parents of fallen soldiers were particularly affected by the loss in the initial year, and as much as ten years after the loss.

Israel's special treatment of bereaved families in the first few years after the birth of the nation may have been driven, in part, by the difficulty of Israeli society to confront the overwhelming trauma of the Holocaust and its aftermath, which was then still raw and prominent. It might be supposed that the grief and guilt over the Jewish victims of the Nazis in Europe was displaced to the fallen soldiers; the extreme nature of this act of displacement is reflected in the fact that the *civilian* casualties of the War of Independence (estimated at up to 20 percent of the total fallen) to this day are not formally commemorated by the state.

Over the years, many brothers and sisters of fallen IDF soldiers felt excluded. Often, they were required to take on a special role in the grief-stricken family, such as the one who can be depended on, or the scapegoat. Grief and mourning were mostly reserved for the parents or spouse. Indeed, the name given to the organization commemorating the fallen soldiers was "Yad La'banim" or "Memorial for Our Sons", underlining the parents' loss, not the loss of the family as a whole. Until recently, the siblings of fallen soldiers received special consider-

alex - 4 28/07/2016 18:35 Page 86

ation only in specific contexts; for example, assignment of a bereaved sibling to a combat unit was contingent upon his or her parents' written consent, resulting in tensions and lasting resentment on both sides. Much later, special loans, student loans, and grants began to be offered to siblings of fallen soldiers. In the 1950s the Ministry of Defense set up the Department of Rehabilitation to act on behalf of bereaved families' welfare, and to provide them with professional and readily-available services (in 2005 the Ministry established the Department of Families and Commemoration, which took over these duties)[5]. However, only many years later were siblings formally recognized as part of the families' tragic situation. Nowadays, siblings are eligible for individual psychotherapy sessions, with a treatment period of up to three years. However, most of the siblings receive (and seek) treatment at public or private clinics, not through the assistance of the Department of Families and Commemoration. Similarly, in recent years Israeli authorities have become increasingly aware of the need to treat siblings of victims of terror attacks; these victims are also commemorated during Memorial Day, albeit in separate ceremonies from those commemorating fallen soldiers, and their families are considered "families of the bereaved" (Moss & Raz, 2001).

Transference and countertransference

The psychotherapy of the brothers and sisters of fallen soldiers raises special issues of transference and countertransference. The countertransference process is unique in Israel, where many of the siblings of the fallen are also the children of Holocaust survivors (as are many of the therapists themselves; see *Chapter 5: Countertransference in the Treatment of Holocaust Survivors by a Second Generation Therapist* for a detailed discussion). We now want to focus on the countertransference processes in the treatment of the siblings, with special attention given to the psychotherapy of siblings who have served in the military. (In Israel, all Jewish, Druze and Circassian citizens are required to serve in the military, unless they meet specific criteria for exemption.) The added mental/psychological burden these siblings bear, while forging their own paths in the army, warrants a discussion on the dynamics of the therapy. It is important to note that the countertransference we describe does not negate other, more common aspects of therapist-patient dynamics shared by many different groups.

As members of Israeli society, Israeli psychotherapists tend to view bereaved parents as those who maintain the memory or heritage of the IDF's fallen soldiers for the rest of the population, and as such, they

alex - 4 28/07/2016 18:35 Page 87

treat these parents with respect, gratitude and compassion, and sometimes, with awe.

Siblings of the fallen may take on the collective role of being part of the "family of the bereaved", or may see their parents as needing their protection and support. However, we have also experienced another type of reaction, of anger towards the parents who have focused all their attention on the fallen brother or sister while they, the siblings who remain, feel discounted (Aleksandrowicz, 1980). In any event, all of these types of emotions are likely to play out in therapy. Accordingly, the patient may exhibit displaced anger towards the therapist instead of aiming at the grieving parents, who have not licensed anyone else to mourn the family loss. A "remaining survivor" sibling may even exhibit rivalry with a therapist's other patients, reenacting a similar dynamic towards the deceased sibling that predates the tragic loss.

Similarly, countertransference can manifest in various ways. In particular, the therapist may feel resentment that the patient is overprotective of his or her parents, despite the fact that the parents are oblivious to the patient's own needs. Moreover, the therapist may feel the need to protect the patient, to try to fill the emotional void caused by the parents' distraction with their own pain. Indeed, the therapist may find it very difficult to treat the surviving soldier-sibling, a "lost-child" who has no one looking out for him or her. This can lead to a fantasy on the part of the therapist, who sees himself as a replacement for the natural parent as a nurturing and caring surrogate concerned with the survival of the living sibling.

In other cases, when the patient is angry at his/her parents, the therapist might identify with a parent, feeling uncomfortable that the treatment does not acknowledge the legitimacy of the parents' own genuine grief.

Case I – The therapist as the patriarch Jacob

Guy, 22, was a second son, two years younger than his older brother, Roni, who was killed in action, leaving Guy an only child. Barely a year after the tragic loss, Guy asked his parents for their written consent to enable him to volunteer for an elite paratroopers' unit. His parents, observant Jews, who were still reciting *Kaddish* (the traditional prayer for the dead) for their beloved Roni, were asked to do the unthinkable – to play an active role in putting their surviving son in harm's way.

For the first two years of his conscription, Guy did everything in his power to stay alive and healthy. He was terrified of the thought

alex - 4 28/07/2016 18:35 Page 88

that if anything happened to him, his parents would be devastated. These thoughts led him to freeze up even under combat conditions. Taking into consideration every contingency, he would plan the least dangerous path and go through a personal protocol to prevent injury from the enemy (i.e., terrorists) as well as from friendly fire. He avoided hitchhiking, which was very common among soldiers, never slept on bus rides, and was always on the alert for "something bad" just waiting to strike him. Towards the end of his tour, he found himself in the midst of an ambush, bullets whistling around him, paralyzed between his fear of getting in harm's way and his sense of duty to his comrades and to his mission. Finally, after what seemed to him like an eternity, with a sudden burst of energy, he attacked the enemy with a frontal charge and overcame the assault.

Guy came for treatment half a year later after completing his military service. He came to the treatment frustrated, wanting to trek in the Far East, to experience what the world had to offer, to live dangerously, but still feeling that he could not afford to be that reckless. The psychotherapy was extensive and not easy for the therapist.

The therapist came to realize that what Guy was asking of him, the therapist, was permission to live – which was tantamount to granting him a license to die. Guy's transference was evident; he displaced his anger from his parents towards the therapist, and wanted the therapist to "set him free", something his parents were incapable of doing. Conversely, the therapist had to resolve an unconscious wish to take on the parents' role as Guy's protector, and his anxiety at Guy's wish "to have it all, and experience it all". In encouraging Guy to live his own life, the therapist, in the countertransference, felt like a parent who was sending his son to his death in battle.

At times the therapist felt like the biblical Jacob, bidden by his son Judah to set free, at his peril, the youngest surviving son (Benjamin) of his mother, Rachel. Guy's Orthodox parents, similar to the vanquished patriarch Jacob, relinquished their hold on their remaining boy against their own better judgment. The therapist too felt an overwhelming burden and responsibility of an almost biblical nature. Only when cognizant of this burden could the therapist approach the therapy with less guilt, and less of a need to contain the patient's conflict between compliance and self-realization.

At the end of the therapy, Guy felt more capable of understanding his feelings towards his injured parents, balancing his need for personal growth and individuality against his fantasy to protect his parents from his own death. No less important, Guy also realized that he would require additional therapy to confront his own grief over his brother's death.

alex - 4 28/07/2016 18:35 Page 89

Countertransference related to the dead

As members of Israeli society, therapists often regard fallen soldiers as heroes, objects of admiration and respect. However, siblings of these soldiers may regard them in a somewhat different manner, feeling that the fallen have been over-idealized, and their faults forgotten, and that those who remain are required to suppress any negative memories of those who have been tragically lost. Siblings may experience anger towards the deceased for not staying alive, and for suddenly abandoning them. Idealizing feelings are evident as part of the transference phenomena in therapy. Less evident are the negative feelings, where identification of countertransference processes may be an instrument for improvement.

Case II – The therapist as the frustrated parent

Dina was only 12 when her brother was killed in battle. She and her family lived on a kibbutz where everyone was encouraged to serve in the IDF. Much attention was paid to the communal bereavement of the fallen brother, but there was no acknowledgement of the surviving sister's emotional needs.

Dina continued her studies at school and in the children's group in the kibbutz without any true mourning period. She later refused any psychological help, did not want to be comforted, and tried to be an excellent student, as was her deceased brother. To her surprise, even though she did get the highest grades in her class, this did not make her parents happy. Despite every effort, she felt that there was nothing she could do to compete with her brother's memory, and felt her parents were impatient towards her and her attempts to gain their favor. Regardless of how hard she strived, it appeared, to Dina, that her parents continued to prefer her dead brother. Dina herself was never satisfied by her own achievements, and at the age of 42, having accomplished academic successes, she came to therapy feeling empty and with a sense of failure. These feelings were in contrast to Dina's conscious recognition of her success in building a family and landing a prestigious job.

During the therapy, Dina felt the therapist less and less empathetic towards her fear of failure. He had little patience for Dina's preoccupation and comparisons with her dead brother. The therapist related that, at times, he found himself exasperated with Dina and her inability to enjoy her successes. Understanding this exasperation led the therapist to the realization that he, similarly to Dina's parents, was not giving enough attention to Dina's positive achievements.

alex - 4 28/07/2016 18:35 Page 90

Only when the therapist connected this transferential and counter-transferential process to Dina's relationship with her parents, and to her deeply-rooted feelings that her parents did not "see" her, was Dina able to begin talking about her brother and the consequences of his tragic death for the family. Dina slowly realized her mixed feelings towards her brother and parents and was able to feel the repressed anger at her brother for winning their parents' love even after his death.

Countertransference connected to the exclusion of the bereaved sibling from the bereavement process

The therapist often finds him or herself identifying with a patient's feeling of resentment. Many times, this countertransferential attitude towards the family underlies a sense of resentment that the patient/sibling has not been included in the "family of the bereaved." As stated previously, this special status has, in the past, been applied nearly exclusively to the parents and spouses of fallen soldiers.

Case III – The therapist at a dead end

Yossi was 13 years old when his older brother was killed in combat. Six years later, while serving as a young soldier, Yossi was admitted to a psychiatric hospital in an acute state of anxiety and depression. His parents stressed to the therapist that their extended family did not have any psychiatric problems, and that they hoped Yossi would recover soon and return to his army duties. The parents emphasized that they did not connect their loss – the death of Yossi's brother in battle – with the hospitalization, and appeared most worried about the possibility that Yossi would not be able to continue his military service and would be discharged.

During the first three weeks of his therapy (as part of his hospitalization), Yossi was reluctant to talk about his brother, and became annoyed whenever asked about his loss. The therapist felt a similarity between his own frustration dealing with Yossi's parents, in their insistence not to go into the topic of the tragedy, and Yossi's own unwillingness to talk about his feelings.

The therapist felt as if he was "walking into a wall"; with every turn he would take, the same obstacle stood in his path. The therapist was able to use this insight to be more empathetic to Yossi's predicament and his sense of being "walled-in" by his family's defensive posture. Moreover, this understanding enabled the therapist to explore, together

alex - 4 28/07/2016 18:35 Page 91

with Yossi, his (Yossi's) fear of touching his own pain and his fear of causing the family to collapse once the grief was finally communicated.

After his acute state resolved, Yossi was determined to return to his home-front army unit, where he felt most comfortable. He became more verbal, and talked about the grieving process that he, his parents, and his sister had begun to work through six years earlier. During supervision, the therapist revealed his countertransferential attitude towards Yossi's family, and his sense of resentment that the family had not extended their "family of the bereaved" status to include their son Yossi.

Countertransference in the treatment of siblings of soldiers who committed suicide

The rate of suicide during service in the IDF has decreased significantly during the last decade, due to improvements in diagnosis, treatment, and commanders' awareness, as well as specific restrictions such as reducing access to firearms when indicated (Lubin *et al.*, 2010). Yet, because all soldiers are screened extensively for psychopathology prior to conscription, suicide during military service comes most often unexpectedly and without any prior indication, only intensifying the trauma for the families (Apter *et al.*, 1993).

Guilt feelings of the bereaved family are predictably prevalent in these situations, characterized by statements such as – "How could I have missed the signs?" "Could I have given more support?" – and they sometimes manifest as displaced anger towards the dead soldiers' commanders. Some families sue the IDF in court, in an attempt to find someone to be held responsible, and "to pay for their child's death".

Therapy of the siblings in such cases may be complicated by their anger towards the army, towards the dead sibling, or towards their parents. In addition, the therapist often finds him or herself in the position of "doing" or acting on behalf of the patient. This is especially true in cases of mental health professionals working within the framework of the Ministry of Defense or the IDF. Similar situations of identification with the families (and even anger against the military establishment) were observed among mental health professionals during the Vietnam War (Camp, 1993).

Case IV – The therapist as the mirror of angry feelings

Avi's brother committed suicide while serving in a unit on Israel's northern border. His suicide came as a traumatic surprise to his family,

alex - 4 28/07/2016 18:35 Page 92

as there were no signs or "red flags" before the suicide. Avi, 17, and his family were treated by the Department of Families and Commemoration, a division of the Ministry of Defense. The program included family therapy for about two years.

When Avi was called up for his military service, he asked to serve in his late brother's unit. The family therapist who was treating the family believed this to be a positive development, and supported Avi's wish. He even helped Avi be assigned to the exact post in which his brother had served. Shortly after beginning his service, Avi began to experience various symptoms; he could not sleep and became anxious, and disputed or procrastinated when given orders. He was then moved to a different post in the same unit, where, following a severe run-in with a staff sergeant, he was sent for a psychological evaluation.

Avi told the evaluating mental health officer that he had lost his temper repeatedly since arriving at the post, something that was uncharacteristic of him. During his therapy sessions, he talked about his parents' persistent attempts to gain access to the army's commission of inquiry's report regarding his brother's death.

The mental health officer, a clinical psychologist, found himself identifying with Avi. He became increasingly outraged at the army's decision to send Avi to his dead brother's unit, even though Avi had requested this assignment with the support of the family therapist.

After the therapist shared his thoughts with Avi, Avi began to realize the level of anger he felt towards his brother's unit for not having done their best to prevent the suicide.

As a result of the therapy sessions, the therapist and patient both came to the conclusion that Avi should be transferred to a different unit in a different part of the country, and continue therapy. Avi was transferred eventually, continued therapy for a few months, and finished his military duty successfully. In supervision, it was suggested that the countertransference was helpful in identifying the negative feelings Avi harbored against the army despite his previous expressed desire to serve in the same unit as his brother. Being able to talk directly and openly about the circumstances surrounding his brother's death enabled the patient to express his feelings of helplessness, insecurity and anger.

Discussion

The transference-countertransference dynamics faced by Israeli therapists who treat siblings of soldiers who were killed in military action (or as a result of their military service) are closely related to the

alex - 4 28/07/2016 18:35 Page 93

bereavement and traumatic loss that are so common in a state like Israel. In Israel, experiences of bereavement and traumatic loss are commonly shaped by several influences, including religion, the ethos of the Israeli state, and the struggle to reestablish the Jewish people in its homeland (Witztum *et al.*, 2001).

Part of the attitude of Israeli society towards the "family of the bereaved", which now includes bereaved siblings, may have begun as a displacement of the attitude towards the much larger group of Holocaust survivors. Three years after the Holocaust, and following the death of 6,000,000 Jews, the grief expressed over the 6,000 soldiers killed during the Israeli Independence War became as pronounced in the young Israeli state as the grief for the Holocaust victims. We now know that despite the overwhelming grief and trauma caused by the Holocaust, its survivors were not regarded as individuals who needed special treatment. Israeli society's attitude towards the "family of the bereaved" may have started as displaced guilt regarding their treatment of the much larger group of Holocaust survivors, alongside displaced grief for the victims, which was projected onto fallen soldiers and their families, who serve as the keepers of their fallen children's memory (Knobler *et al.*, 2015). Recently, many initiatives have begun encouraging young college students to visit the graves of the Holocaust survivor casualties of the 1948 war, those who came to the country directly from the horrors of Europe and died as soldiers for the young state, but who had no one to grieve for them. This and similar social phenomena demonstrate the intensity of the sense of loss and perhaps the collective guilt felt towards the survivors who tragically met their deaths only a short time after coming to the newborn state. In fact, at the time of the birth of the state, these survivors were not even regarded as post-traumatic individuals.

Conclusion

In Israel, where the notion of the "family of the bereaved" is a powerful force in society, the psychotherapy of bereaved siblings of soldiers who have fallen in battle – or who died under other circumstances – has given rise to unique questions involving countertransference. We have addressed some examples of those questions herein. In some cases, the therapist's countertransference reflects underlying guilt caused by Israel's failure to sufficiently recognize sibling grief. Alternatively, the therapist may identify with the bereaved parents, or with the anger the sibling feels towards his or her parents.

alex - 4 28/07/2016 18:35 Page 94

Given recent – albeit subtle – changes in Israeli attitudes towards the siblings of fallen soldiers, it is important to bear in mind that the perception that sibling grief is undervalued may lead to an exaggerated assumption that all siblings are routinely neglected by Israeli society (and by their grieving parents). Needless to say, not all of the mental difficulty experienced by the siblings of the fallen is connected to their bereavement, nor are all of the parents' problems related to their bereavement.

Additionally, in some situations, the therapist must also deal with special sub-groups of siblings, such as those who are also children of Holocaust-survivors, or siblings of IDF soldiers who committed suicide, or those who did not meet their death on the battlefield (road accidents, misdiagnosed medical deaths, etc.) or whose deaths resulted from "friendly fire" (in the latter case, whereas in the past the military did not reveal the exact circumstances of a soldier's death in these cases, now it is impossible to avoid this issue, particularly in the therapy room).

In light of the violent conflict that continues in the region, the dynamics and consequences of therapy for bereaved families – including the siblings of fallen soldiers as full members of these families, deserving of the same compassion and treatment – warrant further investigation.

Note

1 This case was adapted from Aleksandrowicz, D. R. (1978). Interminable mourning as a family process. *Israel Annals of Psychiatry & Related Disciplines*, Vol. 16(2), Jun 1978, 161–169, by kind permission of the Israeli Psychiatric Association.

References

Aleksandrowicz, D. R. (1978). Interminable mourning as a family process. *Israel Annals of Psychiatry & Related Disciplines*, 16(2), 161–169.

Aleksandrowicz, D. R. (1980). Family split as a result of mourning. *Interaction*, 3(2), 85–91.

Apter A., Bleich, A., King, R. A., Kron, S., Fluch, A., Kotler, M., Cohen, D. J. (1993). Death without warning? A clinical postmortem study of suicide in 43 Israeli adolescent males. *Archives of General Psychiatry*, Feb.; 50(2), 138–42.

Camp, N. (1993). The Vietnam War and the ethics of combat psychiatry. *The American Journal of Psychiatry,* Vol. 150 (7), 1000–1010.

Israel Ministry of Defense, Department of Family and Commemoration publication, https://www.mishpahot-hantzaha.mod.gov.il.

Knobler, H. Y., Haber, L., Brutin, B., Zemishlany, Z. (2015). Myth and reality: on "future generations" of the Holocaust. In N. Davidovitch & D. Soen

alex - 4 28/07/2016 18:35 Page 95

(Eds.) *Shoa and Experience – A Journey in Time*. Boston, MA: Academic Studies Press.

Lubin, G., Werbeloff, N., Halperin, D., Shmushkevitch, M., Weiser, M., Knobler, H. Y. (2010). Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: A naturalistic epidemiological study. *Suicide and Life-Threatening Behavior*, 40, 421–424.

Moss, E., & Raz, A. (2001). The ones left behind: A siblings' bereavement group. *Group Analysis,* 34, 395–407.

Rubin, S. (1990). Death of the future? An outcome study of bereaved parents in Israel. *Journal of Death and Dying*, 20, 323–339.

Witztum, E., Malkinson, R., Rubin, S. (2001). Death, bereavement and traumatic loss in Israel: A historical and cultural perspective. *Israel Journal of Psychiatry and Related Sciences*, 38, 157–170.