

The Children of Child Survivors

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"These images ... invade me in a suffocating way. Like in the morning when there are so many cars and exhaust fumes, I think: 'Don't breathe,' and I think that this is how they would gas people, re-directing the exhaust pipes into the trucks full of prisoners. My mother was almost gassed, you know. They dragged her to the showers, but found out they did not have enough Zyklon B. So they failed... another twist of fate! But I think about it... I think about it twenty times a day, a hundred times a day..."

Such intrusive images, Holocaust associations and panic attacks are common manifestations of post-traumatic stress disorders (PTSD) in survivors of the Holocaust. But these feelings were not expressed by the Holocaust survivor herself, but by her daughter (Gottschalk, 2000). She was reliving the Holocaust trauma of her mother on a daily basis, and was developing a full-blown anxiety disorder as a result. Even though she, herself, was born many years after the war, the terrible Holocaust experiences of her mother continued to haunt her more than half a century later. In fact, they had become such a major disturbing factor in her life that they were influencing not only herself, but also her relations with her husband and daughter. In a strange manner, the Holocaust was thus vicariously permeating the existence of the whole family. This is a good example of what has come to be known as the *transgenerational transmission of trauma* (Kellermann, 2001c).

It is a very common situation in Holocaust survivor families and it has been described in numerous publications for more than a quarter of a century. In fact, the professional literature on transgenerational transmission of Holocaust trauma has grown into a vast body of unique psychological knowledge with more than 400 publications (Kellermann, 2000).

Most accounts of such cases have described children of survivors born during the first decade after the 2nd World War, during the baby-boom years between 1946 and 1956. They were born to adult survivors who had lost their original families and who were eager to create new ones as fast as possible. However, many of the survivors who were children during the war (Child survivors = CS), created families (if at all) much later, and their children were usually born in the 1960s and later. For many years, these CSs remained almost forgotten and it is only during the last two decades that they have come into sharper relief as a special subgroup. Despite the fact that these younger 'Second Generation' (2G) of child survivors (2GCSs) have already reached middle age, they are still almost invisible and have only recently received any professional attention at all.

However, because of their experiences of having grown up with child survivor parents, they deserve our special professional attention. While they were born a long time after the war, they were born to 'orphan parents' who had lost their parents under terrible circumstances. We may therefore assume that some of these early survival experiences of the parents in some ways have influenced these 2GCSs. It would for example be interesting to investigate if there are any specific differences between 'ordinary' 2G and 2GCSs and if so, how they influence the functioning of the 2GCSs as parents to the third generation.

In order to try to answer this question, we will have to cover a vast area of research and summarize some of the earlier finding in this rather complex field. I will start by giving an overview of the CS syndrome and then briefly review the research on 2G. Much of this is a summary of earlier published material (Kellermann, 2001a, b, c, d).

Child Survivors

Naturally, children and adults experience war differently. Children are at the same time more vulnerable and more malleable than adults and they dealt with the extreme trauma of the Holocaust in a different manner.

In addition, the developing children were differently affected by the persecution trauma. Since they experienced the horrors of war at various stages of their cognitive, emotional and personal growth, they suffered different kinds of impairment and developmental arrest during the long years of confinement and/or family separation. Dasberg (2001) summarized the main impact on the development of the CSs: "1) A lack of functioning parents or caretakers, who are initially filled with fear and worry, then either disappear, die or may even return, although as changed persons, after liberation, and 2) being at the mercy of strangers in the Holocaust world and afterwards. The child survivors are both gravely deprived and, at the same time, traumatized children" (p. 22). In addition, they adopted a variety of different and extraordinary survival strategies in coping with extreme deprivation. It is therefore not surprising to find a somewhat complex post-traumatic clinical picture in survivors of the Holocaust who were less than 16 years old when the war ended. As expected, such early traumatization reverberates across the entire life span of the CS and many of the early strategies are maintained all through life.

Most obviously, CSs feel that they were prevented from having a normal childhood. As a result, there seems constantly to be an alter ego "child" within them that searches for (infantile) need satisfaction. Because of the circumstances in which they grew up, they became "little adults" with premature responsibilities. A female child survivor exclaimed: "I had no real childhood. As a child, I had to be an adult. It was dangerous to be a child. I had to hide the child within me and pretend to be someone else. Therefore, the child inside me is still yearning to be acknowledged and taken care of. But people find it strange to meet an old woman who is really only a child, and I am careful not to disclose this secret of mine. But when I'm around children, they feel it immediately".

CSs are now between the ages of 60 - 75, depending on their age at the end of the war. This population can further be divided into three subgroups; (1) infant or early childhood survivors who were not older than 6 during the war; (2) child survivors who were between 6-12; and (3) adolescents who were between 12 and 18 at the end of the war. Obviously, age made a big difference for each one of these subgroups in terms of the developmental phase in which the traumatization occurred, for example in achieved cognitive ability to comprehend what was going on and in terms of fixations in specific stages of trust-mistrust, autonomy-doubt, guilt, and identity. Apparently, the younger the survivor, the more traumatic the circumstances and the more damaging the impact of their war experiences (Keilson, 1979).

These developmental phases also indicate some of the themes that child survivors struggle with all through life; (1) Learned helplessness, (2) Abandonment and isolation, (3) Interrupted mourning of loss, (4) Identity problems, (5) Memory loss and (6) Primitive defenses. These CS characteristics will be further discussed below (cf. Kestenberg & Brenner, 1996).

First, since CSs learned early in life that external forces by which they had no control shaped their destiny, there is a strong sense of learned helplessness and a "victim mindset" in which they feel at the mercy of others. In addition, the lack of safety, predictability and trust, together with overwhelming fear, powerlessness and loss of

control became a permanent learning experience which continued to limit their sense of independence and autonomy all through life.

Second, there is an inherent feeling of abandonment, existential loneliness or a vague sense of being unwanted which lead some child survivors to constantly try to prove their worth. Others feel a sense of detachment from the world. Such CSs still feel that they must remain in hiding and that they are somehow isolated from others and also from themselves. This reinforces their self-imposed silence and repression of their inner lives, until they feel that the outer world accepts them as they really are. Conflicting feelings of guilt for having left their parents and siblings are sometimes mixed with anger for not having been properly protected.

Third, the multiple and early loss of parents and family continues to haunt them throughout life. Children were separated from their parents and siblings in a variety of terrible ways. They were handed over to foster parents or to convents and given false names. They were pushed out of trains or left behind and hidden in attics, cellars, or forests. They were put on trains and sent away to distant countries or they were brutally torn from their parents in concentration camps. Seldom was it possible to say good bye and for any proper leave-taking and mourning to take place. Interrupted grief with a frequent and longstanding tendency to deny the overwhelming loss therefore continues to be a life-long struggle for many child survivors. As a result, normative separations later in life may also be very stressful and interpersonal relations are sometimes kept shallow to prevent a future painful separation.

Fourth, identity problems frequently arise in child survivors who were forced as children to take on a false identity in order to survive during the war. For a significant period of their youth, such children were exposed to a radically different socialization experience, which created at least an identity-confusion and at most a total repression of their earlier sense of self. In some of the latter cases, adolescents found it very difficult to return to their former families and presume their original names after the war.

Fifth, loss of memory leaves a void forever in the inner world of the adult child survivor. The absence of any childhood memories creates a breach in the natural flow of the life narrative. Infant child survivors therefore continue to search with fervor for something within or outside of themselves that can bring traces of the past (and their parents) back. They may look for pre-verbal signs, such as a familiar smell, a sound, or an image that can evoke some fragment of their mothers and fathers and original homes, and thus to re-experience and feel again something from their lost childhood. A child survivor who was separated from his parents of whom he has no memories before the age of 5 remembers only one thing from his childhood; how he was walking in mud with soldiers all around. Someone was holding his hand, but he doesn't know who it was. He only remembers that he would fall and that someone picked him up. After more than fifty years, he still feels that he is walking deep in mud and needs someone to hold his hand and lead the way.

Finally, as a result of overwhelming pain, powerlessness and isolation, primitive defenses were frequently developed in order to survive emotionally. Such defenses served to help them not to feel anything as children, and certainly not to express their feelings, because "Children, who cried, died." But when perception of reality became too threatening and overwhelming, "speechless terror" left experiences beyond words. Thus affects were often dissociated and totally forgotten. As adults, this is sometimes manifested in a kind of emotional encapsulation, psychic numbing of responsiveness and total amnesia of the past. Less dramatic survival strategies that also continued

throughout adulthood include not being seen, not standing out, to be quiet, obedient and "good." A 13-year-old girl is sitting in a windowsill, apparently detached from the outside world after a pogrom in which her father had been taken away and beaten at the police station. He was later shot and thrown in a mass grave and she never saw him again. As if encapsulated from all affect, she was reading a book, keeping her overwhelming emotions all locked in. But the emotional development of her life had stopped at that moment. She never created a family of her own and, now in her late sixties, it is as if she is still sitting on the windowsill waiting for her father to return.

While often (too?) well-adjusted and well functioning in their daily lives, child survivors remain a vulnerable group, carrying high risk for emotional instability and distress (Dasberg, 1987). Some are obsessively preoccupied with the untouchable memories of the past, while others have avoided them totally. When they are called upon to cope with recurrent situations of stress, they tend to re-experience the painful moments of separation and loss from the past and then suffer from periods of behavioral dysfunction and increased anxiety and depression.

Valent (1994) compared child survivors of the Holocaust with other traumatized children and found that the CS-syndrome contains a diverse mass of characteristics. The clinical picture of the child survivor of the Holocaust seems in many ways to correspond to what Judith Herman (1992) called 'complex PTSD', which emphasizes that the person has endured a series of traumatic experiences over a long period of time. Typically, developmental arrest in any of these early periods manifests itself as various forms of personality disorders, with the adult personality structure being dominated by unfulfilled needs of the traumatized child from the past. Distrust is an often-added relational component.

Controlled empirical research on the CSs has been scarce. A fairly recent study by Cohen, Brom & Dasberg (2001) used a controlled double-blind randomized design to look at symptoms and coping of CSs fifty years after the Holocaust. The results indicated a slightly higher level of psychosocial symptoms in the CSs than in the control group, a high level of PTSD symptoms (intrusion/avoidance tendencies), and achievement motivation based mainly on the fear of failure. Surprisingly, the CS viewed the world more positively than the control group, which may be understood as a greater need to compensate for the lack of security suffered in childhood by creating a meaningful world in a chaotic reality.

From a psychotherapeutic perspective, Dasberg, Bartura, & Amit (2001) observed that aging CSs who participated in group therapy were faced with the double task of coming to grips with the stresses of aging and of their psychobiological development, as well as the recurrence of the traumatic memories, and losses of their almost forgotten, disregarded, denied, repressed, or dissociated childhood memories. In addition, such CSs also shared their various worries about their own children and about child-rearing problems, which apparently were of major importance.

Holocaust Survivors as Parents

Because clearly, all the characteristics of the CSs described above make a bad start in the difficult job of childrearing. We may assume that the early severe traumatization experienced by the CSs had a detrimental effect also on their capacity for parenting. If for example the parents were hidden during the war, we assume that the children would absorb some of this experience. They would become the children of the 'hidden children'. And if the parents were abandoned, their children would also have anxieties around such issues of attachment. Or in a general sense,

since some CSs felt so helpless and lonely, they would in some way convey these feelings to their own sons and daughters, making them in turn, feel equally powerless. And we may conclude that since some of these fears are so overpowering, many CSs decided not to have children in the first place. They seemed to have enough problems taking care of themselves and were unable to take care of anyone else. Some of the more schizoid CSs chose not to marry at all and live by themselves in partly isolation. Before discussing these specific CS parenting questions further, I will discuss some findings of research on parenting skills of Holocaust survivors in general.

Holocaust survivor parents in general have been sometimes regarded as too anxious, depressed and pre-occupied with mourning to be able to provide an adequate maturational environment for their children. As a result, such mothers and fathers have been thought to pass on their emotional burden to their sons and daughters thus creating child-rearing problems around both attachment and detachment. This literature is based either on anecdotal evidence, on single-case descriptive reports and/or on empirical studies with methodological limitations. Naturally, this makes generalizations of their findings highly problematic.

Kellermann (2001d) attempted to investigate if Holocaust survivor parents really were so different in their child-rearing practices from other parents as the earlier literature suggested. Contrary to these early assumptions, this study showed that Israeli children of Holocaust survivors generally viewed their parents in a positive light and that differences in childrearing practices between Holocaust survivors and other Israeli parents on such major parenting behaviours as affection, punishing and over-protection, seemed to be very small, if taken as a whole. However, despite their devotion and largely successful child-rearing behaviour, Holocaust survivor parents were perceived as unable to prevent the Holocaust from having a significant impact upon their offspring. According to the findings of this study, parents' past trauma continued to have a strong influence on the lives of the offspring who felt that they had absorbed the inner pain of their parents. It was as if they had taken upon themselves a kind of emotional burden from their parents that had a major influence on their lives.

Described in terms of "role reversal with the parent," as "enmeshment," "parent-child role diffusion," or as "parental/parentified child," this "transmission" factor seems to be one of the characteristics in the parent-child relationships in such families. We may assume that these characteristics are also prevalent in the clinical population of 2GCSs. Before discussing the specific manifestations of 2GCSs, however, we need to cover some early empirical material on the psychopathology of the 2G.

2G Psychopathology

For many years, the transgenerational effect of the Holocaust on the offspring was a subject of considerable controversy. The main question involved the presence or absence of specific psychopathology in the 2G. Psychotherapists kept reporting various characteristic signs of distress while research failed to find significant differences between offspring and comparative groups.

In an effort to settle this question, Kellermann (2001b) did an extensive review of the research literature on the psychopathology of Holocaust survivors. This review provided a summary of the findings of 35 comparative studies on the mental state of offspring of Holocaust survivors, published between 1973-1999. The review indicated rather conclusively that the non-clinical population of children of Holocaust survivors did not show signs of more psychopathology than others do. In

fact, children of Holocaust survivors generally tended to function rather well in terms of manifest psychopathology. Differences in the mental state of offspring and people in general were small according to most research. Some new results based on attachment theory have been presented by Bar-On, et al, 1998; van IJzendoorn, et al, 2003, and Sagi-Schwartz, et al, 2003).

The clinical population of offspring however, tended to present a specific "psychological profile" that includes characteristics presented in Table 1.

Table 1
Psychological Profile of 2G

1. Predisposition to PTSD
2. Difficulties in separation - individuation
3. Contradictory mix of resilience and vulnerability when coping with stress
4. Personality disorder or neurotic conflicts
5. Periods of anxiety and depression in times of crisis
6. More or less impaired occupational, social and emotional functioning

This clinical population showed signs of psychological distress in a large number of the studies reviewed. For example, Sigal et al. (1973) found evidence of more disruptive behavior and over-dependence; deGraaf (1975) found more personality disturbances and conflicts in soldiers; Solomon et al. (1988) found that such soldiers were more likely to develop PTSD; Zilberfein (1996) found that offspring had less satisfying relations and were more anxious; and Yehuda et al. (1998) found that offspring with parents suffering from PTSD were more like to develop PTSD themselves. These studies indicated that clinical populations of children of Holocaust survivors, as compared to other people with emotional problems, seem to have some specific characteristics, more or less centered on difficulties in coping with stress (Baron, et. al, 1997) and a higher vulnerability to PTSD. Interestingly, these empirical studies of clinical populations are largely in agreement with the vast number of descriptive studies that reported specific manifestations (and increased rates) of psychiatric symptoms in children of survivors as compared to other populations.

The early differentiation between clinical and non-clinical populations of offspring has made the earlier disparity between clinicians and researchers largely redundant. The old division "into two 'camps,' those who described the adverse effects of the Holocaust, and those failing to note these detrimental effects" (Yehuda, et al, 1998, p. 640), have thus lost much of its relevance. Apparently, clinicians presented data about the negative after-effects in clinical samples of offspring while researchers showed a lack of effect (Bar-On, 1996, p. 231) when investigating a general, non-clinical population. But, although the second generation in general does not differ from others in psychopathology, their latent vulnerability will become more manifest after additional stress (Dasberg, 1987).

Thus it seems that the 2G experiences a contradictory mixture of vulnerabilities and resilience, very similar to their Holocaust survivor parents. Excellent occupational, social and emotional functioning in ordinary circumstances may be interrupted by periods of anxiety and depression that has a distinct 'Holocaust flavor' in times of crisis. Such signs of specific vulnerabilities in the offspring of Holocaust survivors have been found in a number of studies during the last decade and there has lately been a resurgence in studies that attempt to identify the factors that increase vulnerability to PTSD both in trauma survivors and in their children (eg. Sigal, 1998; Bower, 1996).

Aggravating and Mitigating Factors

Which other explanations can be given to the fact that many children of Holocaust survivors have adjusted well despite having grown up in dysfunctional families in which there was a major risk for the development of psychopathology? What increases and/or decreases the likelihood to develop psychopathology as a result of parental traumatization?

Rather than continuing to study the prevalence of psychopathology in this population, future research should focus on identifying the demographic factors, beyond individual differences and genetic endowment that increase the likelihood to develop psychopathology as a result of parental traumatization. According to the literature, the clinical subgroup of offspring who are at particular risk seem to have any or all of the following characteristics in common, as described in Table 2:

Table 2
Aggravating Factors

1. Offspring were born early after the parents' trauma
2. Offspring were the only, or the first-born child.
3. Both parents were survivors.
4. Offspring were "replacement" children to children who had perished.
5. Parents had endured extraordinary mental suffering and significant loss and were highly disturbed as a result.
6. Symbiotic relations were dominant between parents and children and family relations were characterized by enmeshment.
7. The trauma was talked about too little or too much.

These factors may be assumed to be universal in increasing the risk of a child to unconsciously absorb the trauma of his or her parents and to develop mental distress as a result. It will be the task of future research to delineate these factors in a more precise manner.

Several other circumstances may be assumed to influence the process of trauma transmission except the ones described above. For example, Keinan, Mikulincer & Rybnicki (1988) suggested that some children of Holocaust survivors developed unique coping mechanisms that better enable them to deal with their parents' psychological burden. Even if the parents were deeply traumatized, these children might not have absorbed the trauma because of certain "mitigating effects" (Table 3) that may have helped them to withstand the stress despite everything.

Table 3
Mitigating Factors

1. Open communication
2. Extended community
3. A clear Jewish identity
4. Reparative socialization in school or youth movement
5. Parents more stable
6. Successful Individuation-Separation process
7. Successful adolescent differentiation

According to Sorscher & Cohen (1997); "Numerous studies of these children have reported a wide spectrum of reactions, both detrimental and adaptive, to the Holocaust. The variety of responses suggests the presence of mediating factors that may mitigate the transgenerational impact of trauma. Parental communication style, in particular, has been identified as a crucial determinant in the adaptation of families beset by catastrophe" (p. 493). Similarly, Axelrod, et al (1980) observed that

a major difference between functional children and their hospitalised patients seemed to be that the children, while growing up, were exposed to fairly open discussion of parents' camp experiences in "non-frightening" ways. In addition, far from being social isolates, such better-adjusted families were involved in survivor organisations that may have provided support and a sense of extended community that gave perspective to the close-knit Holocaust survivor family. The acceptance of a Jewish or a specific immigrant identity in such close sympathetic communities, as well as the lack of renewed anti-Semitism may also have played a mitigating role.

Furthermore, reparative periods in school, youth movement, summer camp and in other social support systems (Heller, 1982) might have helped the offspring to differentiate from their parents and to alleviate some of their detrimental influence. Indeed, for many such 2G, the phase of adolescence became a time for age-appropriate separation and individuation that helped them move away from home and what it represented. The importance of such "outside-the-home socialization" in the peer groups of childhood and adolescence has been amply emphasized by Harris (1995): "Many psychologists have marvelled at the robustness of development; despite vast differences in the way their parents treat them, most children turn out all right... Children usually turn out all right because the environment that does have important and lasting effects is found with little variation in every society: the children's play group" (p. 458). Those children of Holocaust survivors who failed to experience such "non-familial" support during childhood may thus be assumed to have been more affected by the detrimental effects of parental traumatization than others. They are at higher risk to absorb the trauma of their parents and to develop mental distress as a result.

Children of Child Survivors

We are now finally more prepared to evaluate the 2GCSs situation. Having first reviewed the characteristics of CSs and then applying what we know about Holocaust survivors as parents, considering 2G psychopathology with its aggravating and mitigating factors, combined with our own clinical experience, will enable us to make some initial observations.

As far as I know, there are no specific empirical studies investigating this population, and I did not find any studies that compared the 'older' and the 'younger' 2G's. Because of the multitude of variables involved, perhaps such a study would be difficult to design. A qualitative study, with interviews would probably be a good start to map the characteristics of this population. The following observations may be an initial overview. It is based on clinical impressions of more or less disturbed CSs and their 2G offspring clients in individual and group therapy in Amcha, and with discussions with the staff of Amcha in Israel, and it cannot be generalized to a non-clinical population.

The most obvious and apparent observation seems to be that these 2GCSs 'children of children' took the role of becoming parents to their own (earlier orphaned) parents. This was naturally no simple task, since it in effect made them parentless as well. A female client said: "I had to take care of my mother ever since I was a young girl because she was unable to take care of herself. I did everything for her, and for the family, and I was in effect the only mother present for everybody." This specific client could not marry and create a family of her own, and after the death of her mother, she felt a strange sense of relief, together with all the resentments and feelings of guilt for not being able to be a 'good enough' mother (for her mother). This may in fact be a more common situation than what we expect because such CS mothers become so very demanding towards their children that they live in a relative state of reclusion and seldom ask for help.

A sad aspect of such CS parenting is that they frequently compare the childhood that they themselves had with the childhood of their own children (and even with their grandchildren). "I never had those things," they might say, and then go on to complain about the spoiled children of today. In secret, I have even heard such CS grandmothers express feelings of jealousy against their grandchildren.

As a response to such demanding behavior from the CS parent, many 2GCSs unconsciously internalize the suffering of their parents, minimize their own suffering as compared with that of their parents, and constantly attempt to find a suitable distance and closeness, which is almost impossible to find. There will always be complaint of being either too close or too far and nothing is 'good enough'. One such mother told her daughter: 'You are worse than the Nazi's! You will bring me to my early death!' Some such 2GCSs decide to immigrate to another country to start a life of their own, and others continue to live in the same apartments all through life. In terms of separation-individuation, there is very little understanding in CS parents of this need in their children, since they themselves often suffered from the lack of any parenting at all. Apparently, if there are emotional and mental problems, these will be more severe than in the corresponding 'older' 2G groups.

In addition to the above-mentioned characteristics, Amcha therapists shared that such 2GCSs often have difficulty with any physical touch, and that communication between family members is often very complicated. There will be frequent misunderstandings and longstanding conflicts that often make the family atmosphere unbearable. Some family therapists who are called upon to make some order in these entangled relations feel that the best remedy would be to find some kind of separation between the parties that respect the individuality of each and every person.

Conclusions

Kellermann (2001c) suggested that trauma transmission should be understood within a broader and integrative theoretical framework. Such a view must acknowledge the intricate interplay among different levels of transgenerational influence, suggesting that trauma transmission is caused by a complex of multiple related factors, including biological predisposition, individual developmental history, family influences and social situation. Whether hereditary or environmentally inflicted, trauma transmission can thus be explained as being influenced by any or all of the psychodynamic, socio-cultural, family system and biological factors or by an "ecological" combination of these.

Such an integrative view of trauma transmission explains a specific symptom in a child of survivors as being caused by a multitude of influences. For example, the Holocaust images reported by the child of survivors at the beginning of this paper may be interpreted, first, according to psychoanalytic theory, as a manifestation of the displaced unconscious fears of the parents. The child is experiencing what the parents themselves cannot perceive and express. Second, according to social theory, it may be explained as a specific kind of parenting. The child responds to the anxieties indirectly expressed in deleterious childrearing behavior. Third, according to family systems theory, it may be the result of enmeshment and tacit communication. The child is trapped in a closed environment in which the shadows of the past are ever present. Finally, according to biological theory, the anxiety disorder of the parent may be biologically transferred to the child who also becomes more vulnerable to stress.

These models of understanding trauma transmission will have a bearing on the recommended treatment strategy of the 2G and also the 2GCSs.

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