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Inventing a Pathology of Catastrophe for Holocaust Survival

MICHAEL DORLAND

BRANDEIS UNIVERSITY PRESS
Waltham, Massachusetts

Published by
UNIVERSITY PRESS OF NEW ENGLAND
Hanover and London

BRANDEIS UNIVERSITY PRESS
Published by University Press of New England
One Court Street, Lebanon NH 03766
www.upne.com

Library of Congress Cataloging-in-Publication Data
Dorland, Michael.
Cadaverland: inventing a pathology of catastrophe for Holocaust survival: the limits of medical knowledge and memory in France / Michael Dorland.
p. cm. — (The Tauber Institute for the Study of European Jewry series)
Includes bibliographical references and index.
ISBN 978-1-58465-784-2 (cloth: alk. paper)
1. Holocaust, Jewish (1939–1945) — Influence. 2. Holocaust, Jewish (1939–1945) — Psychological aspects. 3. Holocaust survivors — Mental health — France. 4. Prisoners of war — Mental health — France. 5. Imprisonment — Psychological aspects. 6. Prisoners of war — France — Rehabilitation. 7. Pathology — Philosophy. 8. Medicine — Philosophy. 9. Psychiatry — Philosophy. I. Title.
RC451.4.P7D67 2009
616.85′21200944 — dc22 2009016548

THIS BOOK WAS PUBLISHED WITH THE GENEROUS SUPPORT OF THE LUCIUS N. LITTAUER FOUNDATION, INC.

University Press of New England is a member of the Green Press Initiative. The paper used in this book meets their minimum requirement for recycled paper.

Pour la famille,
les vivants et les morts

. . . il n'y a plus de morts, il n'y a que du cadavre.
Ce n'est même plus le règne de la mort, c'est le règne
du cadavre . . .

EUGÈNE MINKOWSKI, 1948

Skeleton, skeleton, where are you going? What are
you doing? You walk unsteadily, limping, ridiculous,
swaying from one leg to the other, bending to compensate
for the action of your vanished muscles, trying with each
step to keep your balance, arms extended before you,
seeking something to lean on, your head wobbling,
your penis dangling.

FRANÇOIS WETTERWALD, *Les Morts inutiles*, 1946

Nicht erle Wormer soll mein Lieb ernarhen
Die reine Flamme — die soll ihn verzehren
Ich liebte stets die Worme und das Licht
Darum verbrennet und begrabt mich nicht
[So that the worms not eat my body,
The purifying flame will help consume it,
Its light preserves me forever from the worms,
Because, cremated, they can grab me not]

Painted sign-board above the Buchenwald crematorium

CONTENTS

This is the part where the writer of a book thanks the many people and organizations in various countries who assisted with access to the research materials that provide the core information for a work of nonfiction. And these invariably convey a picture of the friendly folk and helpful institutions who do smooth the writer's way. Such a picture is both accurate and not. It is true that this work is not possible without the assistance of many — granting institutions that provide the funding to make travel possible and help absorb many of the related costs involved; archivists and librarians who point you in the right direction, give permission to look at restricted materials, help find you books and such that you can't seem to find otherwise; and others I'll mention shortly.

The other aspects involved are seldom mentioned in "acknowledgments," especially the time that it takes to figure out what you are doing and exactly looking for. This is a long and lonely affair, since you don't quite know beforehand, and that takes the time it takes. For instance, people think that for those of us who like to spend time in archives, reading old files, documents or books, "the stuff" we're looking for is just sitting there waiting to be found. It doesn't work like that. Rather, it's a lot more like detective work or a police stake-out, in which not much happens for a long time, and then suddenly you find a clue — it could be a phrase, a way something is written; or a factual detail. And then, for a moment, you get a sense that *that's* what you are looking for. After which you are back where you were before, waiting for "it" again.

Granting agencies that give you the money to do this sort of thing seemingly have little apparent grasp that this is how research "works" — serendipitously, more than one would think. They expect you to know in great detail what you are doing, years before you really do. You can't blame them for this; they are taking a gamble — and with the taxpayers' money, always wisely spent, as everybody knows, to quote a song. The result is that they make little effort to grasp what you are trying to do, which may be too much to expect from overworked, bureaucratic committees anyway. And yet this imaginative effort is *exactly* what the Humanities Program of the Canadian Institutes of Health Research did do, in granting me the major portion of the research funding that I was able to obtain for this book. I am very deeply

grateful to the CIHR and only too pleased to be able to publicly acknowledge their assistance, as well as a unique research support program that *does* take risks and, moreover, is keen to do so.

Other institutional support that I benefited from for this book came from my university, Carleton University, particularly from the Faculty of Graduate Studies and Research in the form of several small GR-6 grants that, as of 2000, allowed me to begin research trips to New York City to the YIVO Institute for Jewish Research housed in the Center for Jewish History, as well as to the archives of the American Joint Distribution Committee in Long Island City; to the Wellcome Institute for the Study of Medicine in the Euston Road in London; to the National Archives and Records Administration in College Park, Maryland; and also to the International Institute for Social History in Amsterdam, a less well-known but extremely worthwhile archive.

My thanks to the various people involved: Professor John Pammett, Associate Dean of the Faculty of Public Affairs, for fine, sensible advice on writing grants; head archivist Marek Webb at YIVO for permission to consult William G. Niederland's *Artzliche Wiedergutmachung*; archivist Misha Mitsel at the AJDC, and various others, including my colleagues in administrative positions in our department for much signing of applications, writing of letters of support, and heroic lobbying efforts to obtain for me a research grant from my Faculty of Public Affairs: Professors Chris Dornan, Paul Attallah, and Karim H. Karim. Thanks, guys, it's nasty work, but it is greatly appreciated, even if often pointless under the circumstances.

Special thanks to the cadre of mentors and friends who over the years wrote endless letters of support in other attempts to obtain research funding: Linda Hutcheon, University Professor, University of Toronto; Arthur Kroker, Canada Research Chair in Technology & Culture, University of Victoria; Ian Angus, FRSC, Professor of Sociology & Anthropology, Simon Fraser University; Robert Hariman, Professor of Rhetoric, at Northwestern University; Professor Maurice Charland, former Chair of Communication Studies and today Director of the College of the Humanities, Concordia University; and Professor William Straw of the Department of Communication Studies & Art History, McGill University. Many of you I've known as former teachers, co-authors, and as friends and colleagues for decades, and your unflagging belief in my work was a source of great moral support, and so utterly different from the gratuitous slings and arrows fired off by various "peer-reviewers" who lurk beneath the rocks of anonymity.

A sabbatical year in Paris in 2002–2003 furthered widened the circle of friendship: after a lengthy correspondance, finally meeting Maria-Letizia Cravetto, who recently had finished a stint as Professor of Annihilation at the Collège de Philosophie and is the author of one of the best books on Primo Levi (*Fidèlité à l'après*, Editions Kimé, 2000). Letizia opened many doors into the arcana of Parisian psychoanalytic milieux, and especially introduced me to Anne-Lise Stern whom I had been trying to contact for some time. Anne-Lise Stern, despite a phobia for tape-recorders, spent many hours both as a teacher and as a friend talking to me about Lacan and life. Professor Paule Steiner happily shared with me her profound knowledge of Parisian psychoanalytic history and people, as well as the inner workings of Parisian Jewish intellectual networks.

Members of my family were in many other ways central to the long process of research. My aunt, historian Professor Suzanne Citron (née Grumbach) and still a dynamo of energy at eighty-seven, deserves special mention. Arrested in the summer of 1944 for distributing tracts, she was sent to Drancy, and despite patently fake identity papers, was spared the last convoy to Auschwitz. Whether this oversight was an act of stupidity or of kindness by the SS officer in charge, she did witness her cousins boarding that convoy, never to return. Also, her work over the past thirty years on French national history and how to demythologize it has been a strong influence on my thinking. My two favorite cousins, Professor Antoine Grumbach and Maître François Citron, have been involved in this for decades, in endless discussions of French Jewish identity and what it is, as well as exchanging many books and ideas going back to the early 1970s. It was François who at the time introduced me to Pierre Legendre's extraordinary *L'Amour du censeur: Essai sur l'ordre dogmatique* (1974) and Antoine who found in his mother's library from just after the war Gilbert-Dreyfus' books on Mauthausen and Dachau.

My oldest friend, filmmaker Tom Perlmutter, with whom the topic of the Holocaust has been painfully shared for over four decades, the subject of agonizing discussions, readings, many long walks, and an unforgettable trip together to Judenrein Mitteleuropa, was also able to give the manuscript his close attention. You have no idea how much this meant to me, Tom.

Other Parisians who contributed importantly to the research process include Catherine Lavielle, Director of the Bibliothèque Henri Ey at Sainte-Anne psychiatric hospital, who moved mountains to obtain contacts and

to find rare articles and medical dissertations essential to the work here; researcher Olivier Gallois, who out of sheer kindness put together for me a bibliography of little-known articles in French journals, in case I had missed something; the various heads of psychiatric services at Sainte-Anne who did their best to shed light on the continuing mystery of vanished patient files of the post-deportation period; Dr. Michel Gourévitch, who reassured me that I did seem to know what I was doing; Dr. Jean Biéder, who shared time and articles with me on French psychiatric history; Dr. Henri Borlant for explaining the process by which, after returning from the camps at age sixteen, he later became deeply involved in the work of Holocaust remembrance; Jean-Claude Kuperminc, head archivist of the Alliance Israëlite Universelle, as well as other archivists at the Société psychanalytique de Paris, the CJDC, the BDIC, and the Archives de France, for special permission to look at closed files and other unpublished materials; Dr. Jean-Marc Berthomé, whose superb 1997 dissertation now is getting the circulation it richly deserves; and Holocaust memoirist Nadine Vasseur, with whom outstanding lunch-dates are still on the agenda.

Special thanks to my colleagues at Carleton University's Max and Tessie Zelikovitz Center for Jewish History and Culture. Professor Aviva Freeman and Assistant Professor James Casteel made it possible on several occasions to talk in public about this book. Thanks too to fellow Zelikovitzers Elizabeth Bannerman and Professor Jean-Jacques van Vlasselaer for their support.

My departmental colleagues, Professor Charlene Elliott and Professor Ira Wagman, generously took on the task of reading the manuscript and making helpful comments and suggestions. Professor Emeritus G. Stuart Adam's enthusiasm for the project has meant a great deal to me. A very special thank you to Dr. Sarah Schladow of Curtin University of Technology for her awesome close reading of the manuscript, far and above the call of collegiality. Thanks to Professor David Buchbinder, also at Curtin, for alerting me to Sarah's outstanding 2007 dissertation on Jewish identity. My very dear friend and Carleton colleague, Professor Paul Attallah, although gravely ill, was able to bring his laser-like mind to bear upon the manuscript. Sadly, Paul died of liver cancer at fifty-four on 9 January 2009.

My research assistant, PhD in Communication candidate Leif Schumacher, was a joy to work with these past years, for his initiative, resourcefulness, and even for dragging his mother into translating from German difficult war-psychiatric texts. Christine Taylor at Carleton's MacOdrum

Library also deserves a warm thank you for her super work in finding often obscure inter-library loan books and articles, and for her knowledge of journal databases in medicine and psychiatry.

At Brandeis University Press/University Press of New England, Editor-in-Chief Dr. Phyllis Deutsch also "got" what this book is about. My deepest thanks to her for her support, and to the reviewers of the manuscript for the highest praise an author can ask for, as well as useful suggestions for clarifying the manuscript. Special thanks, too, to a crack production team, and to Barbara Briggs for subsidiary rights, and Katy Grabill for marketing and publicity.

On the home front, Professor Priscilla Walton, my partner, not only read various drafts of the manuscript, but bravely fended off annoying phone calls and other interruptions to let me write in peace. Her love, as always, is indispensable. And finally, the dogs — Cam, Max, and Dee-Dee-Oh — grudgingly accepted that, for more months than they expected, I would be at my desk writing for longer than they are used to.

ADIR	Association nationale des anciennes déportées et internées de la Résistance
ADRM	Association pour le développement des relations médicales, established 1920
AF	Archives de France
AKS	Allgemeine Korporschwach, or general bodily breakdown
AIU	Alliance Israëlite Universelle, Paris, research library and community center founded in the nineteenth century by the Rothschilds
AJDC	American Jewish Joint Distribution Committee, a Jewish charitable organization
AMP	*Annales Médico-psychologiques* (journal)
BDIC	Bibliothèque de documentation internationale contemporaine, Université de Paris-Nanterre
CDJC	Centre de documentation juive contemporaine, the research section of the Mémorial de la Shoah
CFLN	Comité français de Libération nationale
CH2GM	Comité d'histoire de la Deuxième Guerre Mondiale
CROWCASS	Central Registry of War Criminals and Security Suspects
CTRP	Compagnie des Transports de la Région Parisienne, which predated the current RATP (see below)
DES	Diplôme d'études supérieures
DSM	*Diagnostic and Statistical Manual of Mental Disorders*, first published by the American Psychiatric Association in 1952, now in its fourth edition (DSM-IV)
FIR	Fédération internationale des résistants
FNDIP	Fédération nationale des déportés et internés politiques
FNDIR	Fédération nationale des déportés et internés de la Résistance
FNDIRP	Fédération nationale des déportés, internés et résistants politiques
FTP	Francs-Tireurs Partisans, Communist partisans
IFW	Internationale Föderation der Widerstandskämpfer
ITS	International Tracing Service

JE	*The Jewish Encyclopedia*, 1902–1906, 12 vols.
KL, KZ	*KonzentrationsLager*, *Konzentrationslager*, differing abbreviations for concentration camp
MNPGD	Mouvement National des Prisonniers de Guerre et des Déportés
MOI	Main d'œuvre immigrée, Jewish resistance group affiliated to the Communist FTP
MPGDR	Ministère des Prisonniers de Guerre, Déportés et Résistants
MPGDIR	Ministère des Prisonniers de Guerre, Déportés, Internés et Résistants; alternative abbreviation, becomes the Office National des Anciens, Combattants et des Victimes de Guerre (ONACVG) circa 1946–1947
NARA	National Archives and Records Administration
OSE	Œuvre de secours aux enfants
PCAS	post-concentrationary aesthenic syndrome
PTSD	post-traumatic stress disorder
RATP	Régie Autonome des Transports Parisiens
RHMH	*Revue d'histoire de la médecine hébraïque* (journal, 1948–1985), published under the auspices of the SHMH (see below)
SE	*The Standard Edition of the Complete Psychological Works of Sigmund Freud*, general editor James Strachey, 24 vols., 1953–1974
SER	Service européen de recherches
SHAEF	Supreme Headquarters Allied Expeditionary Force
SHMH	Société d'histoire de la médecine hébraïque, established in 1936
SNCF	Société nationale des chemins de fer, the French National Railway System
SPP	Société psychanalytique de Paris, founded in 1926
SRCGE	Service de recherche des crimes de guerre ennemis
STO	Service du travail obligatoire
UGIF	Union générale des Israélites de France
UNRRA	United Nations Relief and Rehabilitation Administration
URO	United Restitution Organization
WCB	War Crimes Branch, U.S. Army
YIVO	Scientific Institute for Jewish Research

CADAVERLAND

MY FRENCH "JEWISH QUESTION"

I am both a citizen of France and a Jew of the Diaspora, having grown up during the Quiet Revolution in Quebec, and educated in English and French. Given the timeframe of my undergraduate university education — the explosive 1960s — I received an early exposure to certain strands in French psychoanalytic thought, that still supposedly "Jewish science" of Freud's, as it was being reread by Lacan and differently so by Pierre Legendre, two Catholic psychoanalysts and, at the time, still unknown in translation.[1] Also, as the son of a Jewish mother, or as she put it, "une française d'origine Israëlite," who had had to wear the yellow star at the age of eighteen, I had heard since childhood her many stories about the Occupation years and its hazards; in particular, about how the French defeat of 1940 was for her the collapse of the bourgeois, assimilationist, republican ideology of the Third Republic, and an utter betrayal of the cultural world in which she had been formed.[2]

In my twenties, I discovered among my French cousins the same ambivalence that I had over what it means to be both French and Jewish: that is, to have grown up French in some positive sense of the word, and Jewish in some negative sense — with no religious connection to the rituals of Judaism, and yet with a lifelong identification with "being" Jewish. It took me years to realize that this is a sociological trait shared by many assimilated French Jews, often of a certain time and of the political left, and one that

could reverse itself suddenly, as in the subsequent transformation of some "Soixante-huitards" into Talmudists: the case of Jean-Paul Sartre's former secretary, Benny Lévy, being one of the best known.[3] Perhaps that is why Henri Raczymow writes of the post-Holocaust French Jew as dwelling "in a cloud of neurosis in which the individual cannot orient himself. He must discover his own path, but through one of the perverse tricks that history plays on us, he experiences [it as] a kind of déjà vu" (1994, 104).

The research for this study, then, has been a rediscovery of déjà vu. In 2000, while I was at the U.S. Holocaust Memorial Museum and reading the Vichy antisemitic laws of the fall of 1940 in the *Journal officiel* where legislative texts are published, I found myself suddenly crying as I read that Cartesian legal language of great precision, now banning the access of French Jews to work in journalism, the theater, the radio, and other media of communication (in all of which I also had worked, though of course much later). But perhaps this came closest to my understanding emotionally something of my mother's sense of a deep betrayal. That those laws were *written in French* struck at the core of one's "francité."

Writing History/Inventing History?

The relation of one born in the immediate postwar generation to the Holocaust is a very particular one as a result of a displaced proximity—close enough and yet not so. It was also clear, although later in my intellectual development, that those bodies of French knowledge dealing with collective and individual psychic memory, such as history or psychoanalysis, had had great difficulty facing the implications of the French involvement in the Holocaust until about the 1980s.[4] Why was this?

As Dan Michman points out (2001), while it is undeniable that history and historiography (the study of *how* history is written) have been by far the predominant methods for the study of the Holocaust, he also remarks that the zones of historical partitioning have largely tended to replicate pre-existing patterns of national borders (438).[5] At the same time, each zone of historical partitioning also comprises what Michman calls "a cultural-linguistic circle" in which the language used and the cultural context have played a paramount role that has been disregarded and/or underrecognized.[6] The present study aligns itself with such a cultural and linguistic approach, although Michman underlines that French Holocaust Studies remain comparatively "still rather isolated" (465). As Laurent Dou-

zou points out, French publications on the 1939 to 1945 period published between 1964 and 2001 numbered 11,600 titles. By comparison, publications on all aspects of the deportation (French Jews and non-Jews) in the same period numbered only 620 titles (Douzou 2005, 13).

Emphasizing the uses of language and the influences of the cultural context as this study does, I begin from an axiom of my main research field (Communication) that it is impossible *not* to communicate. But there are *many* ways to communicate—and not to. It also follows that there are situations in which communication of any significance is simply *not* possible. Primo Levi's *œuvre* abounds in such examples, and even so he made it the survivor's "duty to communicate" (1988). However, this was not just the duty of survivors, and we shall see subsequently some of the problems this unevenly shared burden produced. In the case of survivors in France and elsewhere, such communication as there was meant coming to conclusions about the survivors based *solely* on their physical appearance, which supposedly said it all. Similarly, the physicians discussed below based their observations on survivors' symptoms, as would be expected. French psychoanalysts, when they did take up the question of Holocaust survival, very late in the day, were more involved in their own internecine squabbles. In short, no one in the French context asked the survivors what they themselves had experienced until the 1980s. Dori Laub has caracterized the interaction generally between physicians, psychiatrists, and survivor patients as "failed empathy" (Laub and Auerhahn 1989).

However true this assessment may be in many ways, such a failure of empathy needs qualification. As Leo Eitinger (by the 1990s recognized as the dean of Holocaust survival studies) remarked, looking back to the immediate aftermath of the liberation of the concentration camps, it is almost impossible to overstate the utter emotional devastation of Jewish survivors especially: "The newly released prisoners had no one left, there was nowhere for them to go, they were completely through with their old lives, and they hadn't the faintest idea what they could do with the new life so unexpectedly granted them. . . . *They themselves were not capable of understanding their new circumstances.* . . ." (Eitinger 1998, 769, emphasis added). "Scientific studies" of what survivors had been through, Eitinger goes on, were thus "needed" to begin to grasp what the survivors themselves were not capable of expressing.

To be sure, former deportees talked among themselves about their camp experiences, but we are not privy to these conversations except for anecdot-

ally. What further complicates the French context is that it was a defeated country that ended up on the side of the victors. This paradox only tightened the problems, not to mention the fact that the Occupation had distorted many aspects of French life — private, intellectual, etc. — in short, buried them deeper. Or put them off for some forty years as a result of generational and intellectual differences, media changes, and other factors.

What I am attempting here, therefore, in the first two-thirds of this study, is to *reconstruct* the process of coming to terms with the French Judeocide as it occurred within those institutional networks that had the closest contact with French survivors. This began with the liberation of the camps and the subsequent circulation of mainly medical (neuropsychiatric) knowledge, its efforts to establish a symptomatology of camp effects, the struggles over pension compensation, and the broadening out into related medical fields (such as psychoanalysis), and other knowledge-producing disciplines.

I am not, by any means, an "ineffabilist" as regards the Holocaust experience. As I show, a number of approaches to survivors were deeply and immediately concerned with the psychological effects. Proposals were made in 1945 and 1946 for a new branch of interdisciplinary medical sociology to deal with such questions. Profoundly insightful psychoanalytic articles were being written by 1946 on what camp internment did to "the self" (and I don't mean Bettelheim's version of identification with the SS). There was recognition that France had been deeply "traumatized" in unclear ways by the Occupation years. On the other hand, because of the war, limited means and limited personnel were available to do much more than the minimum, and even some limited recognition that the job of caring for more than the immediate physical state of survivors had been botched. And there were also the limits built into knowledge at the time — as at any time. So it goes with knowledge. And so it goes with human suffering. And only rarely do they connect, or if so, fantastically, as Foucault first noted (1963).

The French case was in certain respects exceptional as the first site for the attempted medical understanding of the effects of deportation. In other respects, it was fairly typical of the indifference to survivors wherever they ended up, including in Israel, as shall be seen in the part of this study that deals with comparative, non-French, contexts of survivor research.

As historian Henry Rousso explains in his major book on "the Vichy Syndrome," in the first chapter entitled "Neurosis," when he began his research in the late 1970s, "I thought sufficient time had elapsed to allow me to wield my scalpel. But the corpse was still warm. It was too soon for the patholo-

gist to begin an autopsy; what the case called for was a doctor qualified to treat the living, not the dead—perhaps even a psychoanalyst" (1991, 1). This study, then, proposes to contribute further to untangling the historical knots in the French "national unconscious" that connected (or rather did not connect) wartime memory and the French "Jewish Question," as well as the inability of French psychoanalysis to do so either.

My use of Rousso's words here is quite deliberate. If, as Freud claimed, the unconscious has no sense of time, at what point does "the past" become a corpse capable of being autopsied? One might be tempted to reply "never," and *that* is precisely the interest of the study of history, since the corpse is never quite dead or, if apparently so, lingers on in ghostly and haunting ways, often for a very long time.

A Still Warm Corpse

If writing the history of the Second World War years remained a particular kind of problem for postwar French memory for at least a good forty years—in fact, one could say until enough time had passed for it to become the *exclusive* preserve of professional historians—what is one to say of an event such as the Holocaust, a corpse that is surely still warm? The Holocaust—with its unprecedented magnitude in the scale of mass murder, its lasting impact upon most of both Western and Eastern Europe, as well as on so many other countries, if not on "the conscience" of the world—remains in certain ways "incomprehensible," as historian István Deák put it in a memorable series of essays in 1989 and after. This incomprehensibility, however, did not stem from a lack of materials; the Holocaust, he wrote, is "a uniquely well-documented historical event" (Deák 1989, 1). Rather, even given extensive documentation, such a state of affairs was not sufficient to have cooled down the corpse of the event so as to allow whatever measure of dispassion is requisite for historical or scientific understanding. As Rousso had found, the events were still too close, and so required doctors who deal with the (still) living.

In this study, however, the corpse is definitely warm sixty years later, and so it is still not yet the time for the pathologist but rather, for doctors who deal with the living—*psychoanalysts even*. The following pages are centrally concerned with the French medical practitioners who made it their professional preoccupation to study the "living" figures who emerged more or less alive from the concentration camps following their liberation by Allied

soldiers from July 1944 (Maidanek) through May 1945 (Mauthausen), literally three days before the German surrender. I should make it clear at this point that I will be dealing more with the liberation of the concentration camps of Western Europe than with the extermination camps of eastern Poland. I have various reasons for this choice: One is that the discovery of the Western European camps was later overshadowed by that of the even more hideous death camps found by the Russians and hence "extraneous" (given that Western journalists did view them) to the Western narrative of the Holocaust. Where one initially spoke of Dachau, Buchenwald (arguably initially more significant to U.S. narratives of the end of World War II and less to the Holocaust per se), or Belsen (of greater British geopolitical significance) as the epitome of horror, today we live in a time signified by the metonym "Auschwitz." To the extent that this book aims *to reconstruct an unfolding process of discovery*, I deal primarily with the Western European camps. As well, the scientific studies that concern this book tend to focus more upon former inmates of these camps, many of whom had been in any event relocated from the eastern camps to the overcrowded camps in the west as the Nazis retreated before the Red Army. This is not to deny either that understanding the Holocaust still remains fundamentally decentered. As Yale historian Timothy Snyder reminds us, had the Nazis succeeded in their war on Russia, the implementation of two further dimensions of the Holocaust, the Hunger Plan and Generalplan Ost, would have led to the elimination through starvation of an additional 80 million people in Belarus, northern Russia and the USSR. (See Snyder 2009, 14–16).

Of the prisoners and their condition at the time of Liberation, we shall speak soon enough. Of the doctors who came to devote themselves to understanding what the prisoners had been through in the camps, a number had themselves been incarcerated in several camps: the Frenchman Charles Richet for Resistance activities; others like Leo Eitinger, for being a Jew. (Eitinger moved to Norway as a DP at war's end, where he began to study the effects of concentration camp deportation on survivors.) Of course, none were involved, as doctors, in the kind of "medical" practices sanctioned by the SS; they were unofficial prisoner-doctors who used their medical training to help their fellow prisoners, if they could.[7] Mainly, they tried to get by like the rest; and they made observations of both their own and their fellow prisoners' physical and mental deterioration, due to starvation, cold, overwork, overcrowding, filth, brutality, and terror.

Not all of the doctors we shall encounter in this book, primarily through

their scientific work, were former prisoners. Some, like René Targowla, were highly respected specialists, who had undertaken major studies before the war on the lingering effects of "shell-shock" among veterans of the First World War. Henri Baruk was a former director of the Charenton insane asylum, which he called "the Jerusalem" of French psychiatry. Nearly all had received their medical specialization as neuropsychiatrists—that is, they studied the physiological bases of nervous diseases. Some, however, like Richet, Gilbert Dreyfus, and Louis Fichez, were endocrinologists—specialists in how glandular secretions either help or harm other bodily functions. This means, on the one hand, that it will be necessary later in this book to better understand their medical training, and the various branches of medical knowledge in their relationships with one another in the French university and medical context; on the other hand, just because one has received a certain form of training, it does not follow that one will be confined to it throughout one's medical career. Henri Baruk, for instance, progressively moved away from neuropsychiatry to what he would call "experimental moral psychology." For a more famous illustration of how a doctor can move through various medical fields, remember that Sigmund Freud initially was trained in the anatomy of the nervous system. As is well known, he went from that rather narrow specialization to invent an entirely new system for understanding mental illness.

Curiously, however, none of the key figures we shall encounter initially were psychoanalysts or psychotherapists, or not until much later in our timeline, indeed not until decades later.[8] There are many reasons for this: for one, the pecking order in hierarchies of medical knowledge; for another, the smallness (and indeed fractiousness) of the psychoanalytic profession that did not take off numerically until well into the 1950s, in the case of the United States, but grew relentlessly thereafter. With greater numbers comes greater influence, if not respectability, and, as we shall see, this would cause a considerable change in the understanding of Holocaust survival, in the shift away from the neurological to much stronger psychological, psychopathological, and psychoanalytic perspectives.

One of the key points that this book makes is in stressing the extent to which bodies of knowledge—including medical knowledge—are, like so many other human things, subject to fads and fashions of their own. It is also worth emphasizing that the study of Holocaust survival has gone on for some sixty years now. In those sixty years, it has changed in many ways; this book is the first to examine such changes closely. However, I don't claim

that the following pages are exhaustive in every respect and in all conceivable contexts.

The ways in which Holocaust survival has been studied vary almost as much as the number of countries in which the topic has been examined. As we shall see, soon after the end of the Second World War, a French school (which this book looks at most closely) and a Scandinavian school of Holocaust survival emerged. These were followed in rough chronology by a Polish school, an Israeli school, an American school, and so on. Of course, the idea of a "school" should not by any means suggest a unified way of thinking about something; there are always divisions, factions, tendencies and different emphases, not to mention crossovers from one school to another. And it is to stress these differences that this study looks not only at the French context, but at other national contexts as well for comparative purposes, if more briefly.

For example, the French school was made up of different emphases on the question of Holocaust survival. One of these, more than the others — for reasons of Jewish identity and the renaissance in Jewish thought that was brought about by the creation of the State of Israel — would play a key role in "knowledge transfer" to the new state's budding psychiatric institutions. Given all this variety, crisscrossings of understanding, and mutual influences, it also follows that very little agreement existed on any question, or, if so, not for very long. Sad to say, perhaps, but also unavoidable when it comes to humans and what they think they know, is that even after sixty years, the state of Holocaust survival studies is in as messy a condition as any other field of knowledge when looked at closely, despite whatever brave front may temporarily be papering over appearances. The reasons for studying Holocaust survival stem from an awareness that the Holocaust was, by wide but *not* universal agreement, the largest man-made catastrophe ever experienced.[9] And although wanting to understand how such a catastrophe could have occurred must surely count toward the human good, the desire to understand does not guarantee anything more than temporary agreement about the certainty of findings, the adequacy of methods, or the reliability of results. None of these are reasons why such work should *not* have been undertaken. It seems to me that benefits will always come from a more profound grasp of the contexts of human actions, and even more so perhaps when one is dealing with "the good guys," as is the case here.

Three broad implications may be drawn from this re-examination of several decades of Holocaust survival. One is that the Final Solution defi-

nitely succeeded—if not in total body count, then in the lasting damage it caused. Second is that even among "the caring professions," what practitioners cared about most of all was the further development of their profession. Third, only a tiny minority of survivors came under the medical gaze; the vast majority were simply abandoned to suffer alone and in silence. One need not be a hardline Foucauldian to conclude that this is how it goes in the knowledge biz. One can grieve over this fact. One can also try to understand this better, which is what I have attempted to do in this book.

Stücke/Figüren/Rhetoric

To carry out what they called the Final Solution to the Jewish Question, the Nazis invented, among other "innovations," a bureaucratic jargon to de-emotionalize and dehumanize what they were doing. Governed by "*Sprachregelung*" (speech-rules), these practices consisted of very specific word substitutions to cover up the actuality of the shooting, killing, and gassing (see for instance, Paechter 1944, Klemperer 2000, Michael and Doerr 2002). Thus the bureaucrats of extermination did not use the words "bodies" or "cadavers" in their reports, but instead "*Stücke*" or stuff, "*Figüren*" or figures, "pieces," or "units." The word *figure*—roughly equivalent to something like mannequins, not *real* bodies but semblances—is crucial to the overall argument of this study; namely, how specialized languages make and unmake what we count as human or the traits that make up our humanity. The word *Figüren* has a number of additional connotations that are also important to what follows. It can mean "figure" as in sums, numbers, or statistics. It also can mean "to figure" as in figuring something out, less in a mathematical sense, than as a puzzle or problem, something that needs to be better understood. And third, "figure" is a key rhetorical concept for understanding ways to organize word use for various rhetorical ends of persuasion, argumentation, or logic, as in "figures of speech" or "figurative language." It goes without saying that this is a large topic in rhetorical theory that we won't get into now, but see, for instance, the articles on figurative language and figures of speech in Theresa Enos's *Encyclopedia of Rhetoric and Composition* (1996, 267–71).

The American philosopher Berel Lang has argued at some length that Nazi-Deutsch was not a language and so cannot be considered figurative (see Lang 1990, 81–102). Without engaging with his argument in detail, as my concern here is not with *N-S Sprache* (the language of National Social-

ism) per se, I think that Lang ignores certain important transformations affecting twentieth-century languages, of which the Nazi version was but one, if extreme, example (I've discussed some of this elsewhere; see Dorland 2006). A greater issue, which is also of concern to this study, has to do with the growing influence of scientific or technical language upon human lifeworlds, which precedes the rise of National Socialism.

I would argue that "figures of speech," or acts of figuration, give shape to, form, or stylize what is being said or written so that it will say, or attempt to say, *this* as opposed to *that*. Figuration is precisely the point of contact between a writer and the world outside the writer's mind; it allows a reader to grasp what the writer is trying to say by the manner in which he or she has put down on paper certain specific words or word forms and not others. Obviously, then, figures and figuration are an important key to understanding language use, as well as for tracking changes in language usage, which, like everything else, varies and mutates over time.

As I've indicated and will detail below, the study of Holocaust survival in its sixty-year history has stood for various and changing ways of developing explanations, of what concentration camp incarceration *did* to survivors, physically and mentally, and with what consequences over an ever-receding period of time: five, ten, or twenty years later. By twenty and up to forty years later, that concentration camp experience had affected their children, and their children's children. These explanations and their transformations were all refracted through the prisms of the various figurations of medical knowledge, ranging from internal medicine, neurology and neuropsychiatry, across an axis that moved over time from the bodily to the psychological and its related sciences, psychoanalysis and its derivatives—or what the French today refer to as the "psy" sciences.

This may be putting it too strongly—there is plenty of room for qualification in the pages that follow—but medical language and discourse is as figurative as any other language use, if differently so. In his 1963 *Naissance de la Clinique*, Michel Foucault provides a history of how the medical clinician's approach to the sick body changed with the French Revolution and throughout the nineteenth century. From an earlier, more physical, tactile approach in which he actually touched and smelled the patient and his excretions (urine, vomit, and such), the doctor gradually removed himself to a much more abstract vantage point that could sum up the patient's condition with a mere look ("the medical gaze," as Foucault calls it). The medical gaze was backed by ever more sophisticated instrumentation that allowed

the doctor to see what was going on *inside* a patient's body and, with the rise of psychology, in the patient's mind as well — or at least to speculate about it. In the book's preface, Foucault wondered why there had not been to that point (or for that matter, since then) anything like a "psychoanalysis of medical knowledge" (1963, vi). The lack of such, he went on, did not mean that there was no shortage of "*fantastic links* between knowledge and suffering" (vii, emphasis added). On the contrary, among these fantastic links, there is what I'm calling a rhetoric of "the figures of suffering" (vii) that are *not* dispelled by the rise of the objectifying, rational discourses of modern medicine, only *displaced* both by the fact that bodies continue to get sick, and in the changing situations where bodies and the medical gaze meet. What *has* changed, however, is the relationship between *who* is speaking and *what* is being spoken about. Think here for a moment, as a stark example of what I mean, of the enormous difficulties of those very few Holocaust survivors who did encounter the medical gaze, as opposed to those so many more who remained immured for years in the silent figures of their suffering, just to be able to *begin to speak* about what they had been through.

I am not arguing here for a "psychoanalysis" of medical knowledge. Surely, though, to speak about "the figures of suffering" is at the same time to make a gesture toward psychoanalysis and psychoanalytic concepts that one could also term a grammar of such figures. What is psychoanalysis if not a way of learning to speak one's (frustrated) desire to speak? That is why, in organizing the chapters that follow, I have drawn upon both rhetorical and psychoanalytic figures to shape what I and the many sources upon which I draw are trying to say.[10] Each chapter below begins with a definition of the principal figure deployed; the content of each chapter provides the empirical support for why such a figure was chosen as an organizing frame of analysis.

A great number of figures of speech and various larger and lesser ways of classifying them were available, but for this study I have only drawn upon a half-dozen or so, many of these from psychoanalytic language. All of them, however, are figures of avoidance, dissimulation, and displacement; in other words, of how *not* to have to confront the Holocaust and its human consequences, for reasons that are complex and will be explained in more detail below case by case. Or to put this slightly differently, the magnitude of certain events is such that they can be faced only indirectly and require the passage of a long time before they can be grasped, and even then only in certain ways. In the words of historian Walter Laqueur, "There are certain

situations which are so extreme that an extraordinary effort is needed to grasp this enormity, unless one happened to be present" (cited in S. Friedlander 2007, xxv).

The Limits of Knowledge and Memory

The survivors *were* present, and it is far from certain that this facilitated their understanding of what they had been through. As the following pages show, it did not help the understanding of those who ostensibly were closest to them, be it the few medical doctors who treated them or who studied their symptoms at one remove; their families, if they had survived; or their fellow citizens who thought, if they thought at all about it, that just looking at them was sufficient to grasp what they had been through. When survivors did begin to speak *en masse* as it were through videotaped "testimony," allowing for the passage of too many years, advanced age, and failing or warped memories, what they had to say was—forgive me—banal. (This of course does not apply to the classic literary works of Holocaust memory, although these are not without different problems). To paraphrase Elie Wiesel, who is paraphrasing Tolstoy, all survivors' stories are alike. Lawrence Langer, who has drawn upon the large Fortunoff Video Archive at Yale, exemplifies this when he writes about "the ruins" of survivor memory and subdivides it into "anguished," "humiliated," tainted," "diminished"—all negative descriptors from his 1991 book on Holocaust testimony. So it goes with human memories.

If Laqueur is right and extreme situations such as the Holocaust call for extraordinary efforts of understanding, what we find in the following chapters is that even extraordinary efforts were not enough. For the most part, those who came into contact with survivors made ordinary efforts to understand, if that. Some tried harder, it is true; some made it their life's work. But for the most part, as has been pointed out by scholars such as Georges Canguilhem (1991), Thomas Kuhn (1962, 2002), Michel Foucault (1966), or Ian Hacking (1981, 1995), "normal science" operates within a given paradigm of knowledge and only rarely outside such norms (where the extraordinary resides). Even frailer and subject to distortion, omission, and forgetfulness is ordinary human memory. Philosopher Paul Ricoeur, approaching his nineties, remarked that an act of normal memory was "a small miracle" (2000). The need for miracles increases so much more with

extraordinary and highly complex events such as the Holocaust itself *and* surviving it.

There are no miracles in what follows. Instead, normal human beings struggle within the limits of their capacities, scientific or otherwise, to understand the extreme. As shall be seen, this is not to say that extraordinary understanding was not possible; it was, but these instances were exceptions. What follows is a study of the limits of knowledge and of memory, prompted in part by an epoch that overemphasizes both.

And so we begin with the encounter at or near the end of the Second World War of certain, strange, emaciated, and often speechless figures imprisoned behind barbed wire with the Allied soldiers who freed those creatures who were still alive, the likes of whom they had never encountered before.

FIGURE 3

DISPLACEMENT

The process by which energy (cathexis) is transferred from one mental image to another. . . . More generally, the process by which the individual shifts interests from one object or activity to another in such a way that the latter becomes an equivalent or substitute for the other.

RYCROFT, *A Critical Dictionary of Psychoanalysis*, 1968, 35

The Pathology of Catastrophe

In the previous chapter, we saw how the figure of the concentration camp survivor eventually came to center upon one particular idea; namely, that the survivor was the physical and psychical incarnation of the pathological—the abnormal—as a result of having been made by the Nazis into the unwilling subject of a drastic experimental intensification of external forces. The camps were sites of the deliberate acceleration of "normal" biology: hunger, starvation, cold, overwork, and fear, all combining to rapidly bring about the end point of physical processes prematurely. Ageing, wasting away, Kollaps, the reduction of physical movement, and the loss of the will to live, as far as the physical body went; asthenia and premature senescence for the neurological systems; and this was only the beginning of the medical findings. As Leo Eitinger, the *doyen* of the first generation of survivor researchers, put it in the late 1990s:

> The newly released prisoners had no one left, there was nowhere for them to go, they were completely through with their own lives, and they hadn't the faintest idea what to do with the new life so unexpectedly granted them. [For the new international organizations that looked after them] . . . the individual person was, as yet, of very little importance. . . . Indeed, the individual had no right to decide for himself, to determine his own

> fate. . . . [The Jewish] ex-prisoners . . . themselves were not capable of understanding their new circumstances, so different from the world of which they had dreamed. (1998, 769)

Eitinger added that at the time two possible actions might help Jewish survivors in particular. One was that they could somehow make it to Israel and start new lives there. The second, and another form of displacement, was that "scientific studies," as he himself would shortly undertake in Norway, were "needed to describe life in the concentration camps and the short and long-term reactions to concentration camp survival" (769). Here, medical studies of concentration camp effects might provide at one remove a replacement for the disorientation of the former prisoners.

That the unprecedented set of circumstances confronting survivors would be fascinating to some medical doctors, even if they were at the same time personally appalled by what the survivors had been through, is not surprising. The physicians were the ones with the appropriate training to best understand physical deterioration. Further, the central concept around which their observations would crystallize in the French context particularly, the *pathology* of deportation, also derived from the medical training of the neuropsychiatrists involved; it was an integral part of the dogmatic underpinnings of their profession. And yet, as shall be seen in the present chapter, even given figurative condensation over the survivor, there was room for different ways by which this would be approached, involving fundamental differences over the ethics of medical practice. It is such displacements that we focus upon here. As will also be seen below, those survivors who did receive medical attention — and these were far fewer than the many more who simply were abandoned to their own devices — were by and large all viewed as manifestations of the pathological or the psychopathological. While various diagnostic labels would emerge for these states — most notably KZ Syndrome — the overarching term that I use to group them together is "the pathology of catastrophe," following Marc Dworzecki (see below). In part, this is because the Hebrew and Yiddish word for "the catastrophe" — *Ch'urban* — was the first name given to what subsequently was called the Holocaust and later the Shoah. In part also, it is because "the catastrophe," as will be seen later, covered the broader range of contexts in which the survivor will in turn experience displacement.

The Somatologists, 1945–1948

The word *soma* in classical Greek means the body, or bodily. (This has nothing to do with Aldous Huxley's use of the word in his 1932 novel *Brave New World*, to figure an ecstasy-producing tablet derived from a mythological Hindu plant.) In modern medical thought, the soma refers to all the cells of the body—with the exception of germ cells—and all those parts of the body that make up a mortal individual: the tissues and organs, muscles, alimentary canal, stomach, intestines, kidney, bladders and ducts, liver, pancreas, and other glands. All of these organs and bodily systems, including the autonomic nervous system and the generative organs, have nerve receptors or are conduits for the sensory.

With the question of the content of bodily sensory systems matters become more complicated: in effect, a revival of the mind-body split in many ways, but where the differences between the two have become blurred. Does the nervous system "feel" and if so, in what sense? Similarly, are the organs and muscular system carriers of "emotions" and, if so, which? The various medical sciences also diverge here. If medical sciences generally agree that the sensory or receptor systems of the body may be points of origins of "reactions," are such reactions simple or complex? Psychology, for example, postulates that such reactions may be constitutive of an individual's inner "affective experience." But this in turn calls for a different organizing concept than that of the soma, namely that of "the psyche." However, as we have just seen, it is not a simple matter to clearly separate the two. For instance, one could say that the phenomenon of sleep (and so dreaming) is the precise point at which somatic life turns into psychic life, but, even so, it's not as if physical activity ceases during sleep either. So this problem of boundaries will return again and again in various forms, in part because the primary concern of medical science is crises of the bodily.

Those whom this chapter terms the somatologists tended to be more preoccupied with the consequences of concentration camp incarceration for bodily systems (the heart, the digestive system, glandular dysfunction, and so on) than they were with the psychological. But, as we shall see, such a separation became ever harder to maintain as time passed.

As noted at the end of the previous chapter, with the campaign for pension reform and illness eligibility reclassification led by the FNDIRP in the early 1950s, the revised list of pensionable presentations were all *somatological*. Notably, in the case of women deportees, these included: "sequelae

[lasting consequences] from traumatic lesions and mechanical troubles at the level of the female genital apparatus"; chronic infectious lesions; functional troubles (e.g., dysmenorrhea, endocrinal problems); benign or malignant neoformations (polyps, fibroids, tumors); sequelae from surgical ablation (ovarectomies, hysterectomies); and obstetric complications (FNDIRP Archives, *La pathologie des déportés* n.d., 249–51).

More generally, what Targowla now termed "post-concentrationary aesthenic syndrome" (PCAS) was not to be confused with neuraesthenia, nor neuro-psychaesthenic states, nor psychoses, nor hysteria. Rather, PSAS presented as specific aetiological and pathological factors, the absence of previous psycho- or neuro-pathic factors, and a clinical presentation marked by a tendency to dissimulate or *minimize* problems, and an *absence* of diffuse complaints, compared to the theatricality and egocentrism of classical hysteria. Where hysteria was an illness of extroversion, deportee asthenia was one of introversion, or "involutive neurasthenia," as Targowla put it (1954a, 62).

Targowla, in his dual capacity as Commission rapporteur and neuro-psychiatric expert, made some remarks that are useful in further definition of what he termed "neuro-psychic post-concentrationary pathology." For one, he indicated that concentrationary pathology was a branch of the pathology of war, but surpassing combat pathology in importance. The "originality" of what deportees experienced stemmed not just from mass concentration, but also from having been part of a deliberate process of "*produktiv Vernichtung*," (productive annihilation), the massive, accelerated destruction of "human elements" (177). Having personally examined some twelve hundred deportees since 1946, the majority of them resistants, Targowla sketched out the state of the study of the neuro-psychiatric sequelae (lasting consequences).

In so doing, he was struck by the rarity of grand neurological syndromes—no cases of hemiplegias, Parkinson's, multiple sclerosis, brain tumors, or the like—most likely because such people could not have survived long in camp conditions. Other than some belated sequelae from head wounds, nerve damage, migraines, and four cases of facial paralysis, Targowla's most striking observation was that nearly all cases of nephritis (renal illness) and polynephritis, initially widespread, had regressed without apparent consequence. Similarly, with major psychopathic syndromes, he noted very few cases of chronic delirium, schizophrenia, or manic-depressive psychosis among concentration camp survivors. Some sixty

cases of periodic psychosis or cyclothemia were observed. Repatriation itself, however, was marked by a few instances of transitory mental confusion and anxious melancholy that rarely recurred.

The "capital finding" of the methodical clinical examination of *resistants and political deportation survivors* was a morbid ensemble that, because of its frequency and the constancy of its presentation, Targowla termed "the common residual symptom of the camps": namely, the asthaenia of former deportees (178). This was a three-dimensional form of neurasthaenia, with motor, mental, and neuro-vegetative symptoms. The motor or muscular symptoms manifested themselves as a general lassitude, especially in the morning, but also as exhaustion due to physical effort throughout the day, and marked by chest pain, breathlessness, heaviness of the limbs, constrictions felt at the knees, pain in the tibia, and headaches. One of the aspects of generalized muscular fatigue was a diminishment of auditory capacity.

Psychic asthaenia, or what Janet had called a lowering of psychological tension, here translated into failures of intellectual activity that corresponded exactly to psychomotor asthaenia.[1] Memory troubles were noted most frequently: the inability to take in new information; forgetting names, addresses, phone numbers. Attention was diminished, thoughts distracted, ideas vague, perception incomplete; at the same time, a certain pleasure was derived from morose rumination. Such psychic fatigue appeared clearly in a range of tests of memory, attention, ideas, association, and so on, in which the subject's increasingly evident poor performance produced anxiety, powerlessness, and pain in the forehead and eyes. In addition to such functional symptomatology, affectivity and sensibility were also affected: "moral depression, emotional instability, anxiety, paresthesia . . . which, with psycho-motor adynamism, form a clinical complex" (180).

As Targowla noted, affective depression was equivalent to a diminution of activity. Desire weakened, as did sexual interest and "sentimental pulsions." Ordinary daily activities were experienced painfully, and worries excessively dwelt upon. The subject was "morose and worried, pessimistic, of abnormal and excessive emotivity, allied with irritability, [and] impulsive irascibility which explodes for pointless reasons." The former deportee couldn't stand noise; the crowd oppressed him; society wore him out; he preferred solitude. His malaise diminished when with his camp comrades, but at the same time he also feared that painful memories would resurge.

Deportees suffered neuro-vegetative sensory troubles as well: head and bone pain; back and knee pain; dizziness; fear of falling; inability to sleep

at night; nightmares; anguished wakening with heavy sweating; nightly and daily incontinence.

Finally, Targowla described two characteristic "functional visceral syndromes": heart and digestive problems, separately or in combination. The heart troubles were "essentially subjective," that is, independent of any clinical lesional symptomatology observable through radiology or electricity (182). Digestive problems were also neurotonic. Laboratory examinations, X-rays of the skull, encephalograms, and lumbar punctures did not reveal consistent abnormalities.

If such was Targowla's clinical description of the asthaenia of deportees, perhaps one of its most striking traits was its latency phase (183). An initial period of convalescence was followed by a period of apparent health, but this only lasted several weeks, even at times up to two years. Targowla mentioned several patients in whom the affectation appeared in 1953, *eight* years after their return.

How then did Targowla situate post-concentrationary asthaenic syndrome within the larger neuro-psychiatric context? Surprisingly, perhaps, he described it as "a neurosis in the classical sense of the term," or what Charcot and others of his time would have called "hysteria without crises."

That said, Targowla then went through the historical diagnostic progression from the end of the nineteenth century, and subsequent refinements of the definition of neurasthenia, from very broad to increasingly precise. He concluded that there were two categories of neurasthaenia: primitive and symptomatic, with post-concentrationary syndrome taking either form in any case. Targowla added that what "the ancient authors" had termed *hysteria major* developed on a particular terrain unknown to them at the time; namely, fundamental neuro-psychic asthaenia (186).

Nineteenth-century work on the origins of hysteria and later neurasthaenia (hysteria without crises) had attributed its violent emotional states to social factors such as overwork, insufficient sleep, slum conditions, undernourishment, and poverty, along with infections and tuberculosis, alcoholism, and chronic rheumatisms. Some of these causes could be attributed to hereditary predispositions, but also could be acquired without any predisposition. To be sure, some deportees showed hereditary constitutional elements that could translate into the clinical profile (paranoid tendencies, obsessions, etc.). But, for the most part, the condition of deportees had been, so to speak, created under experimental conditions "colossally amplified" by the torturers. The study of concentrationary illness and its

pathological physiology as presented in the work of Charles Richet and Alfred Gilbert-Dreyfus now made it possible to identify precisely the pathogeny of "neurasthenia" — namely, despite the reversibility of functional and anatomical changes in survivors, a disequilibrium of the central regulators of vegetative life, *including affectivity*, was evident and tended to be located, according to the most recent hypotheses, in the hypothalamus.

"Moral misery" and its substratum "physiological distress," along with the late-presenting asthaenia of deportees, were in many cases triggered by one final factor: the fact that the returnees' readaptation to civil life had not occurred under "the most favorable" psychological and practical conditions. This had produced a terrain of neuro-psychic depression upon which the first symptoms of asthaenia developed. The end of the latency phase often coincided with the attempted return to normal daily activities.

Finally, the residual syndrome common to camp survivors was not an illness *specific* to former deportees; but a well-known — if involuted — neurasthenic syndrome. Adoption of the term "deportee asthaenia," thus had a dual aim: (1) to counter the erroneous conception of neurasthaenia as a constitutional condition independent of external circumstances, and (2) to struggle against the prejudices associated with neurasthaenia and its subjective symptomology in the minds of doctors, the public, and of patients themselves.[2]

In the context of the commission for pension reform, Targowla brought to bear new scientific findings upon the attempt to change state actions. More than this, though, Targowla also addressed his own larger research field — neuropsychiatry — in the history of its debates over hysteria and neurasthenia, and in the process refined the exactitude of these diagnostic categories. Third, by his various references specifically to the work of his colleagues Richet and Gilbert-Dreyfus, Targowla identified an emerging scientific *discourse network*, whose development in France and beyond was beginning to form at this time.

Before returning to this theme, however, it may be useful to learn something more about these men I call the somatologists, beginning with Targowla himself.

RENÉ TARGOWLA (1894–1973)

Not all doctors have a medical syndrome named after them; René Targowla did, in the emerging discussions in medical circles after the war over the consequences of deportation. "Targowla syndrome" was in effect a later

name for what Targowla termed, as we have just seen, deportee asthenia (Dworzecki 1962; Abalan 1987). As we also saw, however, the latter was not in the end a condition entirely specific to concentration camp detention as much as the *inward* displacement of a neurasthaenic condition.

Targowla's thinking was formed by his experience in the mid-1930s of examining World War I veterans still troubled by symptoms up to eighteen years after their wartime injury. According to the work of independent researcher Gregory Thomas, after evaluating eighty-nine cases where troubles reappeared after a long latency period, "Targowla concluded that their post-traumatic symptoms were not in fact lingering sequels to the physical trauma, but rather 'banal,' subjective troubles which appeared in conjunction with arteriosclerosis" (Thomas 2003, 37; see also Targowla 1936). It was the patient, according to Targowla, who incorrectly attributed his symptoms to the wartime injury, based on an association between present symptoms and those suffered originally.

The cases examined by Targowla and colleagues Maurice Pignède and Paul Abély (1930) revealed scores of men who continued to suffer from illnesses with psychological components years after their wartime injuries. As Thomas notes, these veterans had not succeeded in reintegrating into normal life. They were plagued with recurrent memories of war and with affective symptoms, as well as the lingering effects of physical wounds. Their problems were "moral" as well as financial, due to inadequate pensions. On the "bright" side, as they had not been classified as mentally alienated, they had at least avoided the fate of their more traumatized comrades, locked away in asylums, often for many years and unable to see their families.

In the 1920s, Targowla had been associated with the pioneering work of Edouard Toulouse, a prominent psychiatrist (and socialist and freemason) who in 1922 established the first "open" psychiatric service at Sainte-Anne Hospital in Paris. The Service libre de prophylaxie mentale was more an outpatient clinic for mildly psychopathic cases, and supported by laboratory facilities and a dispensary. Although it did possess wards, these were very different from the main hospital's locked wards. As an open facility, Toulouse's Service could circumvent the strict legal requirements for voluntary and involuntary admissions to asylums established under the law of 1838. Indeed, among other things, Toulouse's work was a grim commentary on the wretched state of French public asylums (a further unsuccessful reform of the latter upon Liberation will be discussed in the next chapter). Patients requiring psychotherapy at the service were seen by Eugène

Minkowski, a highly significant figure in French interwar psychiatry whom we also encounter later in this chapter (on Toulouse, see Thomas 2004; also Ohayon 1999, 26–36).

As Annick Ohayon points out (1999), Toulouse's Service, which in 1926 was renamed the Hôpital Henri-Rousselle after the senator who politically supported its creation, triggered bitter debates in the medical profession and particularly among "alienists," as mental illness doctors were still called. The central issue concerned what kind and what numbers of mental patients could be treated by an "open" service. Toulouse himself was not very certain, but had argued in his 1896 book, *Les causes de la folie*, that "an important mass" of patients currently was sequestered in asylums who should not be there. His opponents mocked his "megalomania" and supposed claim that he could cure a hundred thousand mental cases in Paris alone. One newspaper reported that a certain Rambon, a double murderer, had been treated at Henri-Rousselle—effectively suggesting that murderers were on the loose there (see Ohayon 1999, 34). Other opponents claimed that Toulouse was more interested in research than in treatment, largely because of the existence at Henri-Rousselle of one of the first laboratories of applied psychological research. Despite the uproar and jealousies of the medical profession, Henri-Rousselle rapidly became a center for research and social experimentation, where supporters of experimental psychology worked together with subsequently influential psychoanalysts like Jacques Lacan and Daniel Lagache, and phenomenological psychiatrists like Minkowski.[3] Henri-Rousselle was absorbed by Sainte-Anne in 1941.

From this brief overview, we can see that Targowla came out of a medical milieu in an important period—one of intellectual ferment, and especially of the first institutional confrontations among psychiatrists, psychologists, and psychoanalysts that would last for decades thereafter. Most significantly, these new currents of thinking about and treating mental illness were highly contestatory of the more established branches of asylum psychiatry. Targowla's work in pension reform with former POWs, and ultimately with deportees, while still firmly grounded in classical neuropsychiatry, showed that this field was not averse to social reform, nor to the recuperation of patients traumatized by the many dimensions of war long after the events and, as a result, pushed into the margins of social neglect—although not without a lengthy medico-political struggle to bring about change.

CHARLES RICHET (1882–1967)

Targowla's principal colleague in the study of the pathology of deportation, Charles Richet, in many ways continued where the former's work left off, but in the different medical field of endocrinology. Richet came from a distinguished medical family. His grandfather, Professor Alfred Richet, who long taught surgery at the Hôtel-Dieu hospital in Paris, capped his teaching with a celebrated Treatise of Medico-Surgical Anatomy, considered at the time "an original effort" to bring to both medicine and surgery the latest developments in anatomy.[4] His father, also Charles (Robert) Richet, was a world-renowned physiologist (France's first Nobel winner in physiology in 1913), and the originator of the attempt to bring together physiology and psychology, publishing late in his career, following academic custom, a massive *Traité de Métapsychique* (1923). It was gently received by current leading psychologists such as Janet. Richet *père* was also a man of varied other interests, especially aviation—he was a pilot during World War I—and, early in the twentieth century, helped develop the helicopter with the Breguet brothers. He was equally fascinated by psychic phenomena and, during the First World War, developed a plan for rockets propelled by mental energy (C. R. Richet 1916). Richet *fils* followed the family path into medicine but, according to one of his obituaries, with no pressure or assistance from his father. The two would together publish a *Treatise of Medico-Surgical Physiology* where they aligned clinical medicine and physiological thought. Richet *fils*' medical studies took place during the First World War and focused on infectious diseases. In 1917, at Marseille, he was one of the first doctors to detect the cholera infection. He fought in the Dardanelles campaign, a military disaster of the first order, which deeply impressed him with the suffering and death of troops in miserable conditions, camped on the beaches under heavy shelling.

During the interwar period, the scientific work of Richet *fils* focused on problems of nutrition and the physiology of nutrition, the study of the pathologies of nutrition, such as famine, as well as the endocrinal basis of neuro-muscular problems. In 1931, with several collaborators, he published a book on the alimentary conditions of indigenous populations in France's colonies. Each territory was examined carefully by a doctor, an agronomist, and a colonial administrator. The book also looked at the lives, health, and work habits of native populations in relation to agricultural development and the adequate production of food supplies. He was very interested in de-

mographic trends, birth rates, and their impact on national development, particularly in France, publishing in 1939 an article entitled "La Destinée de la France et sa natalité." Six months later, the "Phony War" began, followed by France's collapse before the Wehrmacht in June 1940.

Richet was arrested for Resistance activities in spring 1943 and imprisoned at Fresnes on 20 May. On 21 January 1944, he was deported to Buchenwald; his wife Jacqueline, to Ravensbrück; and their son Olivier was sent to Dora and then Bergen-Belsen. All three survived and jointly wrote a book about their experiences (Richet, Richet, and Richet 1945). Charles Richet was liberated on 14 April 1945. As his 1966 obituary in the *Presse Médicale* put it, "His soul would remain forever marked by the experience" (Debré 1966).

After his return to Paris, Richet was appointed to the Hospital for Sick Children. He had been admitted to the National Academy of Medicine in 1940; and was later given a university chair in alimentary problems at the University of Paris Faculty of Medicine, created especially for him. But his later scientific and humanitarian efforts were entwined predominantly with the study of "the pathology of deportation," in which he was one of France's leading scholars by the mid-1950s, his textbook on the topic going through three editions by 1962 (Richet *fils* 1958). He devoted the rest of his life to furthering the understanding of this pathology in both scientific and political *milieux*, as well as publishing on the related topics of famine, alimentary insufficiency, and the pathology of social misery.

Invited to speak on these topics at numerous congresses (despite cancer of the throat that eventually would deprive him of speech), Richet was associated with peace movements for the neutrality of doctors in times of war, and the Fédération Internationale des Résistants (FIR). The recipient of many national and international honors, Richet stipulated in his will that only two of these should be mentioned: the Grand Cross of the French Legion of Honor along with the German Cross.

One of the key themes running through all Richet's work is the idea of "physiological distress." Here we look at a short 1948 paper on this topic, co-written with Alfred Gilbert-Dreyfus, Henri Uzan, and Louis Fichez, all key figures of the somatological approach.

The notion of physiological distress ("*misère physiologique*") was at the center of many of Richet's concerns, whether in military life and colonial campaigns; among what we today term the homeless and battered women; but also as the "normal" condition of life among the popular classes of

many poor countries, particularly in the Far East. However, up to this time, little scientific work had been done on physiological distress, and even less so on its sequelae.

The central illustration of physiological distress is that of concentration camp deportation, personally experienced by all *four* authors. "For between one to four years, subjects dwelled in fear or rather anxiety, simultaneously victims of both material promiscuity and familial, gender and moral isolation, underfed, unheated, deprived of sleep, overworked, packed in narrow rooms, and afflicted with skin and intestinal infections" (Richet et al. 1948, 649). As all four authors had had occasion since Liberation to observe "a large number of deportees," the observations reported in the paper were felt to be generalizable to other varieties of the aetiology of physiological distress.

They began by remarking on the high numbers of camp comrades who died within days of Liberation, many as a result of fatal diarrhea provoked by sudden excessive food intake; others, having depleted all their physical reserves, "went out like lamps that had run out of oil"; whereas still others survived for several weeks before they rapidly succumbed, affected by the "irreversible" forms of physiological distress.

At the opposite end of the scale were the reversible forms, in which some, remarkably, regained their health or at least the appearance of it. Between these two extremes were a large number of "slowly reversible" forms of alimentary insufficiency, especially among those over forty-five. Richet and his colleagues made passing reference to the striking fact of the late presentation of pulmonary or other forms of tuberculosis whose symptoms appear only *after* the return to normal life. They went on to identify major categories of the symptoms of physiological distress: first, *weight loss* to as low as 40 kilos that, three years after, had only risen to 60 kilos. The cause was not skeletal, but due to the loss of both body fat and muscle.

In some women, however, the four (Richet, Gilbert-Dreyfus, Uzan, and Fichez) observed "curious oscillations" of this pattern: weight gains of up to 5 kilos a month followed by considerable water-retention obesity, attributable to emotional and affective shock, sometimes transitory, but in many cases permanent.

Physical and intellectual *fatigue* was an even more constant observation than weight loss, coming with any kind of exertion. In its discrete form, physical fatigue presented as a painful sensation in the legs. More acutely, the patient had to sit down, or often required prolonged periods of bed-

rest—in one case, for thirty-seven months following Liberation. The decrease in resistance to fatigue appeared to be caused, in part, by more or less irreversible muscular atrophy. Although appetite was conserved, it was often exaggerated. Sleep was difficult, often with insomnia at night or hypersomnia in the day. The central bodily core was subject to hypothermia that seemed associated with thermophobia due to vasomotor instability. The authors raised the important question of whether these were *really* pathologies or, rather, represented the onset of premature senility. They then hypothesized that the latter may be a general state of *accelerated aging*. If a year of military campaigning was equivalent in its toll on the body to two civilian years, might not a year of "physiological distress" count for four?

At this point in time, they found little evidence of lasting cardiovascular disequilibrium. Hepatic functions also appeared unaffected. Gastrointestinal functions remained perturbed, with recurring diarrhea and colitis. Digestive troubles often were related to problems of food absorption, attributable to lack of digestive juices and the persistence of high levels of starch in the faeces.

Psychic troubles were frequent, even when post-infectious factors had been eliminated. Many minor manifestations could be observed in the realm of the affective, to the point that one could speak of "affective asthenia" (Targowla) or "affective anaesthesia" (Minkowski). Numerous cases of psychoasthaenia turned into what the authors called "social apraxia," the inability to socialize. However, most of the frequent nervous manifestations could be attributed to vasomotor difficulties.

Genital problems, including impotence or semi-impotence in men, were characteristic of physiological distress, but were also proportional to aging, both normal and premature. As the authors were unable to find evidence of endocrinal stigmata, they assumed that impotence was of an emotional original, an aspect of general asthenia. Among young female former deportees, puberty was often delayed, and in older women menopause was premature. Amenorrhea (absence of periods) was of considerable frequency. But, in most cases, except for women over forty, the menses returned to their normal periodicity.

At the glandular level, the picture was not clear enough for them to identify sequelae, other than noting a very large number of cases of hypoglycemia, and the relative frequency of caloric or nutritional anemia, although not out of proportion to comparable civilian states. Overall, the four authors concluded that it was "illusory" to think that subjects could, after

years of physiological misery, be brought back to their previous condition. "The best one can hope for is to slow down the advance of lesions" (653). The dominant theme of the study was that long-term sequelae were equivalent to partially or totally irreversible troubles.

This 1948 paper, then, quite clearly laid out the somatological terrain in which these men would work for the next decade and sometimes longer, refining their findings, and in many instances reversing them where initially they had observed few anomalies. The main change overall would be the move from general physiological distress to the specific forms of the pathology of deportation.

[ALFRED] GILBERT-DREYFUS (1902–1989)

For reasons unknown, Gilbert-Dreyfus never used his first name, perhaps because it was too closely associated with that of his famous (or infamous) relative, Captain Alfred Dreyfus of the celebrated "Affair" that rocked late nineteenth-century France to its core, violently revived a lingering antisemitism, and, in reaction to which, gave rise to Zionism. It was always just "Gilbert," the first name that he used even when writing pseudonymously, as he did with several books right after the war and his return from Mauthausen and Ebensee.

In France, endocrinology was initially experimental and physiological, following the work of Claude Bernard. It did not take the present-day form of clinical endocrinology as an individualized medical specialty within the domains of internal medicine until after the 1930s.

Born 17 August 1902 in Raincy to the east of Paris, Gilbert-Dreyfus' branch of the Dreyfus family came originally from Dunkirk. His father was part of the post–Dreyfus Affair opening of previously closed professions to Jews; a polytechnician (engineer) who became a high-level state functionary. His mother was a gifted woman who spoke several languages.

Henri Bricaire speculated in Gilbert-Dreyfus' obituary eulogy that he was drawn to medical studies for two reasons: first of all, the desire to follow in the steps of his elder brother, killed at the Somme in 1916 (Bricaire 1990). The second reason says a lot about the philosophical aspects of French medicine. One could be a doctor by day, and by night a logician, or psychologist, a teacher or a writer. "A writer," Gilbert-Dreyfus wrote, "cannot treat a sick patient, but a doctor can write as much as he wishes." And indeed, postwar, he himself aspired to the role of "man of letters," inspired perhaps by his close friendship with his fellow doctor and camp comrade,

François Wetterwald who, in addition to practicing surgery, was also a published poet.

Gilbert-Dreyfus's medical career was a brilliant one; named "Interne des Hôpitaux de Paris" (roughly, a residency) in 1924, he became laboratory head as well as head of clinic in 1930. In 1934, he was named "Médecin des Hôpitaux" with a consultancy at the Beaujon and then at the Cochin hospitals. At Cochin, he founded his own "school," bringing to clinical practice a more biological approach and furthering research in bioclinical synthesis.

The outbreak of the war saw him refused entry into the army—the result of severe health problems in the late 1930s. With the fall of France, he left Paris for the non-occupied zone, and joined the Resistance. In 1941, he established the Resistance group known as la Brigade des Maures (the Moors' Brigade). In 1943, when the Germans took over the non-occupied zone, Gilbert-Dreyfus went underground, heading the medical organization of the Southern Zone of the Resistance. Arrested by the Gestapo in November 1943, under the pseudonym of Gilbert Debrise, he was deported to Mauthausen and then its sub-camp Ebensee, where he and Wetterwald were prisoner-doctors.[5]

In his 1946 *Les Morts inutiles* (Useless Deaths), Wetterwald dedicated a chapter to Doctor Gilbert-Dreyfus "for me—and many others—forever Gilbert" (141). There, Wetterwald explained what he called "the French concept" of medical duty adopted by himself and Gilbert as prisoner-doctors. "The idea was, first, to try to help as many human lives as possible; and, second, to try to send [back] to work the smallest number of [sick] workers so as to, within our limited means, sabotage the German war machine" (141–42). He also expressed his astonishment at the lack of converts to their medical approach. For a minor infraction of discipline, the nurses promptly denounced it to the kapo or the SS personnel on duty, even when the patient or comrade was of the same nationality as the former. He also commented on the servility of other prisoner-doctors in sending patients who could barely stand back to work, just for an extra ration of soup.

Gilbert-Dreyfus, in the two books he wrote as Gilbert Debrise in 1945 and 1947 about Mauthausen, Ebensee, and Dachau, was unsparing in his denunciation of the perversion of medicine, not only by SS doctors, but in particular by leading university specialists. In *Weekend à Dachau*, a collection of sketches written between 1945 and several years after, he wrote that some people still did not want to know what went on in the camps. He stressed the importance of passing on his experience and the experience of others

of the camps, not out of morbid curiosity, but to show to what abjection a political regime could reduce an entire people. And especially how

> the most famous German medical doctors — the histologist from Hamburg, the oculist from Bremen, or the internist from Jena — became . . . vivisectionists who amused themselves by tearing out the kidneys and livers from living bodies, [who] became deliverers of cadavers to industry, suppliers of bodies to the gas chambers — and this with all the indifference of boys who like to torture toads. (Gilbert-Dreyfus 1947, 95)

After Liberation, Dreyfus stayed on for several weeks to take care of the remaining deportees and to supplement scant medical resources that otherwise would have left them without care.[6] Late in May 1945, he returned to Paris and soon thereafter was appointed to the Pitié Hospital, where he would spend the remainder of his career as a doctor, researcher, and teacher. There, Gilbert-Dreyfus established an endocrinological unit within the internal medicine service and later an Institute of Endocrinology and metabolic diseases that soon gained an international reputation.

Fundamentally, Gilbert-Dreyfus was a clinician. After he became professor of clinical endocrinology in 1959, he gathered around him the most specialized students, as well as many doctors from abroad, by far preferring the intimacy of contact with patients and students in the clinical context to the amphitheater lecturing of traditional academic medical teaching. With almost seven hundred scientific publications to his credit, Gilbert-Dreyfus was what the French call "*un grand patron*," a big boss, of endocrinology.

In his inaugural professorial address, he looked back at the camps "from which no one was meant to return" and where "we lived lives whose unreality is beyond the limits of the intelligible." Yet this was where Gilbert-Dreyfus also learned that "courage, loyalty and solidarity are worth more than many a dialectical subtlety" — perhaps a reference to his former Communist infatuation. He also learned there that a doctor could effect cures with no medicine beyond his own energy and ideals. Gilbert-Dreyfus then asked his audience to observe a minute of silence "in memory of my exterminated comrades: over 200,000 out of 230,000 deported" and, before his surviving comrades from Mauthausen and Ebensee present for the occasion, he swore an oath "to never forget those who died there so that France could live" (address given 4 May 1959 and published in *La Presse médicale* on 6 June 1959).

While this address made only passing mention of his postwar work with Charles Richet, Henri Desoille, and Wetterwald, we saw above in the 1948 article co-authored with Richet and others something of Gilbert-Dreyfus's endocrinological contribution to understanding physiological states of misery.

Of the remaining members of the somatological group who worked on the pathology of deportation into the mid-1950s, such as Uzan (mentioned above) or Antoine Mans, little is known about their careers, in part because their names tended to appear mainly as collaborators on articles and books. For instance, Desoille edited a special issue of *Le Médecin français* on the deportation camps in April 1949; in March 1961, by now a medical professor, he gave the opening address at the Third FIR Medical Congress on the theme of asthaenia and premature senescence among former deportees and resistants (see FNDIRP archives, conference proceedings). In 1947, Wetterwald published an article in *Praxis*, a Swiss journal, on medicine in the concentration camps; it was mainly descriptive and contrasting SS "medical" practices with the (understandably) limited role of prisoner-doctors (at least those who were so disposed) in helping their fellow internees (Wetterwald 1947). We will return below to Dr. Louis Fichez (whose work at the FNDIRP clinic was mentioned in the previous chapter) and his major contribution as organizing secretary of the scientific congresses of the International Federation of Resistants (FIR).

The work of the somatologists to the late 1940s demonstrated a growing network within medical specializations seeking to understand the somatic effects of deportation and their impact upon bodily systems. Interestingly, however, their research subjects were predominantly former political and resistant deportees; indeed, there is no mention *whatsoever* of Jewish deportees, despite the fact that Gilbert-Dreyfus was himself Jewish. Wetterwald's 1947 article noted simply that "the Israelite sick" were treated *apart* from the rest of the camp population, in their own facilities where medication was even less available than for the "Aryan" deportees (11). In other words, the somatologists formed a network that focused on *certain* deportation effects and acknowledging only *certain categories of deportees*. This was due to their medical training as well as to the postwar politics of organized Resistance groups in France (as also throughout much of Europe).

If the "somatologists" blithely ignored that there might be a "Jewish" quotient of camp returnees, it nevertheless seemed clear, both from post-

war accounts by surviving Jews and from captured Nazi documentation about the Final Solution to the Jewish Question that the largest single statistical category of those murdered in the camps were Jews. Inevitably, then, this rather significant aspect, sooner or later, would become the object of attention.

As we have seen repeatedly in France, the Jewishness of the deported and exterminated was for decades (doubly) obscured by the romanticized mythology of the Resistance, as well as within shamed silences about the national humiliation of the 1940 defeat and Occupation, and the subsequent struggle for the liberation of France from both the Nazi Occupier and the collaborationist government at Vichy. In all of this, the tiny numbers of Jewish deportees who returned from the camps were easy to ignore, left to their own fate and resources: subsumed by or, at best, readily absorbed into Resistance and post-Resistance internal political rivalries.

In terms of French medical thought—in this case, in the context of the clinic of trauma—there is a tendency, as Berthomé remarks, to "confer to an ensemble of subjective sufferings a unified form together with a univocal signification" (1997, 263–64). In this sense, to be fair to the somatologists, the very idea that there could be something "Jewish" about a tableau of symptoms was utterly absurd.

However, the somatologists were not the only medical practitioners interested in surviving victims of the concentration camps. Another group in France would pose a considerable challenge to the somatological approach.

The "Halakhists," 1936–1948

Those I term here "the halakhists" were a group of Jewish scholars from a variety of medical disciplines who formed a scientific society in 1936 devoted to the history of Jewish medicine. Among the society's board members were Dr. Isidore Simon, the long-serving—and indeed sole—editor of the society's journal from 1948 to 1985; his thesis supervisor Maxime Laignel-Lavastine, professor of the history of medicine at the Medical Faculty of the University of Paris; Drs. Eugène Minkowski, L. Fildemann, L. Pérel, and others from a number of countries, including the United States (Harry Friedenwald) and from Palestine (Professor Reichertz); as well as Dr. Henri Baruk, head of the National Asylum at Charenton.[7]

At the first conference of the Société d'histoire de la médecine hébraïque (SHMH), Minkowski gave a paper on Freud, "*médicin juif*," his life and work on the occasion of Freud's eightieth birthday. Other papers were presented on what would be consistent themes of SHMH's subsequent journal over the decades: the role of Jewish doctors in the founding of French medical schools; nervous and mental illness in biblical, Talmudic, and rabbinical perspectives; Maimonides and medicine; Spinoza and medicine; and so on. The SHMH pursued its activities until the declaration of war in 1939. Simon was mobilized and then demobilized in July 1940, after France's surrender. He moved to the southern non-occupied zone, served in the "*maquis*" (underground) in the Cantal region, and then as part of the Repatriation medical service until July 1945. He returned to Paris and established himself as a psychiatrist.

In June 1947, the SHMH resumed its activity under the presidency of Henri Baruk, and in June 1948, Simon brought out the first issue of the *Revue d'histoire de la médecine hébraïque* (hereafter RHMH).[8] Since the RHMH will be the principal site for the elaboration of the "halakhist" perspective, I return to its contents below. For now, as was done with the somatologists, it will be sufficient to provide some background on the principal protagonists, although Minkowski's work will be discussed separately, in part because of some of its differing emphases, but also because his was a transitional position in the shift from neuropsychiatry to existential psychiatry in the slow transition toward psychoanalysis. Generally, though, it is worth noting that the somatologists and the halakhists are not equivalent. Even if the former were politically on the fringes of the medical establishment, they were still very much part of it. The halakhists were definitely not part of the medical establishment, although Baruk was the closest to it as head psychiatrist at Charenton. After all, they were just Jews and, for the most part, East European Jews, having received Talmudic educations before their medical or academic training in France. And furthermore, they wanted to reform, not to say revolutionize, medical history, training, and ethics, and from a Jewish perspective. But in the context of this study, they provide an indispensable example of how Holocaust survival affected Jewish medical practitioners.

ISIDORE SIMON (1906–1985)

Simon's lifework was editing the *Revue d'histoire de la médecine hébraïque*, which literally died with him on 17 September 1985. During this remark-

able editorship, Simon's tireless energy enabled him to recruit authors from around the world and maintain links with researchers from his native Romania and elsewhere, as well as faithfully reflecting the Renaissance of Jewish thought in many fields that emerged with the founding of the State of Israel. Born in Bala, Transylvania, on 5 November 1906, Simon arrived in Paris to pursue medical studies at the age of twenty, already equipped with a classical Jewish education. Recall that until the arrival of the Nazis, Eastern Europe contained numerous major centers of Jewish culture of formidable intellectual richness (see, for example, Judith Friedlander's discussion of this generally and in particular of the influence of Lithuanian Judaism on contemporary French thought, in her 1990 *Vilna on the Seine*). Simon undertook his medical dissertation under the supervision of Professor Laignel-Lavastine (1875–1953) on "Assaph ha-Yehudi — doctor and astrologer of the Middle Ages, with a study on medical thought in the Bible and the Talmud." As a young medical practitioner, Simon thereafter continued his work in medical history and especially in the development of the concept of "Hebraic" — in other words, Jewish — medicine, a concept that Freudenthal and Kottek claim that he invented (2003, xii), a remark that calls for more elaboration than I can provide.

In addition to editing the RHMH, Simon taught under the auspices of Laignel-Lavastine's chair in the history of medicine, supervising over one hundred medical theses. He also taught at the University Centre for Jewish Studies, then at the Centre Paul Broca in Paris, one of a number of such institutions subsequently founded for teaching and research in Jewish history and culture. He was a founder and the first secretary-general of the Mogen David Adom, the Israeli equivalent of the Red Cross. Simon was also involved in the creation of Jewish sport associations and secretary-general of the French section of the Friends of Hebrew University in Jerusalem.[9]

As we saw with the somatologists in the 1920s and thereafter, Simon and the other "halakhists" were at the center of a parallel, but specifically Jewish, intellectual ferment in the mid- to late 1940s, which gained institutional density with the founding of the State of Israel's emerging medical and educational institutions. Here, too, new fields of knowledge and further study of history of medicine emerged, along with new possibilities for knowledge exchange among Jewish doctors. Over all this, however, hung the great dark shadow of the "catastrophe" of the extermination of European Jews.

MARK DWORZECKI (1908–1975)

Due to the vicissitudes of transliteration, Dworzecki's name could be spelled any number of ways; the French spelled it Marc Dvorjetski; he himself kept the Marc or Mark first name in his publications in French or English, but for a while changed his first name to Meir when he ran for the Third Israeli Knesset in the 1950s. However one spells his name, Dworzecki (the version that seems to have lasted longest) came to the attention of the RHMH group when he arrived in Paris to study soon after the war. He rapidly gained a reputation in medical circles for "a brilliant Sorbonne thesis," as Baruk recalled in his autobiography (1976, 178), published in 1950 under the title *Ghetto à l'Est*. Active among former deportees while studying in Paris, by the time the first issue of the RHMH came out in June 1948, Dworzecki was one of its first and most long-standing contributors, with a rousing three-page call for "anathema against criminal Nazi science" (1948, 60–63). There, Dworzecki wrote presciently that "the world still does not know what happened in the more than 1,000 concentration camps in Poland nor the innumerable ghettos and extermination camps of Lithuania, Latvia, Estonia, the Ukraine, White Russia, and other occupied countries" (61). But one thing was clear: "the Hitlerite doctors had transformed the *opus divinum* into an *opus satanium*" (62), and so he called for the creation of a new medical ethic ("*une morale médicale*"). His one-line bio with the article described him as a member of the Jewish Medical Association of Palestine; he had moved there in the interim.

Dworzecki's postwar life seems to have been completely entwined with understanding the Holocaust, in which field he was consistently a pioneering figure, and not much else is known about his earlier biography. Most likely a Lithuanian Jew, he already held a medical degree from Vilna. Surviving the Vilna ghetto as well as various concentration camps in Estonia, he somehow got to Paris thereafter. Equally active after among former deportees in the new State of Israel—where one in four new immigrants were camp survivors—as early as 1949 Dworzecki approached the Hebrew University with a proposal to establish an Institute for Research of the History of the Jewish People during the Holocaust. However, the state of Holocaust research in Israeli universities was minimal at the time, some claimed because of the upheavals of the War of Independence, and did not get off to more than a slow start until after the creation of Yad Vashem in 1953.[10] Moreover, Dworzecki's 1949 proposal was viewed with suspicion by faculty members because he was not an accredited historian. This situation

in Israel did not change much until the 1960s, despite important efforts by other researchers.

Dworzecki himself was tireless in his efforts to establish a research chair, meanwhile teaching Holocaust studies temporarily at Tel-Aviv and Bar-Ilan, and social studies at Hebrew University. With the establishment of Bar-Ilan University in 1955, Dworzecki lobbied extensively among politicians, university heads, and other public figures for a professorial position. Finally, in the 1959–1960 academic year, Bar-Ilan established for him a Chair in Holocaust Studies — not only the first such chair *in the world*, but likely the only one ever funded by survivor organizations. As Professor Boaz Cohen writes in a twenty-year survey of Holocaust teaching and research in Israel from 1947 to 1967, for Dworzecki, "Holocaust research was a sacred mission and a calling" (B. Cohen 2004). As long as Holocaust survivors were alive, Dworzecki asserted, research of the Jewish history of the Holocaust era was fundamental to current Jewish life.

Dworzecki's scientific work on the pathology of famine in the ghettos (1954) or on the pathology of deportation and pathological sequelae (1956), for instance, is not without resemblance to the findings of the somatologists, although he is specifically reporting on the effects of famine among ghetto Jews. In general, Dworzecki argued that both the method of constraint and the health conditions of the Eastern ghettos were simply dress-rehearsals for similar methods and pathologies that would reappear in the concentration camps. For instance, the "use" of uncontrolled illness and epidemics to exterminate ghetto populations (although not necessarily a deliberate tactic in the camps, as the SS were terrified of epidemics, and many quicker methods to exterminate Jews were available in the camps); the appearance within the ghettos of AKS (Allgemeine Korporschwach or general bodily breakdown), prolonged severe malnutrition resulting in the barely living who had crossed over into walking death (those who in the camps were termed Musselmänner, the so-called Muslims); stunning rates of amenorrhea of up to 80 percent among women *as of the first day in the ghetto*; sickness caused by lice; oedemas or inflammation of the hands, feet, joints, and face; urinary and intestinal problems; tuberculosis; infantile struma, or hyperatrophy of the thyroid affecting over 75 percent of children.

In discussing the Vilna ghetto, Dworzecki mentioned the 120 Jewish doctors there, of whom he was one, and "their training as intellectuals raised in the traditions of social medicine," their acceptance that they would die in the common tragedy, as well as their consistently high scientific levels

of competence (1954, 260). He himself displayed this competence in his analysis of the Warsaw ghetto's shrinking caloric components that demonstrated clearly that the population would have died of famine within a short period in any case, had it not been for Nazi eagerness to "cleanse" Eastern Europe of all Jews by deporting them to the death camps. The Warsaw ghetto's Jewish doctors kept very careful records—of clinical, pathological, histological, chemical, biological, and hematological examinations—of patients admitted to the one Jewish hospital as a result of famine. These records were collected as *The Illness of Famine* (*La Maladie de la Famine*) edited by Dr. Israel Maleikovski, who described the work in its preface as "the unfinished symphony of a Jewish doctor in 1942." Maleikovski was deported from the ghetto in 1943. The book was later found in the ghetto's ruins and published after the war in Polish and in French (see Apfelbaum 1946).

Here I want to turn to a paper of Dworzecki's on the pathology of deportation and its sequelae, given at the Third World Congress of Jewish Doctors in Haifa in 1955 and published in the RHMH in March 1956. While it takes us a little ahead of our present time-frame, Dworzecki there made a very interesting move: In a word, he provided *a different genealogy* of the concept of pathology of deportation, by that time widely accepted among European scientific circles, as we shall see below. Dworzecki agreed that because of the war, famine, suffering, and the psychic toll of deportation to ghettos and camps, "a new science" had been created: the pathology of deportation or, as he put it, of "the pathology of the epoch of the catastrophe."

Dworzecki situated the scientific origins of the study of the pathology of the catastrophe in the medical practices of the Vilna ghetto's Jewish doctors, who met weekly to discuss manifestations of any new pathology presenting under ghetto conditions and to seek practical means to combat these.[11] Transcripts of these meetings, statistical data, conference papers, and other essays summarizing the findings were–amazingly, given the conditions of the ghetto and its liquidation—found in the ghetto ruins at war's end. Copies of these were placed in the various Jewish documentation centers established throughout Europe (from Amsterdam to Warsaw) at the time—and in the French Contemporary Jewish Documentation Center, established as was seen above during the war itself. (Similar records were also found at Theresienstadt, and similarly preserved.) Dworzecki made the key point about the Vilna doctors' practice of noting the immunological responses of patients, their biological *and psychic* capacity for resistance in both body *and soul*, adding that this practice was approached on a far

greater scale than usual medical observation (Dworzecki 1956, 32, emphases added). He also observed that the Warsaw ghetto medical records published as *La Maladie de la Famine* reached conclusions that "the medical world would find surprising": for instance, that, despite the general famine, there were no signs of classical avitaminosis. This was because the Vilna doctors had observed the lack of iron and vitamins B and D in the rations and had somehow managed, often at great risk, to procure illegal supplies, but apparently enough to make a difference.

More bluntly, Dworzecki wrote—in what some might see as medical *chutzpah*, but is rather a stark illustration of the various, rarely contiguous, cultural-linguistic poles in Holocaust research—"Separated from each other by thousands of kilometers, but everywhere [throughout the ghetto and camp system], it was Jewish doctors who began the [first] research on 'the pathology of the concentrationary universe'" (33). While Dworzecki recognized that it was not only Jewish former deportee doctors (especially in France, but also in Holland, Belgium, and Denmark) who had developed perspectives on the pathology of deportation, he added: "For us Jews, the notion of pathology of the years of the catastrophe is much larger than that of the pathology of deportation, in the same sense that the book of Jewish suffering is also much larger" (33). Dworzecki further remarked that—and it is an entire research program he was presenting here—"we want to include here all the pathological phenomena that manifested themselves among deportees, whether in the ghettos, in the Nazi concentration camps, in non-Nazi labor camps, among those who fled into the forests and became partisans, as well as those who managed to live [through the war] under false identities among the Aryan population" (33).

Dworzecki's paper sharply defined the *key distinctions* between the somatological approach and that of the "halakhists": If the science was largely similar, the approach to medicine was significantly different in that drawing from the Jewish tradition provided a much broader timeline, included in its scope both body and soul, was more preventative than interventionist, and finally reflected a medical ethic that not only applied to the Holocaust (in terms of Nazi medical experimentation), but also that was sorely lacking in "Gentile" medicine, to put it this way—or so the "halakhists" argued.[12]

HENRI BARUK (1897–1998)

Depending upon whom you read—or more likely speak to, as they are less willing to say so in print—Henri Baruk was either one of the most impor-

tant French psychiatrists of the twentieth century or something of a crank, a not very serious if tireless dabbler in far too many matters.[13] The man was certainly indefatigable. Baruk lived to be one hundred, and published many books, ranging from massive treatises to short, classic works of scientific vulgarization, as well as an autobiography in 1976 after he had retired as a practicing neuropsychiatrist, and he continued his ceaseless activity for another quarter-century thereafter.[14] However you look at it, the man was a phenomenon.

To the extent that his life and career was coterminous with that of twentieth-century French psychiatry, I will confine myself here to the postwar period of his involvement with the RHMH and the burgeoning psychiatric institutions of the State of Israel. But it is important to note for the record that there was not a domain of psychiatry in which Baruk was not significantly involved, from infantile psychiatry to gerontology (in which he was a pioneer, opening at Charenton in 1955 one of the first services in psychiatric gerontology). In the psychiatry of adults, according to the celebrations of Baruk's life and career at one hundred published in the *Annales médico-psychologiques*, "he deepened prolonged clinical observation, psychophysiopathology, diagnostics, prognostics, aetiological therapeutics, forensic psychiatry, pedagogy and professional training in medical ethics"—and this is just the short list (see Biéder 1998). Baruk was thoroughly steeped in the work of the great figures of early nineteenth-century French psychiatry such as Pinel (1745–1826), but especially Esquirol (1772–1840)—Pinel's favorite student whose life and religious devotion inspired Baruk to begin careful reading of the Bible (see below)—and, of course, later in the century, Jean-Martin Charcot, under whom he had worked on aspects of hysteria. In the twentieth century, Baruk admired the work of Pierre Janet, Maurice de Clérambault, and his other teachers in neuropsychiatry (Souques, Chauffard, and Klippel).[15] Like them all, Baruk was clinician, generalist, psychiatrist, physiologist, and philosopher. In 1931, after interning at Sainte-Anne Hospital, Baruk was named head psychiatrist at the Charenton Asylum, where he remained until 1968, combining his administrative and clinical work there, from the late 1940s, with teaching neuropsychiatry as a professor at the University of Paris.

In the late 1930s, Baruk began reading the Talmud and related rabbinical texts, learning Hebrew with a certain "Mr Kontoryski," a former Ukrainian yeshiva teacher who had moved to Paris. Baruk wrote that he wanted to learn Hebrew because of its correspondences "with my therapeutic method

founded on [the ideas] of peace, justice, and certain Psalms" (1976, 171). He would also write in a 1939 article in *Evolution psychiatrique*, the journal founded in the mid-1920s by Minkowski and others, that "the study of the biblical traditions are the best preface to understanding human nature, its aspirations, passions and weaknesses" (quoted in Biéder 1998, 127).

Given Baruk's extensive involvement with the RHMH, the psychic condition of former deportees that would continue to preoccupy him at least until the 1967 Six Day War, his many trips to Israel, and his attempts to apply Talmudic and Kabbalistic concepts to psychological testing—notably, his so-called "Tsedek test" (1947), measuring a person's capacity for just actions, that earned Baruk if not scorn, at least plenty of snickering from the profession—the irony is that he was not Jewish himself, although his wife Suzanne was.[16] Rather like the reverse of the case of the Dresden philologist and wartime diarist Viktor Klemperer, whose marriage to an Aryan saved him from deportation, Baruk's unclear Jewish status probably helped save his wife from persecution. As he once said of Esquirol, Baruk too can perhaps be considered "one of the Just."

As we'll shortly look at Baruk's political interventions at the growing networks of medical congresses that, from the late 1940s, turned increasingly to the pathology of deportation, I'll conclude this biographical overview of the leading halakhists with a discussion of one of Baruk's reports from the first issue of the RHMH entitled "Hygiene and Hebraic medicine in Palestine" (1948).

One of the central questions that obsessed the RHMH, and the one taken up here by Baruk, was "Does a Hebraic medicine exist?" ("*Existe-t-il une médecine hébraïque?*"). The question opened what was really a travel report on kibbutzim and early psychiatric facilities. Baruk noted that "certain of our colleagues, even Jews . . . especially Jews, have asked us this question with a lot of doubt and a certain apprehension. They say in effect that medicine is one and that it is regrettable to make such particular distinctions" (42–43).

Baruk went on to observe that the question of "Jewish" medicine—I find the term "Hebraic" medicine so awkward and archaic that I won't use it further—was tied to the existence of a "Jewish people" that had managed (in spite of recent events) to maintain itself in various countries, and to sustain a Jewish philosophy that now in particular needed to achieve a greater awareness of itself. The "resurrection" (Baruk's word) of Palestine and the return to the Holy Land of an important Jewish population posed

the issue of the Jewish people's reconstitution, with the equivalent forging of the living kernel of Jewish civilization, part of which included its medical traditions.

Baruk wrote that what was striking about Jewish social hygiene, or for that matter humoral medicine, was the lack of separation between the bodily and the psychological, although in modern medicine the psychological was still a very recent domain of scientific knowledge.[17] Moses himself, Baruk claimed, had introduced key psychological ideas regarding dreams, the subconscious, creative inspiration, even the sexual life, all of these long ignored by medical thought, and only recently (if partially) taken up by Freud.[18] Baruk then went on to list a number of discoveries attributable to Jewish doctors, past and recent: circulation of the blood (Hayem); sexuality (Erlich); the unconscious (Freud); psychosynthetics (Goldstein); Gestaltpsychologie (no person's name is given here); and the inferiority complex (Adler). More pointedly, Baruk wrote that

> the psychological theme has always been a very highly developed one in the traditions of Jewish medicine and it is probable that properly moral or ethical questions will now be the object of new studies. While modern medicine is more and more driven by pure technology and risks forgetting its human dimensions, the old Jewish medical tradition, preserved in the subconscious, now resurges to rebalance technical progress through renewed attention to psychological notions and the synthetic understanding of the human person. The development of psychology is [utterly] characteristic of such trends. (47)

In its own way, this was as much a research program as that presented by Dworzecki with respect to a broader conception of the pathology of the catastrophe, although Baruk's was perhaps even more ambitious—nothing less than a rewriting of the Western medical tradition, and seemingly of a good part of the Jewish tradition as well.[19] This idea turns on how one understands the meaning of the term "*halakah*."

Needless to say, the term is a highly complex one to which I can provide only the briefest discussion. For one, it "stands *sometimes* for the whole legal part of Jewish tradition, in contradistinction to the Haggadah, comprising thus the whole civil law and ritual law of rabbinical literature and extending also to all the usages, customs, ordinances, and decrees *for which there is no authority in the Scriptures*" (Jacobs 1904, 163, emphases added). In Jacob Neusner's formulation, the halakah (or Halakhah) stands for "the

normative law" of the Oral Torah as the principal medium by which the rabbinic sages set forth their message (2002, 74). As Neusner further notes, the halakah "takes place in a timeless world, establishing patterns of conduct and public behavior that transcend circumstance and locality" (viii). It serves "as the means for the translation of theological conviction into social policy" (10). Given the recognition of a world ruled by gentile power (but not gentile hegemony), this at the same time is a formidable statement of Israel's freedom to make choices in ordinary life (12).[20]

Thus, one can understand more readily the "halakah" as a total ethic of the norms of conduct entailed in being a Jew and so, if one is a doctor, of an ethics of medical practice. The "halakhists" who concern us here wanted an expanded meaning of the halakhic to a wider sense that would permit both a re-view of the history of medicine in which the importance of the Jewish contribution was far more present than previously acknowledged, as well as a new medical ethics that would make it — ideally — impossible for doctors ever again to be participants in the kinds of experimentation on human beings that took place in the Nazi camps. Making at least the *beginnings* of such a contribution — however hesitantly and unevenly — was the mission that the RHMH set for itself during its almost forty-year history. As no doubt Baruk did too in his even longer life, although it is not certain, despite his voluminous writings, whether he ever succeeded in producing a total psychology of the human person. Or for that matter, whether "the experimental moral psychology" that he began writing about in the mid-1940s was in fact possible within the psychiatric field. Not for nothing did Biéder remark that Baruk, with his love for the work of Spinoza, opted for "a monistic conception of man" (1998, 127) in his philosophical work. In other words, that Jewish thought understands the human person as an inextricably spiritual if embodied entity. According to Biéder, the Hebrew word for the body (*gouf*) does not even appear in the Talmud.

Because the RHMH drew upon many collaborators, these are too numerous to mention, as we did with the somatologists under the rubric of lesser collaborators. However, one might point to the work of Dr. Louis Copelman, like Isidore Simon, a Romanian native and psychiatrist who alternated between teaching at the University of Bucharest and in Paris. Copelman contributed various articles to the RHMH on new research on the pathology of deportation (see, 1950; and 1962, a special issue on concentrationary life). We now turn to the broader stage of international scientific congresses in which the halakhists and somatologists would not so much

clash as hold parallel conversations, often in different sites of scientific dissemination. The key reason for doing so is to provide a sense of the comparative contexts that French Holocaust survival research encountered as it came into contact with different medical cultures.

International Congresses on the Pathology of Deportation and Related Issues, 1946–1952

The first discussion of the psychological and psychological consequences of the war and Nazism to take place outside of France most likely was in a report on that topic presented by Eugène Minkowski at the 1946 meeting in Basel of the Swiss Psychiatric Society, but not published until 1948. Subtitled "general aspects of the problem," Minkowski's report began by commenting upon the catastrophic geographic upheavals that resulted from the war, the dispersion of peoples, the so-called DPs (displaced persons), the repatriation of prisoners from camps all over Europe, as well as the return of the deportees from various European sites. Moving from the geographical breakdown of frontiers to the related breakdown of *psychological* frontiers, Minkowski pondered whether the existing conceptions provided by psychiatry and psychopathology were adequate to grasp the new facts of post-Holocaust psychological existence. These included the Nazi "systems of destruction" based on "the unlimited rationalization" of racial hatred, and the damage these may have irreversibly caused to an anthropology of humankind. For example, Minkowski noted that while one could perhaps speak of the resulting "trauma," this was a new form of traumatization "so extravagant that we are left dumb before it" (1948, 283). Not only had "civilization" suffered an extraordinary moral abasement, but related ideas about the individual and his/her social and emotional connectedness no longer appeared to hold true either. Here, Minkowski drew on his teacher Eugen Bleuler's notion of "affective anesthesia," a numbing of the person and extended this idea to the contemporary world, to many aspects of collective life, and now empty notions of personal or inner "intimacy." Death, especially as witnessed in the concentration camps, had also become meaningless: "there are no dead any more, only cadavers" (296). Minkowski added in a later article that in such context, not only had the degradation of death reached its "ultimate degree," but this was also the utter degradation of life itself (1948, 82–98). While the 1946 paper was reflective of Minkowski's own "existential" psychology, it clearly also illustrated some of the power-

ful emotional aftershocks of "the catastrophe," still resonating strongly, here among a gathering of psychiatrists. At the same time and however speculatively so, Minkowski's paper offered an early instance of the possible, unprecedented extent of the catastrophe.

In 1947, the first World Medical Congress was held in Paris, and in 1948 a Congress of General and Comparative Pathology.[21] Other than brief mention of both congresses in *Revue d'histoire de la médecine hébraïque* 7 (1950), few details were given, and the site of the 1948 Congress was also not mentioned. However, the 1950 First World Congress of Psychiatry, in Paris, got much more coverage: for one, because Baruk presented a paper on German doctors and criminal medical experimentation; for another, this was the first postwar congress in which German psychiatrists would participate, arousing a great deal of trepidation. Some participants drafted an open letter to German psychiatrists reminding them "that for the first time [in history living] human beings were used as experimental animals" and that this unspeakable crime had left the world stunned by "the greatest drama in history" that took place in Germany (see full text in Baruk 1950d, 10–11). The non-German psychiatrists were looking for an apology of collective responsibility from their German colleagues, probably not realizing the very limited extent to which German psychiatry had been purged of former Nazis, nor indeed the tremendous conflicts brewing between opposing factions of psychiatrists within the soon-to-be Federal Republic. One instance, as late as 1985, occurred at the first International Psychoanalytic Association's conference to be held on German soil since 1933, when the American psychiatrist and former German Jewish refugee, W. G. Niederland, declared that a majority of medical evaluators involved in reparations payments to victims of Nazism were "former Nazis" (quoted in Pross 1998, 107). We'll return to this in the next chapter. Baruk had extensive correspondence with Professor Dr. (Med.) Dr. (Phil.) G. Mall at Tübingen University prior to the 1950 conference, negotiating the wording of a weak apology by German medical societies to be presented at an International Congress in Copenhagen scheduled for the year after (see Baruk 1950d, 13-21 plus appendices).

Baruk, as vice-president of the World Medical Congress, invited four hundred attendees and notables to Charenton on 24 September. There he spoke about Charenton's "glorious history" and in particular of the development of the "Esquirol School that opened the way to scientific and philanthropic psychiatry," going so far as to call Charenton "the Jerusalem of psychiatry" (Baruk, 1950d).

Acknowledging the presence of German participants in the first contact since the war and its terrible events, Baruk expressed "a certain malaise, not to say a veritable unease," that among the participants there might be doctors "who had collaborated with Nazi criminal medical experiments." He expressed the desire for a statement of collective responsibility, appealing—to the Germans as both a psychiatrist and as president of the Société d'histoire de la médecine hébraïque—to acknowledge the primary place of the Jewish people among the victims, and also "the millions of others of all religions." Baruk asked German psychiatrists for three things: a manifesto solemnly condemning these crimes; a religious or secular ceremony "purifying Germany of the traces of these crimes"; and active aid to the victims of Nazi persecution. How the audience responded was not mentioned, but in Baruk's correspondence with Mall, the response was lukewarm, at best. Mall wrote that he was not for solemn declarations and that "the [Nazi] epoch must be effaced not by words but by deeds," a statement that not only has a Nazi-like emphasis on the act ("*der Tat*"), but is also odd coming from a psychiatrist. (Baruk personally respected Mall for his nondoctrinaire approach to psychiatry.)

Perhaps because of these contentious questions of collective responsibility, it is not clear whether the conference planned for Copenhagen in 1951 took place or not. At least, I cannot find any confirmation of this in the RHMH or other sources. Certainly the first of the Fédération Internationale des Résistants conferences took place there in 1954.

For the halakhists and their parallel network of conferences, it is no doubt more significant to draw attention to the 1952 World Congress of Jewish Doctors, held in Jerusalem. The previous such congress had taken place in British-mandated Palestine in 1936. Between the 1950 Paris conference and the 1952 Jerusalem one, Baruk and RHMH collaborators Dworzecki, Simon, and others had been examining criminological, juridical, and forensic aspects of the Jewish tradition, for example, at a conference at the Sorbonne in May–June 1951. They sought to define the principles of a new medical ethic, debated the question of medical experimentation on animals and humans in medical history, notably as expressed in Claude Bernard's famous 1865 essay on experimental medicine, and, basing themselves on Nuremberg documents, attempted to frame an international convention forbidding the future participation of doctors in chemical, psychological and biological warfare (see RHMH 9–15, 1951–1952).

Delegates at the Jerusalem conference passed a series of resolutions summarizing these discussions and calling for a new international convention. The so-called "Jerusalem Declaration" reiterated the distinction that Baruk had presented to the French National Order of Doctors: that is, between "biological experimentation" (animals *only*, "sacrifice[d] . . . to science to better understand aetiological and physiopathological knowledge") and "therapeutic attempts" ("l'*essai thérapeutique*") involving interventions on human subjects for the *sole purpose* of saving life. The halakhists subsequently often referred to the "Jerusalem Declaration" in an unsuccessful attempt to make new international law.[22] In the long account that Simon wrote about the Congress (1952), he expressed the emotion, real and symbolic, felt by all those present at being in the Holy Land for the first time after two thousand years of exile. While the conference panels did not dwell specifically upon the Holocaust, a number of papers dealt with Israeli military medicine in the recent "War of Liberation"; and one specifically with the psychiatric problems of Israeli soldiers—namely, the surprising appearance of "shell shock" (see Müller 1952).

Baruk himself headed an impressive French delegation to the Congress and was appointed president of the France-Israel Medical Committee, affiliated with the French Association pour le développement des relations médicales (ADRM) established in 1920. Here we see another instance of the important role in medical knowledge transfer, especially in psychiatry, that the French halakhists brought to the new state. Indeed, the influence of the halakhists was decidedly greater upon nascent Israeli medical and psychiatric institutions than that of the somatologists, who were a more visible presence at the FIR conferences.

The FIR Medical and Scientific Conferences, 1951–1981

As its name suggests, the International Federation of Resistants (FIR in French; IFW in German) was an international federation of national political former Resistance fighters. Based in Vienna, it was viewed, particularly by the government of the Federal Republic of Germany, which later banned it, as Communist or at the very least "Communist infiltrated."[23] An undated seventy-page booklet published by the Federation in the 1980s looks back on the thirty years of conferences devoted to "medicine and social practices" that it sponsored. The booklet explains in German that "the initia-

tive [for the medical conferences] came from a group of French doctors notably Professor Charles Richet and Dr. Louis Fichez as well as Danish doctors associated with Dr. [Paul] Thygesen" (FIR 1960). This network of doctors was significant for a number of reasons. First, it was the first international encounter between the French somatologists and their Danish counterparts; second, Fichez sat on the FIR Medical Commission until at least 1979 if not longer, and discovered in himself tremendous "*apparatchik*" skills as organizing secretary of many congresses through the 1950s to the 1970s; third, Fichez translated into French Thygesen et al.'s 1952 study on "Famine Disease in German Concentration Camps."[24] Accordingly, the first FIR congress was held in Copenhagen in June 1954 on the pathology of deportation and its sequelae.

The FIR conferences were the first such conferences until about 1961. Pross (1998, Appendix C: Conferences on Persecution-Induced Health Damage, 219–21) lists fifteen others through 1985, held by different resistance organizations; three conferences from 1963 were held at Wayne State University in Detroit; and another in New York in 1965. The American gatherings were the first to take place outside Europe.

The FIR conferences were held in Moscow in 1957; in Brussels in 1958; in Liège in 1961; in the Hague in 1961; in Bucharest in 1964; in Paris in 1970; in Prague in 1976; in Warsaw in 1979; and in Berlin (DDR) in 1981—and their overall themes were fairly consistent.[25] For instance, the Moscow congress, co-sponsored by a research group from the World Federation of Neurology, looked at therapies and functional aspects of the restoration and rehabilitation of former resistants and deportees; the Bucharest conference dealt with the psychogenesis and therapy of the sequelae of deportation; and the Warsaw one with the fate of children in the Second World War.[26] On average, each conference drew about two hundred medical practitioners (from the various branches of internal medicine, neuropsychiatry, gerontology, and social readaptation) representing deportees from a dozen countries, and was open to a variety of perspectives in addition to the French "somatologists" (Richet, Fichez, and Targowla). Among the halakhists, Dworzecki, for instance, gave a paper at the Hague conference on the late sequelae of internment and deportation; and Louis Copelman spoke at the Liège conference on psychosomatic aspects of the pathology of deportation. (As far as I can tell, Baruk never participated, for reasons not known.) Many of the conference proceedings were published under the imprimatur

of the FIR.[27] Non-FIR conference proceedings were published in various medical journals.

Each FIR conference was an occasion to summarize continuing research on deportation pathology, its sequelae, and other aspects as discussed in the preceeding congress. Over time, the term "pathology of deportation," while still widely used, split into new formulations: The Scandinavians in the 1950s preferred the concept of "KZ Syndrome" (also sometimes KL for *KonzentrationsLager;* KZ is pronounced "ka-tzet"), as did the Poles in the 1960s, although not pleased at having to use German nomenclature. In 1964, the Wayne State conferences began referring to "post traumatic symptomatology." At the 1976 congress in Warsaw, Dr. Elie Cohen (whose work is discussed in the next section) used the term "post-concentration syndrome," which he subtitled "a disaster syndrome." The next chapter looks further at these and other later mutations, as the concept moved away from its initial relationship to the Nazi concentration camps to encompass far more general phenomena.

Meanwhile, the French somatologists hammered away with their findings. Fichez, for instance, in his opening speech to the Third FIR Congress at Liège, stated that FIR conferences so far had established two principal somatological findings: (1) the syndrome of chronic progressive asthaenia, and (2) the early ageing of the organism in the form of premature senescence. The symptoms, he went on, were now known; the aetiology was known; and there was one common cause—Richet's concept of "psychophysiological distress." That said, this did not mean that there was either unanimity or lack of vigorous discussions, dissension even (although the halakhic perspective was almost negligable). Targowla, for example, at the Hague congress, once again raised his doubts about the specificity of deportation pathology. Was it not, he asked, just a modified form of "prison psychosis"? He also went on to suggest that most of the "psychopathologies" probably would have organic origins that laboratory research would in time uncover. Targowla also remarked that the syndrome of premature senescence, rather than being an aspect of concentration camp survival, already could be found in Kraepelin's turn-of-the-century studies (Targowla 1950b, 228).[28] Here, Targowla returned to his previously formulated idea, based on his work with World War I veterans, that these were "subjective syndromes," but that could present "10–20 years later."

A very different point of view was argued by Professor P. Kluyskens of the

University of Ghent. Namely, the various studies and findings suggested that "post-concentrationary pathology revealed symptoms *previously unknown* to [medical] experts" (my emphasis) and, indeed, was one of the *least* explored domains of medicine. Kluyskens went on to express his own "certitude of a causal link between late-presenting symptoms and the period of concentration camp incarceration" (from the FNDIRP archives' conference proceedings).

Was the pathology of deportation in fact a pathology, or something else of a subjective nature? Could the source of its continued, prolonged destabilization of the lives of former deportees be identified within the body? The 1954 Copenhagen Congress, for instance, had opined that the definitive cause could be located in a dysfunction of the hypothalamus. This was a view once favored by Thygesen, among others, although by the Fifth Congress, in a paper that looked back at twenty-three years of survival research, he no longer believed this. But he had no doubt that "KZ syndrome was [by this time] internationally accepted" as a medical condition. By the early 1960s and the Hague Congress on late-presenting sequelae, a sufficient body of research had been amassed for Thygesen and Richet to establish a periodization of the work done so far.[29]

Richet, for instance, in his opening speech (and conceding Dworzecki's point that camp pathology was identical to that of the ghettos) distinguished four research phases. The first, from within the camps themselves, as observed by prisoner-doctors, cited mortality rates of 50 to 75 percent, as a result of death caused by dysentery, pneumonia, typhus, tuberculosis, and famine. A second phase, focused on Liberation and the year of the return home, found continued higher mortality rates among former deportees than among civilians, as well as late-presenting tuberculosis, and the lasting effects of denutrition. The findings of the third phase, from 1947 to 1955, Richet called early sequelae, where *all* bodily systems were affected: the heart, the digestive system, the circulatory system, as well as the psyche, with emerging psychological troubles. The fourth phase, post-1955, included *late-presenting* sequelae, "in which lesions appear up to 10 years after our return." Thus, for three principal reasons, Richet stated, the deportee was "*un éternael malade*"—forever ill: suffering, first, permanent fatigue; second, premature ageing; and, last, premature death. Noting that over half of former deportees showed neurological problems, he also commented on the growing attention by Norwegian and French researchers to "psychic and psychological" abnormalities.

Increasingly, then, by the 1960s, even in the largely somatological context of the FIR congresses, the attention given to the psychological and psychosomatic aspects of deportation pathology became more preponderant. In other words, it is beginning to move *away* from the neuropsychiatric, in part because of the latter's inability after some twenty years to definitively locate the pathology *within* the body.[30] While the research examined here never ventured into the still highly suspect realm of the psychoanalytical, by the 1970s, papers were presented on a new effect—the manifestation of psychological problems in the *second generation*, among children of Holocaust survivors. The fundamental problem was that of the ever-receding appearance of late-presenting sequelae: ten years, then twenty years, thirty-five years, and trans-generationally.

In the remaining part of this chapter, we try to get a better grasp of the transformations going on within the field of psychiatry in France since the war through a brief discussion of the work of Minkowski, but also comparatively in Scandinavia, in Poland, and in Israel.

Minkowski: Psychopathology in Psychiatry and Holocaust Research, 1952–1982

Eugène Minkowski (1885–1972) is no longer as well-known in France as he once was, although English-language sources consider him to be "one of the most original psychopathologists of the twentieth century" (Urfer 2001, 279). Born in St. Petersburg, although from a venerable Polish-Jewish family, he moved to France because of the Russian Revolution of 1905, and fought with distinction in the French army in 1915. Even so, he was never completely accepted within Parisian medical milieux: as a Russian, he was suspected of harboring Bolshevik sympathies; having studied in German-speaking Switzerland, he was seen by others as a Trotskyite (a radical Jew). Although he became a French citizen after the war and completed his *third* medical doctorate in 1926, he was never able to establish himself within leading French medical institutions. As we saw above, in the 1920s, he was the psychoanalytic consultant at Henri-Rousselle, moving on from there to different hospitals, such as the Rothschild. Someone once called him "the oldest intern in France" (Mahieu 2000). More importantly, another scholar remarked that his work represented everything that French psychiatry had repressed ("*le refoulé de la psychiatrie française*") (Thierry Trémine, quoted in Mahieu 2000, 13).

From its foundation in 1926, Minkowski was associated with the editorial group of *Evolution psychiatrique*, a journal that saw its role as advancing the state of French psychiatry. In many articles and books in the 1930s, his major contributions were in deepening the understanding of schizophrenia. During the war years, he and his wife, Françoise Minkowska (Trockman)—also a psychiatrist of note, especially for her work with traumatized children—refused to leave Paris and both wore their obligatory yellow stars, often hiding out at the Sainte-Anne medical library. They were almost arrested in 1943 when the Vichy police turned up at their apartment, escaping thanks to a friend. Both were closely involved with various Jewish organizations, especially the OSE, whose mission was to save Jewish children, managing to protect over two thousand children as well as many adults. As we saw, Minkowski was among the 1936 founders of the SHMH, which began to publish the RHMH in 1948.

Mahieu likens Minkowski's psychiatric work to those Russian dolls or *matryoshkas*, in which you open one only to find another inside and another inside that, and so on. So, obviously there are too many dimensions to Minkowski's thought to develop here. Therefore, I'm going to focus on a 1962 paper he gave in Jerusalem at a meeting of the Israeli medical association that discussed contemporary psychopathology. "Psychopathology" is a term I've already used in this book, but without going into its meaning—so what is it, and where does it fall within the realm of psychiatry?

Minkowski called it "psychology's little sister," in that psychopathology looked clinically at the various dysfunctions (hyper- and hypo-) of the "normal" functions recognized by psychological psychiatry: memory troubles, troubles of consciousness, perception, and judgment. Too tidy, all this, Minkowski remarked, and too neatly schematized. Clinical psychopathological observation had quickly enough seen that there was a difference between auditory and visual hallucinations, and even more variations with perceptual difficulties, not to mention such diagnostic concepts as paranoia, mania, or schizophrenia. These words covered a whole range of cases, each very different from another, as were "the underlying [mental] mechanisms" (Minkowski 1962, 176). It soon becomes clear that the "banal" categories of psychology, such as difficulties of judgment, didn't mean a lot when confronted with a case of delirium. Also, the "psychological" was based on a norm against which were established so-called "abnormal" symptoms: Once again, he felt this was too tidy and also too abstract, as clearly what was labeled "pathological" too often still contained a lot of

"normal." Indeed, the very idea of normal was rife with abnormalities (see Margree 2002 on the work of Georges Canguilhem; as well as Canguilhem 1991). As a result, given the general unhelpfulness of psychological categories, psychopathology had moved further away and established its own concepts and notions, as it became an increasingly autonomous field. For instance, as Minkowski's work had shown, the concept of "affective psychopathology" could be also analyzed by what he termed the "phenomeno-structural" approach.[31]

In the French psychiatric tradition, Minkowski stated, two paths led to the psychopathological. The first lay in Charcot's work on hysteria—or psychoneuroses as Minkowski put it more contemporaneously—where the former eventually gave up on a purely neurological explanation of the enormous varieties of hysteria, and concluded that the problem lay instead at the level of "the representation"—that is, an idea or interpretation of something by the patient. Extending this further led to the work of Babinski, Janet, and Freud.

The other approach to psychopathology came out of asylum psychiatry and focused on the equally grab-bag concept of "dementia praecox," premature dementia, and its causes. Roughly, the difference between the two approaches was that where the latter concentrated on the mechanical, organic causes of madness, the former—as Freud's 1885–1886 studies with Charcot made clear—uncovered, in the representation (or idea), affective and conflictual emotional factors that had been repressed.

There was a third approach, but it came from outside the French tradition and derived from the early work of Jung and especially Eugen Bleuler at the Burghölzli clinic in Switzerland, where Minkowski studied in 1911 and 1912. There, Jung in a small book on premature dementia in 1907, and Bleuler in his 1911 Treatise, produced a veritable revolution in academic psychiatry by foregrounding the concept of *affective content* as key to understanding both psychoses and schizophrenia—to the outrage of their fellow psychiatrists for whom these were "anti-university" (Minkowski 1962, 184), subversive and indeed "anti-intellectual" ideas. Which they were, and which caused Bleuler's career great harm, although he stuck to his guns regarding the importance of nonintellectual factors like emotion and affectivity in the interpretations of life given by patients and their sympathetic understanding by (some) psychiatrists. Minkowski claimed that the human being, here the doctor, always tried to seek "the human," whatever the phenomenon observed—psychoses, madness, autism, or schizophre-

nia. In such a perspective in psychiatry some have seen an old-fashioned "humanism"; others, the penetration into medical thought of the varieties of "existential philosophy" that too often confused content with processes; and others still, the sinister influence of "irrationalist" philosophers from Nietzsche to Bergson, and so on.

The main point here, however, is this: Minkowksi's work opened the way to a dimension of camp survivor understanding that until the 1950s had been virtually nonexistent in the medical literature; namely, how had survivors *themselves* experienced what they had gone through? Everybody, somatologists and halakhists alike, had been too busy either drawing spinal fluid, measuring glucose levels, or campaigning and reforming in the name of wider, albeit important, causes to bother asking survivors the simple, yet not so simple question: What did you experience *there*?[32]

The first to attempt to do so was the Dutch physician, Elie A. Cohen, in his 1952 medical thesis written after his return from Ebensee concentration camp and Auschwitz before that.[33] Cohen's *Human Behaviour in the Concentration Camp* was published in English translation by Jonathan Cape in London in 1954, and republished a number of times since. In his preface to the 1988 edition, not only did Cohen express his continued guilt at having chosen life, at the price of his own conscience, but he also said he had sought over the years since "many explanations about why I managed to survive the concentration camps" (E. Cohen 1988, xviii). The explanation that Cohen favored was "my egoism." At the same time, as one of the 1,052 survivor Dutch Jews who returned (of the some 60,000 deported), and whose numbers were "getting smaller and smaller . . . [w]e are irreplaceable eyewitnesses, passing away" (xx).

While Cohen was apologetic that he was only a physician and not a psychoanalyst, his references drew on a variety of medical, psychological, psychoanalytic, and other sources (e.g., Freud; the 1946 article by Minkowski; the 1946 and later work of Dutch psychoanalyst Eddie De Wind; French writer Jean Cayrol's 1948 article on dreams in the concentration camps, and others).[34] And while Cohen claimed that his "real aim" (xxii) was to find a psychological explanation for the behavior of the camp prisoners, he in fact took his own particular *affective experience* of Auschwitz as the starting point of his observations and reflections.

The first hundred pages of the book dealt with the organization of the camps, followed by a detailed description of camp medical conditions, as well as SS medical experiments on prisoners. Chapter 3 dealt with the psy-

chology of the prisoners. The fourth and longest chapter, curiously for this period (1952 to 1954), discussed the psychology of the SS.[35]

Or perhaps not so curiously in the sense that, for Cohen, the shock of prisoner arrival at the camp, almost from the first day, was so great that it produced, at least in some prisoners, what he called "acute depersonalization" (170). There is much technical discussion against De Wind's views on fright reactions; because something more was involved for Cohen. Acute depersonalization—or what Bettelheim termed "a subject-object split" (E. Cohen 1988, 118)—was attended by a disturbance of the affective reactions brought about by the repression of the emotions, paradoxically allowing the prisoner to find himself "in a more advantageous position than another who was passing through the apathetic or the euphoric phase" (171).[36] With his intellectual faculties unimpaired, Cohen felt he could assess the camp more precisely, draw accurate conclusions, learn to make himself inconspicuous, and observe the maltreatment of others "without compassion." One might say today that such a "fortunate" prisoner had become a sociopath. Cohen himself said that he remained skeptical about this; that acute depersonalization did not last more than several months, then disappeared, or became chronic. His skepticism was based on seeing affective displays between deportees if a long-lost friend arrived at the camp, as well as in the emotions always aroused in prisoners by the selections.

One key—but unclear—point in Cohen's analysis turned on the role of "repression": On the one hand, arrival at the camp *strengthened* the force of repression; but then, after enough time spent in the camps, repression seemed to be overridden, and behavior became determined mainly by instinct, and the life instinct in particular—to survive at all costs—driven most of all by hunger (164).[37] In other words, this is *regression* to a debased form of human life; a number, not a name; a digestive system in search of food. But this does not jibe with Cohen's insistence on the virtual disappearance of sexual life in the camps; if one has become little more than instinct, would not the sexual instincts proliferate also?[38] We'll come back shortly to this contentious point in discussing the work of Michael Pollak.

Centrally, Cohen restated the Bettelheimian argument about the more or less complete identification of most of the prisoners with the SS, "that only few escaped." This identification allowed Cohen to explain why, among Dutch deportees at least, there was no hatred of the SS, who appeared simply incomprehensible. Further, it also let him make the even more crucial

point that the Jews' identification with the SS was a version of "Jewish self-hatred" (189): the ultimate attempt to achieve complete assimilation with their oppressors—as it were, the *lived* form of the Final Solution to the Jewish Question.[39]

Such a line of argument is either pernicious or very subtle, especially as Cohen then went on to argue, based on Freud's group psychology, that since the prisoners did *not* form a group in Freud's sense (the surrender of the ego ideal to a love object, which as Cohen later discussed was precisely the case of the SS with respect to their leaders, Hitler in particular as the totemic father), the attempted complete assimilation can only fail. If it failed, and could only fail, the result—which is not a claim that Cohen made—would be shattering of the "survival" strategies of Jewish deportees at war's end, literally left with nothing, and having been stripped of all psychological defence mechanisms for an indeterminate period of time. In Freudian terms, no ego through loss of self; no superego through the failed attempt at assimilation; and so just id. While Cohen in his conclusion stressed that the human capacity for adaptation was much greater than previously thought, the real point he leaves us with is the reverse: less an analysis of "human behavior" in the camps than a *psychopathology of the Jewish survivor*. And as such, the first attempt to do so, even unwittingly.

By contrast, a later study also tried to explore the subjective experience of the concentration camps. And both were in this sense extensions of Minkowski's work in trying to grasp the affective tonality of the concentrationary experience. Michael Pollak's *L'expérience concentrationnaire* was first published in 1982 and republished in 2000. Subtitled an "Essay on the maintenance of social identity," it is above all the work of a sociologist, and thus strongly influenced by the "symbolic interactionism" approach in American sociology, especially the work of Erving Goffman on "total" institutions such as prisons and asylums (1961). Pollak's focus also reflected later developments in Holocaust studies, such as the analysis of the testimony of survivors, the silences in such testimonial accounts, and the puzzling work of memory with respect to past experience.

Confirming and/or contradicting Cohen's view, Pollak framed the concentrationary experience within the larger context of "extreme experiences" and considered their impact upon *identity* as self-image—with respect to both one's self and that of others. Pollack also looked at the nature of memories of the extreme. In so-called normal experience, common sense relieves persons of much existential worrying about their identity, although

social situations and differing social contexts (the large city, say) allow us to play various roles, using "masks," clothing, and so on, to display or conceal emotions. Manipulating what Goffman called "the presentation of self in everyday life" is the social game played by all, and its rules are reasonably clear. However, the sudden uprooting from ordinary life to be plunged into an extreme situation such as the concentration camps involved a loss of "logic" or common sense. Moreover, not just the lack of social rules, but also the arbitrariness of existence under "rules" so completely outside the bounds of normal experience as to be utterly incomprehensible created for survivors a double problem of identity maintenance. The question of *how*, after being torn from one's ordinary life, family, and social context, to survive such loss was often compounded in the new social context of the "absurd" concentrationary universe by the "impossible" choice between *bodily* integrity and *moral* integrity. How survivors dealt—immediately and subsequently—with this either/or and its lasting damage to both body and soul, Pollak argued, was what made survivor accounts not just factual accounts ("this happened or that happened") but valuable "instruments of identity reconstruction" (2000, 12). Yet, such identity reconstruction was also not without many problems that appear in analyzing *how* survivor accounts are told; what they concentrate on; what they leave out; what survivors *cannot* (either by self- or external censorship) or will not speak about, and so on.

Pollak focused on three of twenty lengthy interviews that he conducted with survivors: three women survivors from Auschwitz and then other camps in Western Europe: "Margareta" from Vienna; "Ruth" from Berlin; and "Myriam" from Paris. Myriam was a prisoner-doctor, which let Pollak observe—consistent with a similar observation made by Cohen—that, to the extent the SS doctors were willing, usually grudgingly, to extend some degree of professional respect to their fellow ("racially inferior") doctors, prisoner-doctors were among the privileged in the camps, relatively speaking (184).[40] Pollak noted that the prisoner-doctors' accounts tended to dwell upon whatever humanitarian actions they were able to accomplish in the camps, as a way of deflecting attention away from their relative privilege. Further, according to Pollack, accounts by former prisoner-doctors and nurses made up the *single* largest category of deportee survivor accounts. This observation speaks to both the relative ease of their living conditions and also to the fact that it was the "literate" survivors who wrote the first accounts of the concentration camp experience. In indirect contradiction of Cohen's claim that sexual instinct virtually disappeared in the camps,

Pollak's three female interviewees made it clear that sexuality in the camps was far more rampant than Cohen (and others of that time) believed. On the contrary, the realm of sexual ambiguity appears considerable, notably in Ruth's account. We are not talking about those deportees who served officially as camp prostitutes, but of relations between male guards and boys, female guards and women deportees, women deportees with each other: that is, considerable variation and degree of sexual activity. One suggestion about female homosexuality in recent scholarship is that it was less policed by the Nazis than male homosexuality (in the SS punishable by death—if caught).[41] The larger (and perhaps obvious) point here is that where there are human beings, however otherwise debased, there is sexuality.

Unlike Cohen's, Pollak's study did not pathologize his subjects. This reflects the turn against "pathologization" that took place in survivor studies in the 1990s. Pollak did write about "mutilated lives" (231), and did not by any means underplay the many hardships faced by his interviewees in adapting to post-camp life. However, Pollak's analysis of the narrative structures of his interviewees' accounts focused more on evaluating proportionalities. For example, he noted that about three-quarters of the narratives he looked at focused for 80 to 100 percent of their content on the camp experience alone, as if before and after had no importance.[42] Of course, these proportions vary, and in some case demonstrated the inverse: 20 percent on the camps and 80 percent on identity reconstruction. Pollak used the term "survivor syndrome," which was a later variant of "the pathology of deportation," "the KZ Syndrome," and related descriptors. More importantly, he wondered whether "the survivor syndrome" observed by many psychiatrists and psychoanalysts—his references are to work published in the 1970s and 1980s—was not, in fact, a projection by these medical professionals of their *own* unwillingness to listen—as well as the difficulty of survivors (or, for that matter, of most people) to speak candidly about the most horrible aspects of their lives (249).

The Scandinavian School of KZ Syndrome, 1952–1980

Why the Scandinavians (Danes and Norwegians) nominated as "KZ Syndrome" what the French termed the "pathology of deportation" is hard to say with certainty. As we have seen, the French term likely was prompted by their more inclusive understanding of "deportation" as standing for the experience of POWs, STOs, and Resistants, under the loose category of "de-

portees" that referred to all of the above—and only occasionally to Jews. For the lead Norwegian researcher, Leo Eitinger, an Auschwitz survivor, the KZ (*Konzentrationslager*) was precisely *where* and *what* the former deportees had been—"kazetniks" in concentration camps.[43] Berthomé observed that the first official medical usage of the term "KZ Syndrome" was at the FIR conference in Copenhagen in 1954 (1997, 267–69), although he found very little difference between Danish work and Norwegian studies.

Eitinger (1963) remarked that Norwegians were deported to Germany mainly for printing secret newspapers, trying to join the Allies, or helping Jews escape to Sweden—but he provided no further data. Other Norwegians, considered less dangerous by the Occupier, were imprisoned in concentration camps in Norway. Of the 1,200 Jews in Norway before the war, about 500 escaped to Sweden; the rest were deported—twelve survived. The Norwegian resistants deported to Germany were released *before* the end of the war, brought back to Sweden, and returned to Norway after Liberation, where they were welcomed as heroes. This meant that, for the most part, they picked up their lives "almost as though nothing had happened" (60), and did not find in the immediate aftermath the adjustment difficulties and self-reproaches described among other Jewish ex-inmates (or not until the mid-1950s and the appearance of sequelae).

Eitinger ascribed the lack of attention to symptoms in part to immediate postwar euphoria but, more importantly, to medical ignorance. "Doctors in our normal and well-organized society had never had the opportunity to see and examine *resurrected corpses*," and moreover had no idea of the circumstances of concentration camp existence (60, my emphasis). In 1957, the Norwegian Association of Disabled War Veterans asked a group of physicians to examine former deportees and veterans still—up to twelve years later—unable to readapt to a normal life; and whose "breakdowns were becoming more frequent as time passed." Furthermore, considerable diagnostic controversy existed among doctors that had affected the attribution of disability pensions. By 1961, a Norwegian team (headed by Professor Axel Ström of the Neurological Department of the University Hospital in Oslo) had examined 500 patients and published data on them.

Eitinger's paper reported on the first 131 former deportees. Of these, over 70 percent presented with more than seven of the ten symptoms of "neurastheniform concentration camp syndrome" as defined by Thygesen at al. (1952). This syndrome "appears in most cases to be the result of organic changes in the brain . . . that seem to have originated after . . . concentration

camp internment as a multiple trauma caused by mechanical and toxic injuries as well as . . . by starvation and exhaustion" (Eitinger 1963, 63). Among the psychiatric symptoms was depression—"total, existential depression" since Liberation—as well as anxiety syndrome persisting for more than *fifteen* years in otherwise psychiatrically healthy persons (stable individuals, fisherman and farmers) who had not been able to work through the horror of their wartime experiences. This led Eitinger back to the always thorny problem of causality in psychiatry—for instance, "premorbid personality predisposition" before the war (ruled out); Kraepelin's "endogenous psychoses" (ruled out); Freud's emphasis on disturbing childhood experiences (also ruled out). "It is thus much more the war experiences than the experiencing personality which seems to be the decisive factor."(65).

Targowla (1954b) had some concerns with the psychiatric and neuropsychiatric work of Danish researchers, particularly Thygesen et al.'s massive 1952 study—over 450 pages long in its original journal supplement form—while considering it "an important study." In a word, the Danish study was not sufficiently clinical; for example, the psychiatric discussion was based on a mere fifty-two individual examinations. And the usual professional and national jealousies cropped up; Targowla frankly preferred his own concept of "emotional paroxystic hypermnesia syndrome" to the Danes' "neurastheniform syndrome," and he also got in a few plugs for the work of Richet et al. (1948). He complained that the study's otherwise important bibliography did not contain enough references to current French work on the sequelae of deportation. However, this criticism was more than just academic pettiness; the inclusion of those references, he felt, would have emphasized further the "striking concordances" between the research being conducted in the two countries.

Above all, Targowla was suspicious of the Danish study's methodology, with its heavy emphasis on statistical data and tables worked up from the questionnaire respondants' material. He wondered about the resulting precision, and whether what the study demonstrated was not, in the end, "more mathematical than real" (Targowla 1954b, 612). This is by no means a minor matter. Indeed, it has implications for all studies, medical and otherwise, that rely on statistically derived portrayals of supposedly real phenomena.

Thygesen addressed this very question in a 1980 paper reviewing Danish work on "the concentration camp syndrome" since 1947 and 1948, when he

and others began examining all surviving Danish former camp prisoners living in Copenhagen.

The discussion came up because, by the 1980s, some psychiatrists drawing from recent political events in Latin America and elsewhere where torture was widely used on opponents, real or imagined, had begun to speak of "a torture syndrome." This gave Thygesen his opening; namely, that "a syndrome" was "a specific unified corpus of sequelae," which is not the case with torture. However, it was the case with concentration camp syndrome, in part "out of respect for history and . . . with the place(s) where the syndrome originated" (Thygesen 1980, 224). Even if concentration camp syndrome by then was listed by the World Health Organization as a "recognized disease," the more important observation that Thygesen made is that "*[i]t took 10 years to establish the existence of the syndrome and another 15 to describe details of the picture — and the job is not yet finished*" after twenty-five years (224; my emphasis).

This was also to say that the work of identifying KZ Syndrome took place within a context of social and other conditions that influenced both the findings and how these were categorized and treated. "We needed a *specifying* term which would denote — as we later discovered — often disabling deterioration of health" (224, emphasis in the original). One of the imperative reasons for the creation of the term was not only to help rehabilitate victims' health, but also as a concept for qualifying under compensation laws.

Thygesen was quite open about how the characteristics of KZ Syndrome also reflected the medical orientation used. In the early 1950s, those methods were primarily neurological and neuropsychiatric. The use of gastrointestinal methods, he remarked, would have yielded "a different kind of concentration camp syndrome." And a more "psychodynamic or psychosomatic approach" would have drawn attention to still *different* aspects of the syndrome. It's a lot like Minkowski's Russian dolls.

Most important of all, Thygesen remarked, in order to help the victims of the camps with compensation, the research findings had to *conform* to existing theories at the time about disability. The work had to meet both "the objectivity requirements of scientific method" (as then understood) and "the socalled medical basis for claimed disability" — in other words, the KZ Syndrome had to be shown to be "biological" (224).

Now this is not to say that Thygesen and his colleagues made up their

findings. As he recalled, their very first examinations in the late 1940s "hinted at a biological cause—something which *perhaps* was irreversible but exact knowledge of which was lacking" (224; his emphasis). But then one doesn't go before a pension disability board and say, "well, perhaps," or "the evidence hints at such a result."

In fact, Thygesen's candor here is more revealing of how science really works, as many other authors have shown. It's the whole problem of evidence, whether in medicine, law, or another research domain: How "solid" is it, or rather how persuasive can it be made to appear? Science requires the additional burden of the replication of results, and clearly, in France, in Scandinavia, and as we shall see, elsewhere, European medical researchers were finding the same results among concentration camp survivors.

Finally, on the Scandinavian School, Jean-Marc Berthomé makes the highly interesting observation that, however "scientistic" it may been with its statistics, tables, histological graphs, and so forth, there was something "democratic" about its overall findings (Berthomé 2002, 268). First, there was no doubt about the origin of KZ Syndrome and where the ultimate source of the evil lay: in the barbarity of the Nazi concentration camps. But this is an ethical point. Second, medically, the metaphor of a sick nervous system caused by the consequences of hunger was also a further way of distancing the Scandinavian medical discourse from the social practices of a state (the National Socialist state) so utterly foreign to their own. Third, as Eitinger's (nonetheless controversial) comparative work (1964a) on Norwegian and Israeli former deportees showed, the results were the same: namely, that anyone, or rather any organism, will succumb to the same degree to the only truly objective causal factor—prolonged somatic degradation. "In a word, that we are equal before the worst, the worst being designated here under the general rubric of deportation" (Berthomé 2002, 269).

Polish Perspectives on KZ Syndrome, 1945–1961

A number of writers have commented that Polish medical studies on concentration camp syndrome "took a fundamentally different approach from American and German studies" (Pross 1988, 91). Leaving American approaches for the next chapter, certainly the German literature clearly reflected the work of the researchers we have encountered so far, the somatologists far more than the halakhists. The Polish literature, while not

unaware of, say, Targowla, did constitute a unique corpus of its own, however. The so-called Krakow School around Antoni Kepinski, Stanislaw Klodinski, and others, many of whom were former Auschwitz deportees, had set up a treatment and rehabilitation center for survivors after 1945. The members of the Krakow School published in the long-standing journal *Przeglad Lekarski* (Medical Review) that first appeared in that city in 1862 and has published ever since, with some interruptions such as revolution, wars, and Nazi occupation.[44] Since 1961, the journal has published an annual supplement devoted to the experiences and consequences of the Nazi concentration camps. At the Warsaw Congress of the FIR in 1979, editor Dr. Josef Bogusz presented a paper on the work of the *Przeglad Lekarski-Oswiecim* supplements since the 1960s; to date, twenty-six volumes have been published (over six thousand pages).

Pross is among the strongest of non-Polish writers to stress what makes the Krakow School unique in its approach. First, that survivors' suffering could not be approached through conventional medical concepts. At the same time, the school also rejected psychiatric as well as psychoanalytical perspectives, preferring to focus on "the analysis of the subjective experiences and the statements of the individual patients" as Kepinski put it (quoted in Pross 1988, 91–92). For Kepinski, the usual approaches to KZ Syndrome were based on an overly rigid separation of psychological and physical factors; on the contrary, they were "firmly linked," so much so that if somatic phenomena produced psychological sequelae, this also worked the other way, with somatic damage resulting from psychological tensions.

For his part, Klodinski importantly remarked that one of the crucial traits that distinguished Polish research was "that it is not linked to pension claims, which often distort the results" and, as we have just seen, subordinate the complexity of phenomena to statistical reductionism (quoted in Pross 1988, 92).

This picture of the Krakow School, however, appears less radically different when approached from within the school itself; here the work of Zdzislaw Ryn, a member of the second generation of researchers. In his "Evolution of Mental Disturbances in the Concentration Camp Syndrome (KZ-Syndrom)," he opened with the observation that "direct contact with former inmates of concentration is . . . a strange and unique experience"—although, he adds, "from a psychiatric point of view." The ex-prisoners were themselves aware that "their psyche is peculiarly different"

(Ryn 1990, 23). He quoted Kepinski's remark that their "otherness" is revealed when they talked about the camps, from which they could not free themselves, either from its endless circles of terror and debasement, or from their experience of acts "of kindness and noblemindedness." The prisoners remained a puzzle to themselves, as much as to the mystery of human beings. As Ryn put it,

> The stamp left by experiencing camp stresses seems to be something permanent or even progressive, in the physical and . . . psychic spheres. The stigma . . . of the concentration camp has been transferred to the second or even third generation. . . . It has become fixated in the population that suffered in the . . . camps and the war. It is . . . a process lasting in time and extending beyond the individual life. . . . It displays a dynamic of its own . . . and is subject to evolution. (24)

The complexity of post–concentration camp effects was reflected abundantly in the world clinical literature, and the various terminology used over the years, from "asthenia progressiva gravis" (Targowla) through KZ Syndrome, "a foreign-sounding expression" but one commonly used. Here Ryn appealed to linguists to help come up with a better term. While Targowla's was close to "the essence" of the disease, it was not ideal. No one term was, really, given the variety of etiological factors and its nosological (diagnostic classification) "uniqueness," although the fact of the disease itself "is today undisputed."

And while there was little question as to the biological effects, the psychic and psychosomatic effects are more complex, because the trauma of the camp experience was "a shock unparalleled in [the] previous experience" of the deportees: the resulting borderline blurring between reality and unreality; mental depression as complete breakdown and prostration; and deep changes in personality structure and values (24–25). Above all, although deportees' injuries and somatic complaints healed, "in their psyches the reality of the concentration camp [has] remained alive" some fifty years later when Ryn was writing, making former deportees' subsequent view of the world and emotional ties stamped for the rest of their lives with the camp's "inhuman habits and stereotypes of behavior" (25).

Since the beginning, research on the medical consequences had been plagued with numerous difficulties that have only "increased with the passage of time." He identified three of these lasting — still unresolved — prob-

lems: (1) the *causal relationship* between illnesses suffered in the camps and present-day states of health; (2) the influence of concentration camp disease on the etiology of subsequent diseases, such as sclerosis, premature aging, and mental disorders; and (3) what he termed "the greatest controversy," namely, the absence of temporal continuity between trauma in the camp and the onset of a disease (25–26). Ryn went so far as to question what was ultimately *the* basic problem: Should a causal relationship be *assumed* between late-appearing effects and incarceration? But, having raised the question, he did not probe it further, and so it remained an assumption, although "there is no doubt that the concentration camp disease will persist in the generations to come" (33).

A third researcher, Barbara Engelking of the Polish Academy of Science in Warsaw, in her 2001 book *Holocaust and Memory*, reflected the turn to the analysis of survivors' personal narratives that we encountered with Pollak's study. While recognizing "the enormous contribution" of the Krakow School (255), she had a number of problems with their work. For one, she questioned the representativity of their research sampling based on volunteers' answers to questionnaires, as opposed to random surveys, as well as the lack of control groups. For another, she considered that social science research instead of medical research was perhaps a better method for dealing with the problems of Holocaust survival.[45] Third and finally, Engelking observed that Polish research, as indeed Western research generally, had focused too much on the pathology of camp experiences and so only on the negative, dysfunctional aspects. And yes, it was "possible to be happy" (258) even after the experience of the camps.

The Israeli Holocaust Problem and Early Research, 1948–1969

Leo Eitinger had remarked that it was "regrettable that . . . Israeli psychiatrists have been so preoccupied with . . . practical work that they have not had the opportunity to work through the large material at their disposal . . . . Until now only case reports and scattered surveys have been published" on concentration camp survival (1964a, 30–31). By "practical work," he meant setting up the infrastructure of hospitals, clinics, research facilities, and other institutions in the medical field that came with the creation of the state, and, as we saw, with which technology transfer in psychiatry the

French halakhists especially were closely involved (for instance, the Baruk psychiatric institute at Tel Hashomer Hospital of the University of Tel-Aviv, and elsewhere).

For the new country, a quarter of whose population were Holocaust survivors, it is possibly an incredible irony—or not? Should Israelis have been different from other nationalities?—that the *sabras*, the Jews born in Palestine before 1948, had a lot of problems with survivors. The damaged "human material" that arrived from European DP camps clashed profoundly with their own self-image as heroic farmer-fighters. Here too, there were all the macabre jokes about the *saponim*—Hebrew for "the soap people"—and the widespread myth that the Nazis had used the fat of burned Jews to create low-quality soap for military and civilian use. The general response to the newcomers, who admittedly came with a lot of psychological baggage, was not all that different from the French response to deportee Jews. Most Israelis did not want to hear about what the deportees had been through "over there" in the Diaspora. And so the best thing was to just shut up and somehow try to put your life together again. This sweeping under the carpet of the Holocaust problem was, of course, definitively shattered in Israeli public opinion by the 1961 trial of Adolf Eichmann. By the same decade, if not occasionally earlier, Israeli psychiatrists were also giving serious, sustained attention to the psychopathological effects of Nazi persecution. A related irony, but not one significantly different from the uses of military psychiatry in the European context, was that, as early as the War of Independence (1948–1949) and the wars of the 1960s and 1970s, a phenomenon surfaced in some ways even more shocking than Holocaust survival; namely, that Israeli soldiers suffered from mental breakdown in battle! (see Müller 1952; Palgi 1963, 1973; Dasberg 1976).

In certain ways, the work of Israeli psychiatrists with survivors, to which Eitinger was also a contributor between 1962 and the end of that decade, was not all that different from the findings we have discussed above. The psychiatric pathology from a ten-year study (1952–1962) of several hundred survivors found that, compared to the common psychiatric illnesses of hospitalized patients, German concentration camp survivors presented a clinical syndrome "not amenable to classification according to the accepted psychiatric nosological entities" (Nathan, Eitinger, and Winnik 1963).[46] The pathology was chronic, there were no psychotic symptoms; but instead fatigue and depression; anxiety manifestations; nervousness and hypersensitivity; social maladjustment and withdrawal from everyday life. The

syndrome was independent of previous personality patterns, significantly related to the specific experience of war, but, unlike other studies elsewhere, there was no evidence of "organic etiology" (113).

Not being tied down as much as some of the Europeans to the organicist aspects meant that Israeli psychiatrists turned to psychoanalytic explorations much sooner, by about the late 1960s.

This was especially the case with the work of Heinrich Zvi Winnik (1902–1982), a pioneer of Israeli Holocaust research and a president of the Israeli Psychoanalytic Society, founded in 1933 as the Palestine Psychoanalytic Society. Winnik was born in Bukovina, studied in Vienna, Prague, Breslau, Chemnitz, and Berlin, where he was senior physician of neurology at the Lankwitz Hospital until 1933. With the Nazi takeover, he fled to Vienna and then Bucharest after the 1938 Anschluss, escaping to Palestine in 1942, where his family also managed to join him. He was one of the first Israeli researchers to make contact with other researchers such as Eitinger in Norway, in Holland, and later in the United States (see Hertz 1993).

Like Richet, who tried to find in various larger fields and ultimately in gerontology, where exactly to locate his psychophysiology of distress, Winnik spent the decade 1969 to 1979 trying to make something of the new if short-lived science of victimology, invented in 1949 by the French psychoanalyst B. Mendelsohn, as a domain in criminology and applied psychology.

Here, however, I want to look briefly at a 1969 paper of Winnik's entitled "Second Thoughts about 'Psychic Trauma.'" I mention this paper in part because of the importance that American research would give to the concept of trauma from the late 1950s on. Winnik's main argument was that trauma, defined as an emotional shock that makes a lasting impression on the unconscious mind, had to be distinguished as an *event* and as an *experience*. As an event, which was how the concept had been used historically, trauma was seen as an external factor, an injury or an accident, that provoked abrupt changes to which the organism could not adapt; basically a form of extreme stimulus. As an experience, however (that is, in the context of psychic disturbances), it was Freud who had borrowed the term from somatic medicine and transposed it to psychic states, stressing that "Trauma cannot be assessed in terms of an external event alone" (quoted in Winnik 1969, 83). For Freud, one of the psychic planes of the ego consisted of "a stimulus barrier," or protective shield strong enough to resist many excessive forms of stimuli, but "trauma" was a psychic force strong enough to break through the barrier. For example, in another writer's usage, trauma

was "an eruption of the death instinct" (84). More importantly, a British psychoanalyst writing in 1950 had used the concept of trauma in a discussion of war neuroses and concentration camp survivors to ask what exactly this "stimulus barrier" consisted of. And why did it suddenly collapse, even long years after the initial occurrence of the stimulus? The questions, Winnik noted, were especially significant in understanding why a morbid recurrence ensues in the concentration camp syndrome when a patient could be seemingly healthy for many years, turning abruptly into "the most difficult traumatic experience"? Winnik believed that Freud's writings could provide an answer to these questions. Later and later sequelae—up to forty years later, and then skipping generations—would be one of the central concerns of Israeli Holocaust research.

Early on in his paper, Winnik noted that the Neuropsychiatric Society's focus on the concept of trauma was no accident, and in fact "may be conditioned by the incessant threat to the security of our country" (82). Furthermore, he remarked that the very concept was perhaps deeply entangled with Jewish and Israeli history, a history that had to endure and overcome "so many traumatic" experiences. This too would concern later Israeli research.

As we end the chapter with a brief look at early Israeli studies, what we have covered in the pages above has been the dissemination and displacement of ideas around the pathology of deportation throughout Europe. In France first, where as Richet remarked in the third edition of his and Mans' *La Pathologie de la déportation*, "the French School had largely played the leading role," adding that "the Anglo-Saxon world" had yet to show much interest (1962, 34). But, as we saw, French approaches split unevenly between a widespread somatological emphasis and a minority Jewish ethical re-examination of the history of Western medicine. Both perspectives then sought to link up through international conferences with fellow researchers in other countries; the somatologists far more successfully so, in part for political (Resistance) reasons, but also because of a shared approach to medical training, with various differing emphases here and there. The halakhists, so to speak, lost their struggle to influence the medical profession, with some exceptions in the Israeli context, and even there these were still exceptions. The importance of recovering their work here, however, adds yet another layer to the unknown history of Holocaust survival research. We can speak, then, to some extent, of a postwar phase of displacement in that *Europeanization* brought with it specific refinements, as well as

lasting questions, to the understanding of the sequelae of deportation. The Europeanization of the KZ syndrome, as it were, skipped across the Mediterranean to grow somewhat different roots in Israeli soil, such as a greater reliance on psychoanalytical approaches.

Why this latter move did not occur in France, as well as affecting the ways in which U.S. Holocaust researchers turned the question of survival into a dimension of the larger problems of modernity, is the subject of the next chapter.