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Holocaust Traumatology in Australia

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This essay is a personal perspective of the history of views on Holocaust trauma in Australia. It looks at attitudes to psychological consequences to the traumatic events of the Holocaust from soon after the war to the present day. It discusses the contribution of Holocaust traumatology to traumatology generally, as well as Holocaust traumatology's dilemmas and potentials.

In 1942, at the age of 4, in the middle of the night my parents and I crossed the border illegally from Slovakia to Hungary. In Slovakia persecution of Jews had reached the stage of deportations to Auschwitz. Hungary was relatively safe. For three years we lived in open hiding, that is, as Aryans, except for three months of separation when my parents were caught and returned to Slovakia. Luckily they escaped and we returned to open hiding in Budapest. Hunger and bombing stressed me less than three years of fear of discovery.

After the war we returned to Slovakia, and in 1949 when I was 11 years old we arrived in Australia. I did well at school, graduated in medicine, specialised in psychiatry, and developed special interests in insight psychotherapy, liaison psychiatry in emergency departments and traumatology.

In retrospect, the Holocaust shaped my professional life. My

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propensity to delve into the mind, unearth traumas and their ripples, and to search for universal answers rather than simplistic models stemmed from suppressed activity and an overactive child mind that tried to unravel the breadth and depth of what was going on and tried to work out how to stop it.

Yet, amazingly, it was only in 1989 at a trauma conference, that Sarah Moskowitz, co-discoverer of child survivors, discovered me as a child survivor of the Holocaust.¹ That label acted like a diagnosis that lifted the lid on feelings and symptoms that had lain below words and awareness. I wanted others to have the opportunity to feel such liberation. That year I founded the Child Survivors of the Holocaust Group in Melbourne, and co-founded the Australasian Society for Traumatic Stress Studies. I was president of that association in 2000 when it hosted the third world conference of the International Society for Traumatic Stress Studies in Melbourne.

My (re)discovery of myself allowed me to integrate my Holocaust past and my earlier explorations of disaster situations.² For instance, I came to realise to what extent moral judgements (guilt, shame, justice), dignity, and above all meaning and purpose were important to traumatised individuals.³ It is from this perspective that I have viewed the contribution of Holocaust trauma to the nascent science of traumatology – that is, the scientific study of psychosocial trauma and the treatment of its consequences.

In fact the Holocaust has contributed tremendously to traumatology; it was one of the seminal sources in its development. The tale has been told widely, from many angles, and in detail for 70 years by educated people. As well, and unusually, Holocaust trauma has been documented and confirmed by unusually pedantic perpetrators.

Early Years

Australian and especially Melbourne Jewry have been pervaded by Holocaust trauma and there was no shortage of survivor traumas to try to understand. Holocaust survivors who migrated to Australia, as those who migrated to other countries, had few resources. They concentrated on making the most of the opportunities their new countries offered in the years after the war. They worked extremely

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hard, married and had children.⁴ They tried to push away their memories, yet when alone or in company with fellow survivors, they were immersed in their wartime experiences. Certainly from a later perspective their thoughts, fantasies, nightmares, panic attacks, uncontrolled emotions and physical symptoms indicated post-traumatic consequences of major proportions.⁵

However, survivors were adamant that they were not psychiatrically ill. They knew that they were suffering, but they saw that as normal. To not be disturbed after what they had undergone and the losses they had incurred – that they would have considered as abnormal, even callous, and dishonourable to the memory of those who had perished. Only physical symptoms were allowable and doctor attendances among survivors were high.

I found similar attitudes much later among survivors of the Cambodian genocide, and the Vietnamese and Bosnian upheavals. Just like Holocaust survivors, these survivors stayed in survivor modes directed at building up security and education for their children. They rejected psychological help. They were all afraid to be labelled mentally ill; that would have been an added stress for them.

Nor were survivors encouraged to see themselves as sick. Australians wanted survivors to leave the past behind and to get on with the future. A conspiracy of silence existed between immigrants and their hosts.⁶ Psychiatrists too at the time ignored Holocaust traumas or considered them too intense to treat. Nor was it obvious what could be treated and how. Overall, everyone knew about the Holocaust, the pictures from Bergen Belsen were still vivid. But as with trauma generally, memory of the Holocaust was avoided.

In retrospect trauma therapy was too immature to deal with Holocaust traumas. It was too close to view from outside, analyse and change perspectives on. Only a few psychoanalysts such as Anna Freud and Henry Krystal made fragmented observations on survivors.⁷ Even willing therapists were frustrated with survivors' insistence on only physical symptoms, their communication (typical of the traumatised, we now know) which had no narrative, and their uncooperativeness and mistrust of treatment (later realised to be transference responses).

Yet survivors were vulnerable. Eitinger found that they had higher morbidity and mortality rates than the local population, and my

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impression is that in Australia too, many survivors died at higher rates age for age than their Australian peers.⁸ Many died in their 50s, once they established security and gave up their survivor modes, that is, concentrating on increasing safety while suppressing memories and emotions.

1960–80

The first major challenge to the denial of psychological effects of the Holocaust both internationally and in Australia came in the early 1960s when the German government offered restitution to Holocaust survivors. Initially only physical symptoms clearly linked to specific Holocaust events were compensated. German psychiatrists resisted acknowledging psychiatric symptoms, saying they were due to pre-existing conditions. They were assisted by the absence of trauma-related diagnoses.

However, psychiatrists such as Niederland and Chodoff who examined survivors saw clear psychological consequences of Holocaust experiences and they believed that they should be compensated too.⁹

An anomaly quickly surfaced. Here was a population that had undergone the most severe hardships and afflictions, who suffered extreme psychological consequences as a result, but there was no label or diagnosis for those consequences. Trauma diagnoses were missing. The last trauma diagnosis, since forgotten, was combat exhaustion.¹⁰ It was used for Second World War soldiers and it was not appropriate for Holocaust survivors. The commonly used anxiety and depression diagnoses also did not capture the suffering of survivors. The black hole of Holocaust trauma cried out for recognition and words.

The first Holocaust trauma diagnosis was offered by Eitinger, a Norwegian psychiatrist and himself a survivor, who coined the term Concentration Camp Syndrome.¹¹ He said that extreme starvation affected the brain and caused symptoms similar to head injuries. Others, such as Niederland and Krystal, maintained that extreme psychological and emotional experiences without brain damage could cause intense psychological and social consequences.¹²

For instance, survivor guilt¹³ – first described in Holocaust

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survivors – was a psychological consequence of emotional experiences. Krystal and Niedeland coined the term Survivor Syndrome for these psychological consequences, which included survivor guilt, pervasive depressions, terror of repetition of traumas, withdrawal and emptiness of life.¹⁴ Psychiatrists came to claim that extreme events could produce such symptoms irrespective of previous personality.

In Australia a few psychiatrists were accredited to examine Holocaust survivors for restitution purposes. Herbert Bower and Fred Hocking were two who published their findings.¹⁵ Hocking claimed that irrespective of previous history, everybody was vulnerable and could break down if the stress was great enough. This became an accepted maxim in traumatology to this day.

In Australia as among Holocaust survivors in other countries, trauma was fragmented between a struggle for recognition driven by restitution issues, a desire to avoid the pain, and the lack of a conceptual framework to understand and treat Holocaust trauma and its consequences. I personally remember struggling with questions such as: What was there to treat, and how? Was it worth taking reluctant survivors back to their extreme traumas? Would they not be overwhelmed by them? Were they not too engraved to be undone? Were the wounds not too deep? Could they/should they be healed? Would healing them not affront the memory of the dead millions?

Early recognition of Holocaust trauma in the literature was driven by a splinter group of psychoanalysts.¹⁶ Mainstream psychoanalysis denied the importance of trauma since Freud changed his mind about the cause of neuroses. He came to deny his previous contention that they arose from sexual abuse of children.¹⁷ Rather, he claimed, neuroses were due to innate infantile perversions.¹⁸ As a result, most psychoanalysts ignored their clients' Holocaust traumas even over years of analysis and concentrated on early innate conflicts. This happened to me too.¹⁹ Reports on actual Holocaust trauma consequences did not translate into treatment of them.

1980–2000

The last two decades of the millennium were perhaps the golden age of recognition of Holocaust trauma. Survivors were approaching the

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ends of their lives and were prepared to tell their stories. More survivor testimonies, stories and articles were told and received in the last decade of the millennium than at any other time.

The early 1980s saw the discovery of psychological consequences of their parents' traumas in survivors' children. Helen Epstein in her book *Children of the Holocaust*,²⁰ and other clinical literature described the consequences on children of overt and covert parental perceptions of continuing Holocaust traumas, and the conflicting demands of bearing witness to the Holocaust yet at the same time providing innocence and normality to the children.²¹ Holocaust literature crystallised the now widely accepted concepts of the conspiracy of silence,²² transgenerational transmission of trauma,²³ and countertransference resistance to Holocaust trauma,²⁴ as well as other trauma recognition.²⁵

In the late 1980s Sarah Moskowitz and Judith Kestenberg discovered child survivors of the Holocaust.²⁶ These were children aged 15 or less in 1945. The children were used to being appendages of their parents' traumas, and accepted their parents' views: 'What would you know, you were only a child then', and 'You don't remember anything'. When Sarah Moskowitz discovered me at a conference I rejected her statement that I was a Holocaust survivor. 'My parents were', I said.

In 1985 Moskowitz was guest speaker at a Holocaust commemoration meeting in Sydney. This led to the establishment of the Sydney child survivor group. In 1989 I co-founded the Melbourne child survivor group. The stories of these groups are told in Kestenberg and Kahn's book *Children Surviving Persecution*.²⁷ Over the ensuing years the Melbourne group convened two international meetings attended by Moskowitz and Kestenberg respectively. Both groups are still going. Between them they have published three anthologies,²⁸ and many individual members have published their own stories.²⁹ Many individuals have been, and are still being, helped to write their stories by the Makor Library in Melbourne, a service started and shaped by Julie Meadows.

In 1991, 1,600 child survivors, including Australians, gathered in New York for their first international conference. Alongside Moskowitz, Kestenberg and Robert Krell, I represented Australia in the keynote presentations. More importantly, from whichever

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country we had arrived, we felt part of a 'new family'. We could exchange our stories freely for the first time. We understood each other. We found that our stories were of interest to the world at large.

Child survivors of the Holocaust contributed in special ways to traumatology. They contributed to the acceptance of the validity of memories of childhood trauma and how such memories could be suppressed.³⁰ Child survivors also contributed to understanding levels of awareness, that is, degrees of consciousness and unconsciousness in the mind generally.³¹ The literature on Holocaust trauma expanded exponentially in these two decades. By 1997, Krell and Sherman could publish a bibliographic review of Holocaust publications which contained 2,461 entries.³² In Australia survivor autobiographies were joined by second generation writers such as Arnold Zable, Mark Baker and Dianne Armstrong.³³ Ruth Wajnryb, in *The Silence*, examined the meaning of silence in her survivor parents, and the importance of silence in communication.³⁴ A Melbourne second generation group has produced comedies on intergenerational miscommunication.

Apart from Holocaust-related literature, 1980–2000 saw an efflorescence of traumatology generally. In the 1980s a trauma diagnosis was at last accepted back into psychiatry. Post-traumatic stress disorder (PTSD) was the result not only of Holocaust survivors' need for clinical trauma recognition, but also of other groups: Vietnam veterans, victims of rape and assault, sexually abused children, and torture victims.³⁵ Trauma societies were established around the world, the Australasian Society for Traumatic Stress Studies being among the first. The discipline of traumatology was born.

Australians were at the forefront of this movement. Beverley Raphael at Newcastle University had written books on bereavement and disasters.³⁶ Alexander McFarlane at Adelaide's Flinders University co-edited the first authoritative text in traumatology, and at one time was president of the International Society for Traumatic Stress Studies.³⁷ Torture and trauma centres were established in the major cities, and Melbourne established a centre for treating Vietnam veterans at the Austin hospital. Prince Henry's Hospital and Monash University in Melbourne were hubs of traumatology in Australia. Literature on disasters,³⁸ acute interventions,³⁹ compassion fatigue,⁴⁰ and texts on conceptualising trauma⁴¹ and its treatment,⁴² including of

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the Holocaust arose from there. In 2000 the International Society for Traumatic Stress Studies World Conference was held in Melbourne. In addition, veteran trauma centres and torture and trauma centres were established in Australian cities and acute trauma intervention in the form of debriefing became common. Trauma became part of everyday vocabulary.

Holocaust traumatology continued to be a seminal source of trauma knowledge. It remained a pillar of humanism as mainstream traumatology, in order to survive, became more 'scientific' (meaning reductionist, simplistic, measurable). Holocaust traumatology maintained the soul of traumatology as much mainstream trauma became a simplistic cognitive concept pruned of emotion such as guilt and grief. Mainstream traumatology had lost its soul. Trauma treatment was similarly simplistic: psychiatrists applied drugs, psychologists cognitive behaviour therapy (CBT).

In this atmosphere, the ever-expanding recognition of the ramifications of Holocaust trauma provided a fine balance to simplistic scientism. It was ridiculous to think that the wounds of Holocaust survivors and their children would be healed through tablets or a 10-session CBT package. Those dealing with sexually abused children and torture victims took up the cause. However their suggested diagnosis of complex PTSD has been rejected to this day.

In spite of the ferment and acceptance of trauma and its consequences in this period, ambivalence persisted to recognition of core traumatic wounds. Trauma treatment became a specialty among therapists. Similarly in the Holocaust field, Jewish care workers and nursing home staff learned to recognise special needs of Holocaust survivors, but not always. In the mental health field Holocaust trauma was accepted generally, but treated by perhaps only 10 per cent of practitioners. It became a specialty within a specialty.

Even in Holocaust families one could often hear children complain that they had given up trying to talk to their parents, who in turn complained that their children were not interested in their traumas. These parents denied that their children could have Holocaust related issues. 'Look at these young people going to therapists with their problems. We had worse problems and we did not need therapy. We got on with life.'

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Second and third generation survivors were much more ready to enter therapy. Many of them then researched aspects of the Holocaust that had touched them through their parents.

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Stark as the Holocaust was, its hidden depths have continued to be plumbed. Many workers have researched particular aspects of the Holocaust and its ripples. Australia contributed significantly to this literature. For instance, Konrad Kwiet and Jürgen Matthäus researched contemporary responses to the Holocaust in previously Nazi-occupied countries, while Paul Bartrop explored the history of Australian views;⁴³ Deborah Staines analysed the relationship of the Holocaust and the camera;⁴⁴ Valent examined the question of resilience;⁴⁵ Klein examined the objectivity of Holocaust testimonies and their effects on viewers;⁴⁶ Halasz examined the detail of eye and facial expressions as means of transgenerational transmission of trauma;⁴⁷ Valent speculated on how information in the right hemisphere of the brain of the parent is transmitted unconsciously to the right hemisphere of the brain of the child.⁴⁸

Transgenerational transmission of trauma, pioneered in Holocaust literature, has been applied in the Australian context especially in relation to the indigenous population, and especially in relation to forcefully removed children. The Human Rights and Equal Opportunity *Bringing Them Home* report (1997) documented how the trauma of forcefully removed children reverberated down the generations.⁴⁹ Interestingly, child survivors of the Holocaust had meetings with descendants of removed children and found much in common with them.

Considering the interest in transgenerational transmission of trauma, it is surprising how little intergenerational therapy of trauma has taken place. Perhaps unique in the world, transgenerational groups comprising three generations have met in different forums in Melbourne under the auspices of Tania Nahum. Many participants communicated transgenerationally for the first time and came to understand the other generations' concerns. Survivors' children expressed their resentment for their parents' denigration of their own 'insignificant' concerns, and requirements to be parents to their

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parents. In turn some survivors shared their traumas for the first time. That made their otherwise bizarre or non-feeling behaviour understandable. Empathy and compassion developed across the generations.

To this day survivors are 'coming out of their closets'. However, many have died without sharing their stories. Some have kept their religion and experiences hidden as the best way to survive and to protect their children, though some confided their origins near the end of their lives or left clues to their Jewishness after their deaths.

Australian survivor stories and traumatology literature closely resemble those of survivors in other western countries. Perhaps Australian Jewry is more close-knit and Holocaust-identified than others such as in the US where Jewish communities are larger and have relatively fewer survivors. In Israel survivors were recognised more slowly because the emphasis was on assertiveness, not 'going like lambs to the slaughter'. In Communist countries the Holocaust story was suppressed. Russian immigrants to Australia and to other countries are only now starting to tell their stories, compounds of Nazi and Communist atrocities.

In the last decade the world has perhaps become a little Holocaust-weary. At the same time, Holocaust denial and resurgent antisemitism have caused a rise in anxiety among many survivors across the world, but has also induced many to reveal their stories with an intensified determination to testify to the truth.

In Australia and other countries Holocaust clinicians and researchers have presented their findings to their professional and academic colleagues, but Holocaust trauma has become only one of several subspecialties in traumatology, both locally and overseas. Many original contributors have retired and new traumatic events have garnered interest. Besides, the widespread nature of Holocaust repercussions still does not sit well with PTSD. Yet Holocaust traumatology remains a seminal source of wisdom in traumatology, and is a constant reminder of what traumatology is about.

Holocaust Traumatology and Healing of Trauma

Most of the discussion so far has been about recognition of Holocaust trauma. Recognition however, is only the first step in

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healing. Holocaust traumatology has taught how recognition of trauma is difficult in all traumas. It taught that extreme meaningless suffering of any kind threatened to overwhelm not only survivors, but also anyone, including therapists, who might be immersed in survivors' traumas.⁵⁰

Holocaust traumatology exposed clearly the nature of core traumas: separations and immense losses; sense of abandonment and betrayal; guilt for not effecting the survival of spouses, children, parents and friends; shame for indignities and one's dehumanisation; anger with others who could have helped but did not. Further, exposure risks hurting those whom they love, and/or being further wounded if ignored and denied. For survivors to break the conspiracy of silence is risky. Holocaust traumatology has taught about resilience but also its costs. One survivor said, 'Well, I survived, and I am successful, so I am resilient. But I cannot love. Intellectually, I know that I love my family, but I can't feel it.'

Yet Holocaust traumatology has been a source of hope to traumatology in general. Learning that Holocaust trauma was human trauma and could be treated if one understood one's own responses, led to professionals being willing to reverberate with other survivors of major horrific events. Holocaust trauma taught that neither the extent of the trauma, nor the age of the survivor or the time that elapsed since the trauma were contraindications to therapy. In fact recognition could have immediate benefits. Many survivors were triggered into reliving past panics when admitted to hospitals and nursing homes. They saw their carers as Nazis, and syringes as murder weapons. Understanding by carers of survivors' past traumas helped them to help survivors to realign their perceptions of reality so that they came to trust their carers' motivations. A child survivor demanded love from her dying father. He confessed to her his lifelong remorse for having caused her mother's death and her own suffering by not taking them from Holland when he could. His confession led to a reconciliation of feelings that were cut off for decades due to the father's guilt.⁵¹

However recognition and healing can take a long time. A father blamed himself for the deaths of his children. He saw the new child as a memorial candle for them. When this child was boisterous or happy, she was punished. It took a long time for this child to

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recognise her father's perspective and to overcome her own ingrained responses. When she did it allowed her to love her father and to claim her own life.⁵²

Healing, or more likely partial healing, of Holocaust traumas occurred in hospitals, in peer groups, intergenerational groups and in therapy. In all cases Holocaust trauma healing contributed to recognition of general healing principles. These were first, recognition of survivors' wounds in sympathetic environments that provided respect, faith and hope. Next, reverberative sharing allowed emotional understanding of the wounds, judgements of them that included guilt, shame and injustice, as well as emotional understanding of the meanings of the wounds. The wounds were then recontextualized within history, up to the present. The process did not change the original events; it could nevertheless disinfect current joyful meanings that were infected by festering wounds from the past.

The principles of treatment of Holocaust trauma reminded professionals of the limits of drugs and simplistic cognitive behaviour therapy packages in treating complex traumas. Similarly, complex psychoanalysis of survivors even with sympathetic analysts may be insufficient because of the lack of recognition of core traumas and their radiations and lack of trauma treatment principles. Some analysts, such as Kestenberg, have tried to rectify this from within a discipline that still believed that neuroses stemmed from innate causes.⁵³

In summary, Holocaust traumatology has taught of the difficulties of trauma recognition and the depths and infectiousness of traumatic wounds. It has provided hope for all who suffer psychic wounds: 'If Holocaust trauma can be treated, all trauma can be treated.' Holocaust traumatology has helped to maintain the soul of traumatology. The dead were not diminished. But trauma was not allowed to infect new loves and more innocent victims.

The Wounds of Others

One reason why survivor stories were sought in the 1990s was because by then survivors 'had made it'; they were heroes, not victims; they taught from a basis in experience. In that sense they were inspiration to other traumatised people. Survivors wanted to

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help others. First, in Australia, as in other countries, survivors and their children were prominent in the helping professions and in human rights activities. Next, inadvertently perhaps, they contributed as we saw to understanding and healing the wounds of other traumatised people.

The ultimate desire that would provide meaning to the Holocaust was prevention of such events in the future. 'Don't forget us', cried the victims. 'We won't', and 'Never again', said survivors. But in spite of bearing witness to the Holocaust, genocides have happened subsequently. Yet this does not mean that Holocaust traumatology will not contribute to elimination of genocides in the future. Perhaps it required generations to pass to do so.

Yehuda Bauer said that alongside victims we need to study perpetrators and bystanders.⁵⁴ Victims have the power to draw attention, bear witness, recognise, document, alert and evoke healing. But unfortunately they cannot prevent recurrence of traumatic events. Exposure of evil, proof that it exists, does not eradicate it. For some, the study of perpetrators may be sensed as sacrilegious for it sees them as humans like ourselves and finding reasons for their actions may be seen to excuse them. Yet atrocities are part of human potential and can be understood, and the Holocaust has already contributed to such understanding. We must research perpetrators: what makes them what they are, what are the steps in violence, what influences, encourages and abets atrocities. For instance Lifton has studied Nazi doctors, and Browning described how ordinary Germans participated in mass shootings.⁵⁵ Political atrocities have been testified to in truth and reconciliation tribunals in South Africa and Rwanda, and meetings between children of victims of Nazi persecution and children of Nazi perpetrators have considered the redemption from evil over the generations.⁵⁶

The Holocaust, with ever more facts being available, is still a prime source of study of perpetrators and bystanders. Perhaps it falls on this generation to explore the Holocaust from this standpoint, and redeem some meaning from the Holocaust. The spur from Holocaust traumatology to study perpetrators as well as victims has influenced traumatology to expand its mandate too. For instance a recent international conference was devoted to the study of violence and cycles of violence across generations.

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Conclusion

Holocaust traumatology has been a constant reminder of how trauma radiates throughout the physical and spiritual human and others around them over indefinite time. Such a reminder discourages simplistic mindsets and emotionally detached therapies. Holocaust traumatology has indicated core traumas that need recognition and re-contextualisation in all trauma therapies, and has contributed to principles of achieving this.

Holocaust traumatology has applications in understanding and treatment for its own survivors and descendants, for victims of other genocides and their descendants, and for all trauma survivors. Holocaust traumatology has pointed the way to the study of perpetrators and bystanders. Akin to finding the germ of a disease and trying to understand its mode of action, traumatology must understand perpetrators and find ways of neutralising their noxiousness. There are still ever increasing depths of the Holocaust to be plumbed. We in Australia continue to do our part.

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