

Psychopathology in Children of Holocaust Survivors: A Review of the Research Literature

Natan P. F. Kellerman

AMCHA, the National Israeli Center for Psychosocial Support of Holocaust Survivors and the Second Generation, Jerusalem, Israel

Abstract: The literature on transgenerational transmission of Holocaust trauma has grown into a rich body of unique psychological knowledge with almost 400 publications. For the time being, however, the transgenerational effect of the Holocaust on the offspring remains a subject of considerable controversy. The main question involves the presence or absence of specific psychopathology in this population. 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, the present review of the research literature provides a summary of the findings of 35 comparative studies on the mental state of offspring of Holocaust survivors, published between 1973-1999. This extensive research indicates rather conclusively that the non-clinical population of children of Holocaust survivors does not show signs of more psychopathology than others do. Children of Holocaust survivors tend to function rather well in terms of manifest psychopathology and differences in the mental state of offspring and people in general are small according to most research. The clinical population of offspring, however, tend to present a specific "psychological profile" that includes a predisposition to PTSD, various difficulties in separation-individuation and a contradictory mix of resilience and vulnerability when coping with stress.

Offspring of Holocaust survivors have been the object of special attention by clinicians and researchers, by their parents and also by themselves, almost since they were born. Everybody seemed to be interested in finding out if the traumatic Holocaust experiences of their parents may have had a detrimental influence on them as well. Such effects, if found, would provide evidence for the existence of the transmission of psychological trauma across generational lines, a finding that would be of considerable importance not only to mental health workers and their patients, but also to insurance companies and perpetrator agencies who would then be held responsible for injuries inflicted on generations of victims.

For the time being, however, the transgenerational effects of the Holocaust on the offspring of survivors remains a subject of considerable controversy. Some feel that the concept of the "Second Generation" is an illusion and that the process of transmission is a fallacy. Others question whether there is psychopathology that is specific to children of survivors. Still others hold that the descendants, as well as the Holocaust survivors themselves, are such a diverse group that any generalization of their characteristics tends to be biased. Therapists assume that it is impossible to grow up in a Holocaust survivor family without absorbing some of the emotional scars of the parents. Researchers disagree, pointing out

that offspring in general do not present any more or fewer signs of psychopathology than comparable groups. In fact, many have lately suggested that the "legacy" of the Holocaust has influenced the personal lives of offspring in a positive manner by making it more meaningful and by increasing their compassion for human suffering. Similarly, Rieck (1) suggested that "although the damaging effects of stress have been investigated and demonstrated amply, its strengthening effects have remained relatively unexplored" (p. 654). As descendants of Holocaust survivors are approaching their fifties (45-55 if they were born between 1945-1955), they themselves continue to ponder the effects of the Holocaust on their lives, especially when evaluating their own parental influences on what has been called the "Third Generation."

During the last four decades, the literature on transgenerational transmission of Holocaust trauma has grown into a rich body of unique psychological knowledge with almost 400 publications (2-5). This knowledge has developed in a cumulative fashion similar to that of the increasing sophistication of most psychological research; from observation to generalization, to theorizing that stimulated empirical research. Four overlapping and somewhat arbitrary stages of development can be identified:

First, in the middle and late 1960s, the first case studies were based mostly on clinical observation and description of clinical populations of children of Holocaust survivors who were then adolescents (e.g., 6). These youngsters showed signs of mental disturbances that seemed to have a decidedly different flavor than their peers. Second, in the 1970s, these reports were followed by many more such descriptive studies, as well as a few empirical research studies that later were criticized for being biased by various methodological flaws (7). For example, small sample groups of clinical populations, then young adults, were investigated mostly

without any controls. Third, more well conducted comparative research, including also non-clinical populations, was conducted and reported in the 1980s (8), representing a peak in interest in terms of the largest number of reports published. Finally, in the 1990s, with fewer publications, there seemed to be an attempt to integrate the discrepant earlier findings. Comprehensive reviews by Felsen (9) and Solomon (10), in Danieli (5), and by Berger-Reiss (11), Bar-On et al. (12), Baranowsky et al. (13) and Seifter-Abrams (14), summarized the findings and tried to draw new conclusions on the basis of this cumulative research.

The present overview of the literature is a continuation of this last phase in its attempt to synthesize the current research on the existence of psychopathology in children of Holocaust survivors. This is important because psychotherapists who traditionally have relied more on clinical experience than on empirical research have become more aware of the need to provide evidence of trauma-transmission that is less susceptible to subjective interpretations. The very idea of transmitting a trauma from parents to children, initially regarded as preposterous, has gained a larger acceptance in professional circles. Indeed, it has become part of the general field of traumatology and is now studied as an integral part of all kinds of traumatic experiences, including the effects of war, abuse and natural catastrophes (5). As a result, terms such as "multi-generational," "trans-generational," "inter-generational," and "cross-generational" are more commonly used in various fields within sociology, psychology and psychiatry. According to deGraaf (15), "there seems at present to be a general consensus among researchers that the psychopathology displayed by children of Holocaust survivors is by no means unique.... As a matter of fact, the problems we have met in families of survivors of the Holocaust are now believed

to be similar to those found in families in which the parents have been traumatized by other circumstances" (p. 234). The extensive knowledge gained from studying children of Holocaust survivors can thus be utilized to better understand the children of other traumatized populations as well.

Earlier studies and reviews on the trans-generational transmission of Holocaust trauma from survivor parents to their offspring (e.g., 9, 16) have differentiated between on the one hand "direct and specific" transmission (a mental syndrome in the survivor parent leads *directly* to the same *specific* syndrome in the child) and on the other hand "indirect and general" transmission (a disorder in the parent makes the parent unable to function as a parent which *indirectly* leads to a *general* sense of deprivation in the child). While such a differentiation seems to be valid, it confuses aspects of the process of transmission, which are more or less "overt and covert," "manifest and tacit," and "conscious and unconscious." It further fails to clearly separate the aetiology (or assumed *cause*) of the transmission from the manifestation (or assumed *effect*) of the transmission. Apparently, there is as yet no consensus as to how to define the field, some limiting it to its descriptive meaning whereas others include possible explanations of its aetiology.

In order to limit such ambiguity, I will here differentiate between the *process* of transmission (how the trauma was carried over from one generation to the next), and the *content* of transmission (what was in fact transmitted). The first would contain the assumed cause of transmission, in terms of what parents did to their children, and the second the effect, in terms of the psychological responses of the child. While both perspectives apparently involve direct and indirect (as well as specific and general) aspects, the basic differentiation of parental influence and infant response is essential for

making sense of the complex theories and available research findings. I will present here an overview of the research conducted on the psychological responses of the child and not discuss the literature on parenting and the family.

The Psychological Responses of Children

What was transmitted from Holocaust survivor parents to their children? What are the manifestations of trauma, if any, that can be observed in children of survivors? A frequent assumption in the clinical literature was that a "secondary posttraumatic stress disorder" (17) was being transmitted, suggesting that "since many Holocaust survivors suffer from PTSD, their offspring will also suffer from a syndrome of similar dimensions with diminished proportions (13, 18). "As unwilling witnesses of the Holocaust" children "picked up on parent's defensive structure and intuited the repressed, dissociated and warded off trauma that lurked behind" (19, p. 37). When vividly associating about the Holocaust, the offspring seemed to be vicariously traumatized by the horrific experiences of the parents, though they themselves had no first-hand experience of it.

Such a direct "transposition" (20) of trauma was thought to have been inherited, absorbed, or contracted by the child, as if the persecution complex of the parents was contagious, infecting offspring across generational lines. As leftovers from the past, this traumatization was perhaps denied or "forgotten," but was assumed to find expression in some emotional distress or irrational behavior. Thus, when children learned to behave in disordered ways similar to those of their parents, there was a direct transposition of a distinct disorder (such as the survivor-syndrome, PTSD, depression or general anxiety disorder) from the parents to

the children (9, 16). An "anniversary syndrome" can also appear in which offspring might re-experience a trauma of their parents or even grandparents at a similar age, or at the same date as the original trauma (21). For example, over half of the 30 hospitalized children of survivors described by Axelrod et al. (22) apparently relived their parents' wartime experiences at the same age as their parents had been during the Holocaust.

The more general manifestations of psychopathology in children of survivors, caused by developmental deficiencies rather than by direct "transposition," were assumed to find expression in the controversial and ill-defined "Second Generation Syndrome." This syndrome was recently described by Kellermann (23) in DSM-IV terminology as either referring to an anxiety disorder related to various neurotic conflicts and especially to identity problems, or to a personality disorder, because of impaired social and occupational functioning.

The existence or non-existence of either specific or general manifestations of psychopathology in the offspring of Holocaust survivors has been the subject of the greatest disagreement between clinicians and re-

searchers. While psychotherapists characteristically observed and described various manifestations of emotional distress in this population, researchers failed to confirm these observations with more objective and reliable instruments. The following overview of the empirical research on the contents of transmission attempts to synthesize earlier findings of the mental state of the children of Holocaust survivors. Though this research has included instruments that measure various general variables, including Jewish identity, knowledge about the Holocaust, and family communication patterns, the scope of the present review will focus only on the mental health and adjustment of the offspring, including their intra-psychic characteristics, family relations, as well as specific signs of psychopathology.

Thirty-five such comparative studies published between 1973 and 1999 are presented in Table 1. Only published studies with at least quasi-experimental research design, that required matched assignments of subject to experimental and control groups, are included, without doctoral dissertations and MA theses that were included in Felsen (9) and in Solomon (10).

Table 1. Controlled Research on the Mental State of Offspring of Holocaust Survivors

Note: O = Offspring of Holocaust survivors; Non-O = not offspring of survivors

C = Clinical population (in psychotherapy, mental health agency) [Refers to both O and Non-O]

NC = Non-clinical population (general population, not recruited from patients)

Author & year	Offspring O n	Control Non-O n	Measures	Findings
Aleksandrowicz 1973 Israel (24)	34 O C families	Other survivors	Interviews of parent and child psychodiagnostic tests	No difference in psychopathology
Sigal et al. 1973 Canada (25)	25 O C adolescents	20 non-O adolescents	Parental behavior rating	O more disruptive behavior & over-dependence
Gay et al. 1974 Israel (26)	23 O C adolescents	23 non-O adolescents	16 PF Questionnaire	No difference in personality functioning

Author & year	Offspring <i>O</i> <i>n</i>	Control <i>Non-O</i> <i>n</i>	Measures	Findings
deGraaf 1975 Israel (27)	24 <i>O</i> C soldiers	20 non- <i>O</i> soldiers	Symptom rating	<i>O</i> more personality disturbances, conflicts
Gay & Shulman 1978 Israel (28)	29 <i>O</i> NC students	21 non- <i>O</i> students	Fitt's self concept scale	No difference in self image
Last & Klein 1980 Israel (29)	76 <i>O</i> NC	76 non- <i>O</i>	MMPI	No difference in strength of self
Leon et al. 1981 US (30)	47 <i>O</i> NC	16 non- <i>O</i>	MMPI — current life functioning, etc.	No difference in adaptive functioning
Heller 1982 US (31)	42 <i>O</i> NC High Stress	63 Low stress Europe	Historical & Cultural Questionnaire, TAT	<i>O</i> more sensitive to culture and ancestry
Lichtman 1984 (based on thesis: 1983) US (32)	64 <i>O</i> NC	43 non- <i>O</i>	MMPI-scales Mosher FCS Guilt Hogan's Empathy	Guilt-inducing communication lead to low ego strength. No difference in psychopathology
Russel et al. 1985 UK/Canada (33)	68 <i>O</i> NC survivor families	51 control families	Questionnaire on identity, separation-individuation, etc.	No difference on other variables than worldview
Nadler et al. 1985 Israel (34)	19 <i>O</i> NC	19 non- <i>O</i>	Rosenzweig Projective Frustration Interview	Difference in reaction to frustration but not in psychopathology. <i>O</i> less aggressive, more guilt.
Zlotogorski 1985 US (35)	73 <i>O</i> NC	68 Jewish non- <i>O</i>	Well-being Quest. WU-SCT Family Adaptability	No difference in levels of adaptive functioning coping and well-being
Weiss et al. 1986 US (36)	25 <i>O</i> NC	25 non- <i>O</i> immigrants 25 US-born	Nettler Alienation Guilt Inventory Mental Health Index	No difference Probable immigration effect
Rose & Garske 1987 US (37)	20 <i>O</i> NC 17 Children of immigr.	20 Jewish 16 non-Jewish	California Psych Inv Defensive Style Trait-Anxiety, etc.	No difference in adjustment and defensive strategy
Okner & Flaherty 1988 US/Israel (38)	140 US <i>O</i> NC	54 Israeli <i>O</i>	Psychiatric Research Buss-Durkee, Locus of control, Guilt, etc.	No difference in guilt, depression, anxiety
Nathan 1988 Israel (39)	60 <i>O</i> NC 18 years	125 non- <i>O</i> 18 years	Brief Mental Health Social functioning	No difference in mental health
Keinan et al. 1988 Israel (40)	47 <i>O</i> NC	46 non- <i>O</i>	Semantic Differential State-Trait Anxiety Depression Adjective	No difference in emotional stability.
Solomon et al. 1988 Israel (41)	44 <i>O</i> C Soldiers	52 non- <i>O</i> soldiers	PTSD-inventory	<i>O</i> with PTSD rehabilitate slower

Author & year	Offspring <i>O</i> <i>n</i>	Control <i>Non-O</i> <i>n</i>	Measures	Findings
Sigal & Weinfeld 1989 Canada (42)	242 <i>O</i> NC 76 Jewish Immigrants	209 Jewish control	Psychiatric Research Anxiety, depression, dealing with death	No difference in psychopathology and family dynamics
Rubenstein et al. 1989 US (43)	40 <i>O</i> NC families	10 non- <i>O</i> families	Mini-Mult Death Anxiety Scale	No difference in death anxiety
Felsen & Erlich 1990 Israel (44)	32 <i>O</i> NC	30 non- <i>O</i>	Self-Concept, PPQ, Semantic differential	No difference in self and identification patterns
Halik et al. 1990 Australia (45)	19 <i>O</i> NC	19 immigrant 20 control	Parental Bonding Personal Authority	No difference in personal authority
Baron et al. 1993 US (46)	241 <i>O</i> NC	109 non- <i>O</i> escaped	CPI (I-p adjustment) OMNI, NAPD, Hardiness Coping	No difference in inter-personal adjustment, coping & narcissism
Rieck 1994 Israel (1)	847 <i>O</i> NC 29 <i>O</i> mixed children	38 non- <i>O</i> Europe 569 non- <i>O</i>	referrals to psycho-educational service	No difference in referrals to counselling
Rieck 1994 Israel (1)	22 <i>O</i> C	20 non- <i>O</i>	Wechsler's WPPSI, Wisc-R, Koppitz	No difference in psychodiagnostic pattern
Schwartz et al. 1994 Israel (16)	291 <i>O</i> NC 147 <i>O</i> NC	957 control 476 control	Psychiatric Research PTSD Inventory	No difference in psychopathology
Major 1996 Norway (47)	19 <i>O</i> NC	37 non- <i>O</i> escaped	Questionnaire Interview	<i>O</i> more depression & sense of responsibility
Zilberfein 1996 US (48)	38 <i>O</i> C	38 non- <i>O</i>	Dyadic Adjustment State-Trait Anxiety	<i>O</i> less satisfying relations, more anxiety
Baron et al.* 1996 US (49)	208 <i>O</i> NC	70 non- <i>O</i> escaped	Stress resilience Locus of control	<i>O</i> more vulnerable to stress
Sorscher & Cohen 1997 US (50)	40 <i>O</i> NC	38 non- <i>O</i> Jewish	Communication & Holocaust imagery	<i>O</i> more Holocaust ideation
Yehuda et al. 1998a US (51)	22 <i>O</i> C	22 Holocaust survivors	C.M. Scale, CAPS-1 Impact of Event	<i>O</i> with PTSD parent more likely to develop PTSD
Yehuda et al. 1998b US (52)	100 <i>O</i> C/NC	44 non- <i>O</i>	Antonovsky Life Crises Scale, Trauma history, PTSD, etc.	<i>O</i> presented more vulnerability to PTSD & more diagnoses
Yehuda et al. 1998c US (53)	13 <i>O</i> Axis I 10 <i>O</i> no Axis I	non- <i>O</i> control	Impact of Event C.M. Scale, PTSD, Urinary cortisone	<i>O</i> with trauma more symptomatic, <i>O</i> more vulnerable to stress
Magids 1998 US (54)	50 <i>O</i> hidden child surv, NC	50 non- <i>O</i> US-born	16-PF Questionnaire	No difference in personality characteristics
Brom et al. 1999 Israel (55)	31 <i>O</i> NC female	31 non- <i>O</i> female	blind depth interview questionnaire	<i>O</i> more separation-individuation problems No difference in psychopathology

Though these studies are more complex than indicated here, the table provides a clear overview of data on the samples, measurement instruments and findings of relevant research conducted during a time-span of almost three decades. Taken together, they contain a large database on the mental state of Holocaust survivor offspring that is certainly more objective than the earlier subjective interpretations reported by clinicians.

Investigated populations included altogether some 3,300 offspring, compared with an even larger number of non-offspring subjects, and other comparison groups. Studies were conducted in a wide number of countries, most in the US and in Israel, with a few studies in Canada, the UK, Poland, Australia and Norway, which represent the major areas of post-war resettlement of Holocaust survivors. A variety of measurement instruments were employed to study such central variables as personality functioning, adjustment patterns, general and specific psychopathology, as well as self-image, ego strength and general well being. Several studies included a measure of specific PTSD-symptoms, assumed to have been transmitted to the offspring from their more or less traumatized parents. The obvious biases of self-report measures were acknowledged (8, 9) and attempts were made to substitute these with more objective measures, including "blind" evaluations. Finally, validity and reliability data of the measurement instruments were reported with increased frequency, together with improved sampling procedures, attempting to come to terms with self-selection of subjects.

When summarizing the findings of the above studies, most failed to confirm the assumption of increased rates of psychopathology in the offspring of Holocaust survivors as compared to matched control groups. Out of the present 35 studies, 23

found none or insignificant differences in the mental health of offspring as compared to controls. Only about a third of the studies found differences on various measures.

It is important, however, to further analyze these overall results through a breakdown of studies that included samples of offspring that were drawn from 21 non-clinical and 7 clinical populations. As expected, among the non-clinical populations, most studies failed to confirm higher rates of psychopathology in offspring. This might sound self-evident in view of the fact that it states nothing that was not already implied in the term "non-clinical," but it is important to corroborate in view of the repeated, apparently faulty, assumption that it is impossible to grow up in a Holocaust survivor family without being influenced by some kind of mental ailment. More difficult to understand is the fact that four studies did find evidence of more distress in non-clinical offspring samples as compared to other populations. However, after careful analysis these studies fail to provide contrary evidence of the above results for various reasons. Nadler et al. (34) ascribed differences in reaction to frustration to different adjustment patterns rather than to psychopathology among the survivors' children. Major's (47) findings were based on a very small and peculiar sample of Norwegian offspring (42 % of these children reported having depression during adolescence, versus only 16% in the comparison group). The findings of Heller (31) that offspring were more sensitive to culture and ancestry and of Sorscher and Cohen (50) that offspring had more Holocaust ideation, seem to indicate a particular "state of mind," in terms of their inner world rather than a sign of more psychopathology with distressing symptoms.

Among the clinical populations of offspring investigated, it is less surprising to find signs of psychological distress in a large

number of the studies reviewed. For example, Sigal et al. (25) found evidence of more disruptive behavior and over-dependence; deGraaf (27) found more personality disturbances and conflicts in soldiers; Solomon et al. (41) found that such soldiers were more likely to develop PTSD; Zilberfein (48) found that offspring had less satisfying relations and were more anxious; and Yehuda et al. (51) found that offspring with parents suffering from PTSD were more likely 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 (cf. 49) 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 above 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" (53, 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 (56, p. 231) when investigating a general, non-clinical population. But, although the second generation in general does not differ from others in psychopathology, after additional stress their latent vulnerability will become more manifest (57). Thus it seems that offspring seem to experience 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 (16, 41, 49, 51, 52, 53) 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 (58, 59, 60).

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:

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 and objective manner.

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