

## Diagnosis of Holocaust Survivors and their Children

Natan P. F. Kellermann, PhD

*AMCHA, Jerusalem, Israel*

*Abstract:* Survivors of the Holocaust and their children have tended not to be given formal diagnoses by their therapists. There seem to be a series of reasons: the events themselves were so terrible that it seems inappropriate to focus on the response, diagnosis implies comparing the condition with responses to other more minor traumata, the process of diagnosis is dehumanizing, the evil nature of the perpetrator is neglected, therapists feel it distances them from their patients, and it ignores the extraordinary achievements of many survivors who cope and live full lives. The DSM and its five axes are proposed as a suitable diagnostic vehicle, and Holocaust survivors with serious symptoms will tend to be diagnosed as chronic PTSD, child survivors as complex PTSD often with associated personality disorders, and second generation may well have identity problems and personality disorders. Only by using diagnoses can comparable research be carried out.

More than half a century after the war, a large number of Holocaust survivors are haunted by their past experiences and suffer from periods of depression, anxieties and psychosomatic symptoms which impair their daily functioning. Some of these survivors also struggle with everyday challenges, mental crises and with the woes of aging, retirement and illnesses which may seem insurmountable when viewed in perspective of the shadows of the past. While a large proportion of survivors and their offspring acknowledge their Holocaust-related anguish, and seek professional help at various stages of their lives, others deny feeling distressed or live with their mental suffering without seeking help. Whether recognizing their need for psychiatric treatments or not, both groups of clinical populations tend to resist labels that delineate their ailments in terms of psychiatric disorders. Mental health professionals who treat them and/or their families are themselves also largely ambivalent about

using such labels in their case summaries. As a consequence, it is presently difficult to get a consistent picture of Holocaust-related psychiatric disorders and to conduct studies on the characteristic psychopathology and epidemiology of Holocaust survivors and their offspring.

What kind of diagnostic classification system, if any, would best suit Holocaust survivors and their children? Do diagnostic evaluations help or hinder the psychological treatment of these populations? In order to answer these questions, the present paper will discuss the possible negative and positive consequences of using diagnoses with survivors of the Holocaust and their offspring, suggest the DSM-IV as a diagnostic, prognostic and screening device for these clients and propose a general description of a "typical" Holocaust Survivor Syndrome, Child Survivor Syndrome and Second Generation Syndrome in DSM-IV terminology.

### Resistance to Using Diagnosis

Traditionally, diagnosis in psychiatry consists of a clinical description of a patient based on symptom clusters, distinguishing various mental disturbances according to an atheoretical approach. Most commonly, clinicians employ the terminology used in the diagnostic and statistical manual of mental disorders prepared by the American Psychiatric Association (1), released in a fourth version (DSM-IV), or the classification of mental and behavioral disorders (ICD-10) published by the World Health Organization (2).

It is my experience from Amcha, the National Israeli Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation, that therapists working with Holocaust survivors and their children usually feel uncomfortable with such a standard nosological system. While it may be useful in other mental health settings, such clinicians feel that a disease-oriented system is inadequate within the social, cultural and psychological frameworks of such treatments. Psychotherapists mention at least six main reasons for not using conventional psychiatric diagnoses with a clinical population of Holocaust survivors and their children. They say that diagnoses (1) do not fit, (2) underestimate the unique nature of each Holocaust survivor, (3) stigmatize already disempowered people, (4) blame victims for their suffering, (5) create distance between therapist and patient, and (6) neglect the adaptive and successful coping abilities of the survivors and their families. These arguments against the use of diagnoses will be further elaborated below.

First, the existing psychiatric diagnoses incorrectly describe the experiences of Holocaust survivors. According to Herman (3), "the diagnostic categories of the existing psychiatric canon are simply not designed

for survivors of extreme situations and do not fit them well. The persistent anxiety, phobias and panic of survivors are not the same as ordinary anxiety disorders. The somatic symptoms of survivors are not the same as ordinary psychosomatic disorders. Their depression is not the same as ordinary depression, and the degradation of their identity and relational life is not the same as ordinary personality disorder" (p. 119). Furthermore, the fact that psychotherapy with these populations does not directly focus on deviant behavior which easily can be translated into clinical entities makes the classification process even more difficult. On the contrary, the treatment of Holocaust survivors and their children deals with human experiences and dilemmas that poets and novelists and historians write about: the pain of loss and bereavement, the cruelty of war and persecution, survivor guilt, separation-anxiety and the painful memories of ghettos, freight trains, concentration camps, death marches and entire families lost forever.

A second reason for opposing the use of diagnoses of Holocaust survivors is that all diagnoses involve some amount of comparison with survivors of other kinds of trauma and generalization to commonly experienced stress responses. As each Holocaust survivor demands to be acknowledged as a unique person with individual memories and emotions, any comparison with other survivors and victims of, for example, wars, earthquakes or sexual abuse make them feel greatly offended and largely misunderstood.

A third source of resistance to diagnoses lies in the dehumanizing ideology underlying psychiatric formulations. From this point of view, the diagnosis may be "socially regressive and discriminatory in impact, since it would be used to stigmatize disempowered people" (Herman, 3, p. 118). This would be especially true for Holocaust survivors who inevitably would be reminded

of anti-Semitism, Nazi persecution, camp selections and the efforts of perpetrators to dehumanize the Jews through negative labeling. Furthermore, as psychiatric diagnoses are products of social forces that operate upon people in a self-fulfilling manner, people who are treated as if they were mentally ill become more ill and later permanently adopt the role of disturbed. Yehuda and Giller (4) explained this difficulty of clinicians and researchers to utilize diagnostic concepts of mental disorders, particularly PTSD, to describe the experience of Holocaust survivors: "On the one hand, there is a need to document the horrors of racial prejudice, and on the other, to demonstrate the dignity of the Jewish people and its capacity to survive. To describe Holocaust survivors as vulnerable, particularly if this has biological dimensions, is to document traits similar to the ones that were actually used to justify the extermination of the Jews. To mitigate the scars of the Holocaust is equally problematic" (p. 13).

A fourth reason for resisting diagnoses of Holocaust survivors is that diagnoses naturally focus on the psychopathology of the victim, rather than on the evil nature of the perpetrator. Such "displacement" of responsibility prolongs victimization by blaming the victim tacitly for responding in an inadequate emotional manner. According to Herman (3) "the tendency to blame the victim ... has interfered with the psychological understanding and diagnosis of a post-traumatic syndrome. Instead of conceptualizing the psychopathology of the victim as a response to an abusive situation, mental health professionals have frequently attributed the abusive situation to the victim's presumed underlying psychopathology" (p. 116). This situation in itself may be a subtle reinforcement of the self-imposed silence of many victims.

Fifth, psychotherapists resist diagnoses because they feel that the "objectification"

involved in labeling would distance them from their patients. For therapists who are themselves survivors of abuse or who identify with survivors, diagnoses would reinforce treating the patient as an object, an "It" (in Martin Buber's terminology), and thus destroy the I-Thou relationship founded on mutuality, trust and partnership. Though some of these therapists would justify using diagnoses for compensation payment, they would violently resist diagnoses within the treatment setting.

Finally, the protest against diagnosing Holocaust survivors is not merely a dissatisfaction with existing labels or even a human protest against objectifying people. It is a rejection of any reification, a protest against viewing Holocaust survivors in terms of their psychopathology, rather than in light of their extraordinary ability to cope and their successful achievements after the war. As repeatedly reported in the literature, a vast majority of Holocaust survivors and their families have shown an unusual degree of psychic strength and resilience in overcoming the effects of their traumatic experiences and multiple losses (5-10).

In sum, many professionals feel that psychiatric diagnoses are spectacularly useless as an indicator of adjustment in Holocaust survivors and their children and various efforts to categorize the behavior of these people as normal and abnormal against this background would be largely futile. According to these critiques, psychopathology should rather be viewed as normal behavior in very abnormal circumstances, as explained by Frankl (11): "an abnormal reaction to an abnormal situation is normal behavior."

### **Benefits of Using Diagnosis**

These are all well-known arguments against the use and abuse of classical psychiatric nosology in the treatment of Holocaust

survivors and their children. A complete abandonment, however, of all diagnostic evaluations might have substantive negative consequences. For example, without some differentiation of the people who apply for help, even the most basic conclusions of when and with whom to do what would be impossible. Most importantly, it would prevent a preliminary evaluation regarding the therapeutic effects of specific approaches and preclude comparative outcome research. Moreover, by refusing to use a standardized and generally accepted nomenclature, psychotherapists unwittingly would isolate themselves from the mental health establishment and academia and indirectly obstruct the cumulative progress of knowledge that would be achieved only in cooperation with these institutions. This would separate treatment of Holocaust survivors from the rest of psychiatry, and prevent it from both drawing knowledge from and contributing to it. As a result, the growth of the profession at large would be retarded.

Actually, the protest against diagnoses seems to be exaggerated and superfluous because, whether we like it or not, all psychotherapists are regularly involved in clinical assessment of clients. Before and during treatment they ask themselves: Is this person happy or sad? Is he or she suicidal? Or psychotic? Should he or she be hospitalized? Could he or she gain something from drug treatment? Though not always verbalized, these questions continually arise and they demand immediate answers. In such inquiries, some personality assessment is inevitable and categorization with psychiatric diagnoses becomes a language as good as any in describing abnormal, psychopathological or dysfunctional behavior. Abstaining from giving names to observations, or avoiding viewing them as pathological, does not thwart the therapists' natural tendency to evaluate others, nor does

such relinquishment of assessment make the ailment less disturbing for individuals, or the relationship more humane. From the point of view of counter-transference, avoiding diagnostic labeling may lead to burn-out and/or to vicarious co-traumatization as well.

Patients themselves do not necessarily react negatively to being diagnosed. Contrary to our expectations, patients often react favorably when their symptoms are recognized as responses previously observed in similar situations. When talking to traumatized people, Ochberg (12) reported that responses to being diagnosed with PTSD ranged "from satisfaction that the symptoms were officially recognized, to surprise that anybody else had a similar syndrome" (p. 775). Lifton's (13) explanation of the post-traumatic stress disorder as a normal adaptive process of reaction to an abnormal situation also led to a greater acceptance, on the part of the patient, of his or her symptoms.

Some diagnostic assessment and/or psychosocial evaluation is therefore imperative for the proper treatment of Holocaust survivors and their children, both for clinical convenience and for research purposes. Raw clinical data must be arranged in a way that is suitable and understandable both for the therapists themselves and for the outside world. Naturally, such diagnoses should not be used merely for the sake of labeling people, but to provide prognostic information, as well as give clues for the therapist regarding possible strategic interventions with various sub-groups of the survivor population and their descendants. But the question remains: Which kind of diagnoses can relevantly and accurately describe the characteristic psychopathology of Holocaust survivors and their children? How is it possible to label these predicaments with a standardized classification system without losing their essential qualities?

It is my proposition that we employ the DSM-IV as a diagnostic, prognostic and screening device because, while there might be various inherent problems in the DSM-IV, (14, 15), and though it might be less culturally sensitive than the ICD-10 (16), "it is the most thorough and empirically well-supported book on the classification of mental disorders now available" (17). The DSM-IV is standardized, comprehensive, atheoretical and widely used. Most importantly, however, it includes the delineation of a "post-traumatic stress disorder" which is imperative for describing the manifestation of symptoms in the clinical population of Holocaust survivors and their children. As a multi-axial diagnostic system, the DSM-IV gives attention not only to a wide variety of common mental (Axis I), personality (Axis II) and physical (Axis III) disorders, but also to aspects of the environment (Axis IV) and of functioning (Axis V) that might be overlooked if the focus were on assessing only the behavioral manifestation of psychopathology. The specific importance of prolonged traumatization in Holocaust survivors make axes IV (severity of psychosocial stressor) and V (global assessment of current functioning - GAF) especially relevant.

### **Holocaust Survivor Syndromes Described in DSM-IV Terminology**

The terms "Holocaust survivors," "child survivors," and "second generation" are simple characterizations of people according to their own or their parents' Holocaust experiences. These descriptions do not, in themselves, imply any mental disorders nor do they call for any psychotherapeutic interventions. But if there are specific, common and typical mental ailments of these populations, how would these be described in DSM-IV terminology? Is it at

all possible to make such global generalizations?

Holocaust survivors clearly differ from one another in a great many ways, in their pre-war personality make-up, in their various traumatic war experiences, and in their post-war readjustment. Of all these differences, their varying vulnerability and resilience to stress are perhaps the most striking in rendering them more or less susceptible to mental ailments. There are of course further differences between and within groups of male and female survivors: age differences during the war, differences in occupation, cultural and religious background, immigration effects and pre-Holocaust personality traits. Similarly, the children of survivors, to whom the Holocaust trauma was transmitted, are also a highly heterogeneous group, differing for example in the kinds of parenting they received, in the sort of family environment in which they grew up and in the sort of communication about the Holocaust they absorbed, beyond the obvious differences in their survivor parents described above. As a consequence, the range and severity of emotional disorders in these patients, when present, are comparatively large.

Despite all these variations, however, there are striking similarities across the clinical populations who apply for help. As pointed out by Weisaeth and Eitinger (18), "considering the enormous variety of traumata and stressors inherent in disaster, war, and other traumatic situations, it is ever more astonishing that the human response is so similar across social, demographic, and other variables" (p. 69). People who have experienced severe trauma seem to present similar clusters of symptoms that occur simultaneously under specific conditions, with a common cause (19, p. 127). Such syndromes appear with some consistency in the literature on Holocaust survivors and their children (e.g., 20). Basing ourselves on

the similarities of the symptoms reported in this vast literature, I will propose a short and comprehensive description of a typical Holocaust Survivor Syndrome, Child Survivor Syndrome and Second Generation Syndrome which may then be translated into DSM-IV terminology.

### **The Holocaust Survivor Syndrome**

The early literature of Holocaust survivors who were being evaluated for psychiatric treatment and/or compensation presented a gloomy picture of severe symptomatology with affective, cognitive and behavioral impairments (e.g., 21-23). The usual complaints of such survivors included persistent anxieties, fear of renewed persecution, chronic depression, psychosomatic symptoms, concentration and memory difficulties, maladjustment, sleep disturbance with terrifying nightmares and a general difficulty to verbalize their traumatic experiences (or alexithymia, a lack of words for what they felt). Guilt for having survived when others did not was an often added emotional component.

According to Krystal and Danieli (24), the "emerging descriptions of survivors' problems helped to shape awareness of the post-traumatic pattern and to form a prototype of what came to be recognized as PTSD in DSM-III" (p. 1-2). Consequently, the DSM-IV disorder most suitable to this clinical picture seems to be "*Chronic Post-Traumatic Stress Disorder*," with depression as a frequent associated feature (25). According to the DSM-IV, this type of anxiety disorder includes the following common features, frequently observed in a clinical population of Holocaust survivors: (1) exposure to a traumatic event that invoked intense fear, helplessness or horror; (2) the trauma is re-experienced, for example, through recurrent distressing recollections; (3)

avoidance of stimuli associated with trauma, and a numbing of general responsiveness; and (4) symptoms of increased arousal (e.g., sleep disturbances, irritability, concentration difficulties and startle responses).

However, since PTSD may be felt as a grave underestimation of the trauma of the Holocaust, comparing the prolonged suffering of the Holocaust survivor erroneously with the stress responses of comparably limited traumatic events such as car accidents, earthquakes or rape, the term "complex trauma" or the distinct subcategory called "victimization sequel disorder" may be added as a more precise denomination because, according to Herman (3), "survivors of prolonged abuse develop characteristic personality changes, including alterations in affect regulation, consciousness, self-perception, perception of the perpetrator, relations with others and alterations in systems of meaning" (p. 121).

Though Yehuda and Giller (4) observed that references to PTSD were conspicuously absent from the Holocaust survivor literature, clinicians and researchers seem lately to have become less opposed to diagnosing Holocaust survivors with PTSD. A good example is Krystal, one of the early authorities in the field, who initially (23) found the existing category of "traumatic neurosis" inappropriate for describing concentration camp survivors. In a "spirit of compromise" (26, p. 841) and in order for the treatments of Holocaust survivors to be covered by public health care, he now seems to advocate the diagnostic criteria of PTSD for this population.

Researchers have undergone a similar change. For example, while Wilson et al. (27) did not include Holocaust survivors in their comparative analysis of PTSD among various survivor groups, Weisaeth and Eitinger (18), almost a decade later, did. Hence, during the last few years, an increasing number of studies (25, 28-30) have applied

the formal diagnostic criteria for PTSD to Holocaust survivors. Advocating this research philosophy, Yehuda and Giller (4) concluded that "if Holocaust survivors had been considered from the vantage point of either having or not having post-traumatic stress syndrome, this might have helped clarify prior observations of other aspects of post-traumatic adaptation, such as affect dysregulation, character changes, psychiatric comorbidity and resilience, and might have provided a more cohesive literature" (p. 13). Kolb (31) was in agreement with this latter view, suggesting that Holocaust survivors should be investigated in the light of what is known about traumatized people in general.

### **The Child Survivor Syndrome**

Survivors of the Holocaust who were less than 16 years old when the war ended usually present a somewhat different clinical picture from their older brothers and sisters. These were severely traumatized children who survived in hiding or in very difficult circumstances, sometimes with changed identities and in total isolation from their families of origin (32). Extraordinary psychological adjustment strategies were developed by these children in order to survive mentally, including dissociation, psychic numbing and denial (30). As expected, such early traumatization reverberates across the entire life span of the child survivor and many of the early strategies are maintained all through life. Some are obsessively preoccupied with the untouchable memories of the past, while others have avoided them totally.

While often well-adjusted and well-functioning in their daily lives (mental state seems to be correlated to the intensity of childhood trauma they suffered), they are a highly vulnerable group, carrying high risk for emotional instability and distress (33,

34). 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. Suspicion and distrust in interpersonal relations are often added emotional components.

This clinical picture of the child survivor of the Holocaust seems in many ways similar to the above-mentioned *Complex PTSD* of the DSM-IV. However, the specific characteristic of this group of child survivors is the various kinds of developmental impairments, depending on their age of traumatization. Typically, developmental arrest in early ages manifests itself as various forms of *personality disorders*, with the adult personality structure being dominated by more or less unfulfilled needs of the traumatized child from the past. Clearly, however, because of the great variation in traumatic experiences and ages of traumatization, the Child Survivor Syndrome includes a diverse group of manifestations, as described by Valent (30) in his comparison of child survivors of the Holocaust with other traumatized children.

### **The Second Generation Syndrome**

Recent reviews of the vast literature on intergenerational transmission of Holocaust trauma (35, 36) indicate that while most offspring of Holocaust survivors are essentially healthy and well-functioning individuals, those who do suffer from mental ailments present a pattern of distinct intrapsychic difficulties that may be observed in the following areas:

- 1) *Self*. Impaired self-esteem with persistent identity problems, over-identification with parents' "victim" status, a need to be super-achievers to compensate for par-

- ents' loss, carrying the burden of being "replacements" for lost relatives.
- 2) *Cognition*. Catastrophic expectancy, fear of another Holocaust, preoccupation with death, stress upon exposure to stimuli which symbolized the Holocaust, vicarious and fantasized sharing of traumatic Holocaust experiences which dominates the inner world.
  - 3) *Affectivity*. Annihilation anxiety, nightmares of persecution, frequent dysphoric moods connected to a feeling of loss and mourning. Unresolved conflicts around anger complicated by guilt. Anger is either internalized or projected outwardly without differentiation and control.
  - 4) *Interpersonal functioning*. Exaggerated family attachments and dependency or exaggerated independence and difficulties in entering into intimate relationships and in handling interpersonal conflicts.

According to the DSM-IV, two groups of second generation clients evolve from this description. On the one hand, there are those who suffer from anxiety related to various neurotic conflicts and especially *identity problems*. On the other hand are those who may be characterized as *personality disorders* because of their impaired social and occupational functioning. As a result of their inadequate parenting experiences, of their developmental deficiencies and their failures in emotional disengagement and individuation from their families of origin, both groups seem to suffer from inflexible and maladaptive patterns of perceiving, relating to, and thinking about the environment and about themselves. In the final analysis, there might be a need for a new category here also, such as "transmitted trauma syndrome."

### Conclusion

Rather than viewing Holocaust survivors as one homogeneous group, it is now more

common to emphasize their diversity in terms of psychopathology (4, 24, 37, 38) differentiating not only between the clinical and the non-clinical populations, but also between various typical syndromes observed in these groups. It is my hope that a clear delineation of these syndromes will make it possible to contribute to the understanding of the general nature of post-traumatic adaptation as well as to the transgenerational transmission of trauma. This might enable us both to learn from and to contribute to the vast progress of post-traumatic stress research that has developed during the last decade.

### References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-IV). Washington, DC: AMA, 1994.
2. World Health Organization. Tenth revision of the international classification of disease (ICD-10). Geneva: WHO, 1993.
3. Herman JL. Trauma and recovery. New York: Basic, 1992.
4. Yehuda R, Giller EL. Comments on the lack of integration between the Holocaust and PTSD literatures. PTSD Research Quarterly, 5(4), Fall. Vermont: National Center for Post-Traumatic Stress Disorders, 1994.
5. Dimsdale JG. The coping behavior of Nazi concentration camp survivors. Am J Psychiatry 1974;131:792-797.
6. Ornstein A. The aging survivor of the Holocaust: The effects of the Holocaust on life-cycle experiences: The creation and re-creation of families. J Geriatric Psychiatry 1981;14:135-154.
7. Davidson S. Psycho-Social Trauma in the Life Cycle of Holocaust Survivors. Quarterly Medical Review, Tel Aviv: I.M.A., 1986; 1:12-14.
8. Harel Z, Kahana B, Kahana E. Psychological well-being among Holocaust survivors and immigrants in Israel. J Traumatic Stress 1988;1:413-429.
9. Bergmann M, Jucovy M. Generations of the Holocaust. New York: Basic, 1982.



10. Helmreich WB. Against all odds: Holocaust survivors and the successful lives they made in America. New York: Transaction, 1996.
11. Frankl V. Man's search for meaning. Boston: Beacon, 1959.
12. Ochberg FM. Posttraumatic Therapy. In: Wilson JP, Raphael B, editors. International handbook of traumatic stress syndromes. New York: Plenum, 1993:773-783.
13. Lifton RJ. Understanding the traumatized self: Imagery, symbolization, and transformation. In: Wilson JP, Harel Z, Kahana B, editors. Human adaptation to extreme stress: From the Holocaust to Vietnam. New York: Plenum, 1988:7-31.
14. Scurfield RM. Post-trauma stress assessment and treatment: Overview and formulations. In: Figley CR, editor. Trauma and its wake. New York: Brunner/Mazel, 1985.
15. Wakefield JC. DSM-IV: Are we making diagnostic progress? *Contemporary Psychology* 1996;41(7).
16. Kirmayer LJ, Young A, Hayton BC. The cultural context of anxiety disorders. *Psychiatric Clinics of North America* 1995;18:503-521.
17. Nietzel MT. DSM-IV and its (many) derivatives. *Contemporary Psychology* 1996;41(7).
18. Weisaeth L, Eitinger L. Posttraumatic stress phenomena: Common themes across wars, disasters and traumatic events. In: Wilson JP, Raphael B, editors. International handbook of traumatic stress syndromes. New York: Plenum, 1993:69-77.
19. Eitinger L. The concentration camp syndrome and its late sequelae. In: Dimsdale JE, editor. Survivors, victims and perpetrators. New York: Hemisphere 1980:127-162.
20. Eitinger L, Krell R. The psychological and medical effects of concentration camps and related persecutions on survivors of the Holocaust: A research bibliography. Vancouver: University of British Columbia, 1985.
21. Eitinger L. Pathology of the concentration camp syndrome. *Arch Gen Psychiatry* 1961;5:371-380.
22. Chodoff P. Late effects of the concentration camp syndrome. *Arch Gen Psychiatry* 1963;8:323-333.
23. Krystal H, Niederland WG. Clinical observations on the survivor syndrome. In: Krystal H, editor. Massive psychic trauma. New York: International Universities 1968:327-348.
24. Krystal H, Danieli Y. Holocaust survivor studies in the context of PTSD. *PTSD Research Quarterly* 1994, 5(4), Fall. Vermont: National Center for Post-Traumatic Stress Disorders.
25. Yehuda R, Kahana B, Southwick SM, Giller EL. Depressive features in Holocaust survivors with post-traumatic stress disorder. *J Traumatic Stress* 1994;7:699-704.
26. Krystal H. Beyond the DSM-III-R: Therapeutic considerations in posttraumatic stress disorder. In: Wilson JP, Raphael B, editors. International handbook of traumatic stress syndromes. New York: Plenum, 1993:841-854.
27. Wilson JP, Smith WK, Johnson SK. A comparative analysis of PTSD among various survivor groups. In: Figley CR, editor. Trauma and its wake. New York: Brunner/Mazel, 1985.
28. Kaminer H, Lavie P. Sleep and dreaming in Holocaust survivors: Dramatic decrease in dream recall in well-adjusted survivors. *J Nerv Ment Dis* 1991;179:664-669.
29. Kuch K, Cox BJ. Symptoms of PTSD in 124 survivors of the Holocaust. *Am J Psychiatry* 1992;149:337-340.
30. Valent P. Documented childhood trauma (Holocaust): Its sequel and applications to other traumas. *Psychiatry, Psychology and Law* 1995;2:81-89.
31. Kolb CC. Commentary. *Integrative Psychiatry* 1985;3:120-123.
32. Moscovitz S. Love despite hate: Child survivors of the Holocaust and their adult lives. New York: Schocken, 1983.
33. Dasberg H. Psychological distress of Holocaust survivors and offspring in Israel: Forty years later. A review. *Isr J Psychiatry Relat Sci* 1987;24:243-256.

34. Robinson S, Rapaport-Bar-Sever M, Rapaport J. The present state of people who survived the Holocaust as children. *Acta Psychiatr Scand* 1994;89:242-245.
35. Felsen I. Transgenerational transmission of effects of the Holocaust: The North American research perspective. In: Danieli Y editor. *International handbook of multigenerational legacies of trauma*. New York: Plenum, 1997.
36. Solomon Z. Transgenerational effects of the Holocaust: The Israeli research perspective. In: Danieli Y, editor. *International handbook of multigenerational legacies of trauma*. New York: Plenum, 1997.
37. Danieli Y. The treatment and prevention of long-term effects and intergenerational transmission of victimization: A lesson from Holocaust survivors and their children. In: Figley CR, editor. *Trauma and its wake*. New York: Brunner/Mazel, 1985.
38. McCann IL, Pearlman LA. *Psychological trauma and the adult survivor*. New York: Brunner/Mazel, 1990.