

## Abstract

### The Conceptualization of Transgenerational Transmission of Trauma.

2008

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Presented in symposium on "The Holocaust as Paradigm of Trauma for the 20<sup>th</sup> Century: Historical, Social and Therapeutic Perspectives". German revised translation published in José Brunner & Nathalie Zajde (eds.) *Holocaust und Trauma: Kritische Perspektiven zur Entstehung und Wirkung eines Paradigmas*, Göttingen: Wallstein Verlag (2011) pp. 137-160.

Children of Holocaust survivors seem to have inherited some of the deleterious effects of their parents' traumatic experiences from World War 2. For example, a child of survivors may have nightmares of annihilation that are similar to those of their Holocaust survivor (HS) parents. While first observed among the "Second Generation" children of Holocaust survivors (2G), this complex process of 'transgenerational transmission of trauma' (TTT), has now been widely observed also in children of other traumatized populations, and has become a new paradigm for the effects of trauma, not only upon the first-generation trauma survivors, but also of their offspring. The present chapter will discuss the theoretical and conceptual ramifications of such trauma transmission, and summarize some of its recent research findings. When describing this intergenerational process, a conceptual differentiation should be made between the contents of that which was supposedly transmitted, and the process of transmission, according to various theories. Such a differentiation will help to clarify that not all effects were negative, but that they may include, vulnerability and resilience, as well as psychopathology and legacy. It will be shown that while some 2G seem to have absorbed the trauma of their parents as if it happened to themselves, others have been able to transform this tragic past from being a heavy burden and something to be afraid and ashamed of, to a life-affirming legacy.

*Was du ererbt von deinen Vätern hast,*

*Erwirb es, um es zu besitzen.*

[Goethe, *Faust*, Part 1, Scene 1: 'What thou hast inherited from thy fathers, acquire it to make it thine.']

## Introduction

Outwardly, he appeared at ease. But he had no inner peace of mind. An overwhelming sense of panic was vibrating within his entire being. Something was tormenting his soul.

"I am having terrible nightmares", he whispered. "I dream that there will be a catastrophe!" "What's in the dream?" I inquired. And he answered: "I am being chased, and I try to escape." In a louder voice: "They will come to take us away!" "Who?", I asked. "I do not know. The Gestapo, perhaps?" He looked frightened. "They will kill us all. I will be unable to protect my family..."

A quick glimpse into his personal history revealed that he was born in the infamous Dachau DP-camp in Germany in 1946 and had come to Israel in 1950. He himself had not been exposed to the Holocaust, but his parents had both been through the camps and lost most of their families. Now, about 60 years after the 2<sup>nd</sup> World War, he was reliving the Holocaust as if he himself had experienced it. The man obviously needed urgent psychiatric evaluation. Except for immense fatigue, there were signs of anxiety, agitation, dissociation, mood lability and poor stress tolerance and the preoccupation with the Holocaust seemed to have increased lately. Most disturbing for him was his latent sense of catastrophic expectancy; one of the most common, if not *the core symptom* of traumatization. Since 'it' had already happened before, he thought 'it' would surely happen again. For him, it was not a question of 'if', but of 'when' it would happen again. So he lived on the edge, jumping at every knock at the door, every telephone signal and every TV or radio News broadcast, always expecting the worst. Looming in the distance like an unborn embryo in the womb of time, he felt that he had to prepare himself for a future disaster, so that he would not just suddenly be taken away and killed like his family had been during the war.

During the last 2 decades, thousands of these more severely affected 2G clients in Israel have turned to Amcha – the National Israeli Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation – for psychotherapeutic counseling. It is my impression that many of these people still suffer tremendously from their heritage, even though they already have reached middle age.

This is no new discovery. Over 500 studies have been published on the transgenerational transmission of Holocaust trauma from Holocaust survivors to their children (c.f. bibliography by Kellermann, 1999a). This literature has described in detail how the psychological burden of Holocaust survivors was passed on to their children who seem to have 'inherited' the wounds of their parents. And though it was first observed among children of Holocaust survivors, this

complex process has increasingly been widely observed also in children of other traumatized populations, including those who endured war, genocide, terrorism, slavery, atomic bomb, interpersonal violence, and “natural” catastrophes in many parts of the world. Some of this research was described in the International Handbook of Multigenerational Legacies of Trauma (edited by Danieli, 1998). More recently, Han (2006) published a study on the deleterious 2G effects of parental trauma on children of Southeast Asian refugees in the US.

Though the 2G children triggered the first conception of transgenerational transmission of trauma (TTT) it has now become a widely accepted paradigm for the enduring legacies of trauma upon the second, third and perhaps subsequent generations. This notion of ‘inherited trauma’ has become widespread among psychotherapists who today will inquire, not only about a client’s own traumatic experiences, but also about those that the parents might have suffered. 2G Holocaust trauma transmissions thus became a new paradigm for the offspring of various traumatized populations in the same way as Holocaust trauma became a new paradigm for direct trauma in the first generation.

The purpose of the present chapter is to discuss the theoretical and conceptual ramifications of this new paradigm and to summarize some of its more recent research findings. When describing this inter-generational process, a conceptual differentiation will be made between the contents of that which was transmitted, and the process of transmission, according to various theories. It is my hope that such a conceptual/theoretical differentiation will provide a more congruent and adequate basis for future empirical research.

### **Transmission terminology.**

A review of the literature suggests that there are a multitude of different terms that describe trauma transmission (Kellermann, 2001c). First, regarding the term “transmission,” Albeck (1993) suggested that we talk about “intergenerational aspects of trauma” instead of trauma “transmission”, and the concept was changed accordingly within the International Society of Traumatic Stress Studies in the early 1990’s. Despite this, I feel “transmission” is a useful and adequate concept since it conveys something that is transferred from one person to another, and I have therefore retained it here.

Second, this transmission process is delineated as *trans-generational* (e.g. Felsen, 1998); *inter-generational* (e.g. Sigal & Weinfeld, 1989); *multi-generational* (e.g. Danieli, 1998); or *cross-generational* (e.g. Lowin, 1983). However, since the trauma was invariably passed on from one or both of the parents, “*parental*” transmission would perhaps be the most adequate term since it emphasizes the generational interchange specifically from parent to child.

Third, earlier literature on the transmission of Holocaust trauma (e.g. Schwartz, Dohrenwend & Levav, 1994; Felsen, 1998) 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). In addition, the process of transmission may be more or less "overt and covert," "manifest and tacit," and "conscious and unconscious."

Fourth, additional concepts such as "secondary" and "vicarious" traumatization have been suggested in order to differentiate this phenomenon from the "primary" and "direct" traumatization of the first generation. But such transmission includes also the effect on spouses and caretakers. The term vicarious trauma has rather come to be used to describe the emotional responses of rescue workers, therapists and other helping professions who assist trauma survivors after disasters.

Finally, transgenerational transmission of trauma should be differentiated from various kinds of collective effects of historical trauma upon a group or a society 'as-a-whole'. While such collective trauma surely has long-term effects upon specific communities, including for example the American Indians, on African Americans, and on the Jewish People as a whole, these should not be regarded as part of the TTT process, which occur only within a specific parent-child family constellation and not in a wider community context.

Earlier literature on the transmission of Holocaust trauma has failed to clearly separate the aetiology (or assumed *cause*) of the transmission from the manifestation (or assumed *effect*) of the transmission. There is as yet no consensus as to how to define the field, some focusing on its descriptive meaning whereas others include possible explanations of its aetiology (Kellermann, 2001c). In order to limit such ambiguity, I will here differentiate between the *process* and *theory* of transmission (*how* the trauma was carried over from one generation to the next), and the *content* of transmission (*what* was in fact transmitted) (Levine, 1982). The first would contain the assumed cause of transmission, in terms of what parents did to their children, and the second would contain 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/child response is essential for making sense of the various theories and research findings within this field.

The underlying model for the parental transmission of Holocaust trauma may thus be characterised as a functional relationship, in which the responses of children of survivors (C) is a function (f) of Holocaust survivor parents' childrearing behaviour (P), leading to the formula:  $C = f(P)$ .

However, there is seldom a clear and simple linear connection between P and C. As Prince (1985), pointed out, "The mechanism of second generation effects is seen as an extremely complex one in which cumulative trauma of parental communication, the aspect of the parent-child relationship determined by the Holocaust context, and the historical imagery provided by the parent and by other cultural processes are mediated by interaction with normative developmental conflicts, family dynamics independent of the Holocaust, variables of social class, culture, Jewish heritage, and immigrant status" (p. 27).

The above simple paradigm therefore needs to be expanded to include various psychological responses of children of survivors (B1, B2, B3, etc.) to a variety of parental factors influencing the process of transmission (P1, P2, P3, etc.) under different circumstances (C1, C2, C3, etc.). In such an expanded model, the simple question: "Are children of Holocaust survivor parents affected by their parents?" is replaced by the more elaborate and appropriate question: "*Which kinds of Holocaust survivor parents influence which kinds of children in which ways under which circumstances?*" This functional relation may be described by the following formula: 2<sup>nd</sup> Gen. B1, B2, B3, etc. = f (Parental P1, P2, P3, etc.) + (C1, C2, C3, etc.).

In order to more fully describe this complex process, I will first discuss some of the prevalent theories of trauma transmission, and then summarize some of the more recent empirical findings of the various effects of that which was transmitted. Before doing this, however, I will discuss the basic process of transmission in a more theoretical manner and try to determine if 2G transmission is at all possible.

### **Is 2G transmission really possible?**

Is it possible for a Holocaust survivor parent to transmit his or her trauma upon the child and can a child really absorb the burden of Holocaust trauma from its parent? If so, how does such a trauma transmission occur? How is a trauma transmitted from one generation to another? If the 2G did not personally experience the Holocaust, how can they suffer its consequences and claim that it dramatically has shaped their lives? Since the process of transmission is very complex, there are no simple answers to these questions.

Because on the one hand, such transmission theory is based on the strange view that it is possible for a father to get a blow on his head by a Gestapo officer in the camp and his son would develop headache some 60 years later. Or, that a woman would be afraid of getting pregnant because her mother had lost a child during the war. In addition, the transmission paradigm would assume that it is possible for a mother who barely survived a terrible fire in her childhood to somehow transmit the emotional aftereffects of this event to her daughter who would be afraid of fire and dream of being burned more than half a century later. Or, that a

father who broke his leg at a football match as an adolescent would somehow transmit this experience to his son, who would be paralyzed and unable to walk many years later.

"Explanations like these which connect past experiences of a parent with a present state of mind in a child may be regarded as at least farfetched and at most ridiculous" (Kellermann, 2001c, p. 260).

Most people would probably dismiss such causal reasoning as being based on magical thinking, or upon some superstitious belief of how the mind can affect the physical world. Other more incredible descriptions of the 2G, who feel that they are indeed possessed by spirits or ghosts or by a kind of *Dybbuk* – a malicious spirit that is believed to be a dislocated soul of a dead person who died in unnatural conditions – would be regarded as superstitious. Even if such conceptions were translated into more professional terminology, including psychoanalytic jargon or extra-sensory communication, they would not be taken seriously.

On the other hand, transmission theory may be more easily digested if explained in terms of popular folk wisdom who claim that 'an apple doesn't fall far from the tree', indicating that there is a certain continuity in family characteristics from parents to their children and that flawed parenting obviously has a detrimental effect on any child's behavior. Specifically, if a child's problems are explained as caused by parental behavior, it will be readily accepted. In addition, the ancient folk notions 'like father, like son,' and 'like mother, like daughter,' are immediately accepted since they indicate that children inherit much of their basic characteristics from their parents. In fact, most people would find it difficult to disregard the observation that all kids pick up some of the idiosyncracies of their parents and that parental behavior in general will profoundly affect the child.

Why would it then be so strange to assume that children of traumatized parents has absorbed some of their parents' trauma, at least from a common-sense perspective? Because such reasoning would clearly have serious difficulties holding up in a court, in which the 2G would claim restitution from the German government for the suffering inflicted upon them while growing up in dysfunctional Holocaust survivor families (Gordon Smith, 2007). Beyond the question of legal precedent, however, how is it possible to prove, 'beyond reasonable doubt', that 2G psychopathology was caused by the parents' Holocaust trauma?

### **Should 2G be eligible for compensation?**

In order to answer this question, I will examine some of the evidence, or lack of evidence, in two actual cases, which involve some kind of physical ailment in the 2G (so that at least one part of the claim can be easily proven).

The first case concerns a boy who was born 1951, by a HS mother from Auschwitz / Bergen Belsen who was still infectious with tuberculosis (TB). She was not allowed to touch him and take him home from hospital for a year and as a result, he suffered from enuresis all through childhood and developed a lifelong history of separation anxiety. He spent a fortune on psychotherapy and various pharmacological treatments but experienced only short periods of emotional balance. Though his psychological problems might not have been *directly* caused by the Nazis, they were certainly a direct result of what the Nazis had done to his mother (giving her TB) and there was no doubt that his first (perhaps most formative) year as a toddler was severely affected by maternal deprivation. Though his mother gets German restitution for the damage inflicted on her lungs, he is not eligible to make a claim.

In the second case, a young 2G woman believed that she could not become pregnant because her mother had been given a chemical substance (perhaps Brom) that made her menstruation stop in Auschwitz. This apparently happened to many women in the concentration camp and if they survived, they later had normal lives and gave birth to what appeared to be healthy children. Naturally, one would immediately argue that if this substance was so detrimental how could the women, including her own mother, give birth at all? In addition, as any family physician or gynecologist would suggest, there may be many other, more plausible male and/or female causes for infertility. Since about 20% of all US couples experience such problems, it is a common biological predicament with prevalence similar among the 2G- population. And, if no biological explanation was found, another plausible explanation for the above state of infertility might be psychosomatic; the infertility is explained as a physical expression of an unconscious mental state. Or, it might be simply dismissed as 'imaginary' since the young woman also suffered from anxieties and associations connected to the Holocaust. At the end of the day, she would probably be considered untrustworthy since she would have a clear secondary gain from this claim.

The 2G-daughter, however, was convinced that the reason for her infertility was the chemical experimentations inflicted upon her mother in Auschwitz. Thinking about the life of the women in camp had a profound emotional influence upon her and, in an almost obsessive fashion childbirth was a theme of constant preoccupation. In addition, she asked: 'How can I bring a child to life in this (terrible) world?' Thus, from a subjective perspective, the predicament of the 2G-daughter was intimately connected to the Holocaust.

Clearly, however, such subjective states of mind cannot justify a legal claim of the 2G and as far as I know, there has been no legal precedent of a child of trauma survivors who have received compensation from a claim against the perpetrator of his or her parents. The difficulties involved in such a claim would be based on a variety of reasons. Primarily, the simple

fact that there may be a multitude of other, equally plausible reasons for a person's present mental state, which have nothing to do with the traumatic past of their parents.

**Transmission Theory**

All the above emphasizes the need for a more comprehensive transmission theory that would substantiate the various claims of TTT and possibly stimulate further empirical research. Such a comprehensive theory would try to explain the intergenerational effects of Holocaust trauma from either a biological or a psychosocial perspective, including the psychoanalytic, family system, and the socialization models. An integrative view of TTT (Kellermann, 2001c) would include a range of these theories, or a mix of them all.

All of these theories tacitly assume that there is a 'mediating agent' between the transmitting parent and the absorbing child. Such a mediating agent would be similar to the one observed in the transmission of a virus, in which a mosquito carries the virus from one person to another. In TTT, however, the Holocaust trauma is perceived as a kind of infectious disease and may also be transmitted by both direct and indirect contact, through a mediating agent. The different mediating agents and transmission factors of each theory are schematically described in Table 1, and will be further discussed below.

**Table 1**

<b>Theory</b>	<b>Mediating Agent</b>	<b>Transmission Factor</b>
Psychoanalytic	The Unconscious	Displaced Emotion
Family System	Communication	Enmeshment
Socialization	Parenting Style	Transmission
Biological Predisposition	Blood hormones, Genetic Factors	Hereditary Vulnerability

- (1) **Psychoanalytic** theory assumes that the unconscious in itself is 'infectious', especially if it is not acknowledged. If however, Holocaust survivor parents become aware of their loss and start to work through their repressed emotions, these will become less malignant.



- (2) **Family system** theory assumes that communication is the main mediating agent. If the Holocaust trauma is talked about in a 'balanced' manner, it is easier for the child to digest it. However, if it is talked about too much or too little, it will become malignant.
- (3) **Socialization** theory assumes that parenting style is the primary mediating agent of trauma transmission. Inadequate parenting leading to enmeshment will affect the general family atmosphere and have a detrimental affect on the child's behavior.
- (4) **Biological** theories are based on the assumption that there may be a genetic and/or a biochemical predisposition to a person's illness. Genes transmit constitutional elements from parent to child and some mental illnesses seem to have a clear hereditary etiology.

### 1. Psychodynamic models of transmission

Intergenerational transmission of trauma is not a new finding in the history of psychoanalysis. Almost a century ago, Freud described how emotional processes may be transmitted from generation to generation. In 'Totem and Taboo', Freud (1913), wrote that "an emotional process, such as might have developed in generations of sons who were ill-treated by their father, has extended to new generations which were exempt from such treatment ..." (p. 158). It is therefore not surprising that psychoanalysts have dominated the clinical study of Holocaust transmission (e.g. Auerhahn and Laub, 1998; Kogan, 1995; Vardi, 1992; Rowland-Klein and Dunlop, 1998). They assumed that emotions that could not be consciously experienced by the first generation were somehow transmitted to the second generation. The child thus unconsciously absorbed the repressed and insufficiently worked-through Holocaust experiences of their traumatized parents. According to Volkan (1997), "Transgenerational transmission is when an older person unconsciously externalizes his traumatized self onto a developing child's personality. A child then becomes a reservoir for the unwanted, troublesome parts of an older generation. Because the elders have influence on a child, the child absorbs their wishes and expectations and is driven to act on them. It becomes the child's task to mourn, to reverse the humiliation and feelings of helplessness pertaining to the trauma of his forebears" (p. 43).

This quote emphasizes that it was the lack of trauma resolution and successful coping, rather than the loss in itself that contributes to trauma transmission. According to Main & Hesse (1990) such a lack of resolution is characterized by parental fear, which causes the parent to be perceived by their children as being either a frightened model, or as directly frightening, both of which might promote disorganized behavior in infants.

Obviously, if Holocaust survivor parents are more preoccupied with the tragic events of the Holocaust, their children will be more influenced. In such cases, a 2G child might try to comfort

his or her father or mother. A striking example of such subtle parent-child interaction was a 2G daughter who used to wake up from hearing the screams of her father who had terrible nightmares. After having talked to her father about his terrible dreams and after having tried to calm him the best she could, she returned to sleep and continued to dream the frightening nightmares that her father had dreamt before waking up. In daytime, she tended to cover up her true emotions and hide her fears of persecution, but her annihilation anxieties were a constant companion and she suffered in silence for as long as she could remember.

Most trauma transmission, however, is more indirect and 'secondary' in that the 2G-child does not re-experience the events consciously. Rather, it is more often a distorted re-construction of the trauma of the parents, a kind of 'echo' of the disowned unconscious of the parent; a sound wave as it were of the interminable mourning, the pent-up anger, and the overwhelming terror triggered by the trauma, which were earlier repressed. These feelings were somehow digested, absorbed and incorporated by the child all through childhood in a process, which Gampel (1998) called 'projective identification'. Even though the parent might have insisted that he or she never intended to burden their children ("I did not even talk to them about it and I kept it for myself because I did not want them to know about these things and be saddened by them"), the 2G-child still absorbed much of it. Such indirect effects especially occurred in children who worried about the health of their parents and who tended to feel guilty about their parents' past sufferings (Wiseman, Mezl & Barber, 2006). Thus, the trauma was passed over to the next generation through different mechanisms, including symbiosis, empathy, attachment, enmeshment, identification and acculturation (Kira, 2001).

## **2. Socialization and parenting models of transmission**

Socialization theory assumes that the 2G children have been socialized in a certain psychological "milieu" which they internalized (Sigal and Weinfeld, 1989). Decades of social science research have documented correlations between the social, educational, behavioral, and economic outcomes of parents and children. For example, children of more highly educated and economically successful parents tend themselves to complete more schooling and earn more. In addition, children of parents who smoke, take drugs, commit crimes, and engage in early sex are more likely to do the same compared with children whose parents do not engage in these activities. In addition, victims of child abuse often become child abusers themselves (Blumberg, 1977) and, as a result, vicious cycles of violence are passed on from generation to generation within many families. Positive correlations have also been established for mental states such as depression, emotional withdrawal and locus of control. It is important to emphasize, however, that this kind of intergenerational transmission was caused by environmental and parental influence rather than by biological and genetic predisposition. The socialization environment provided by parents may even moderate such biological transmission

of psychiatric disorders. In studies of adopted children, for example, children with a schizophrenic biological parent were more likely to develop a range of psychiatric problems, but only if they were adopted into a dysfunctional adoptive family (Maccoby, 2000).

Many 2G internalized their parents' Holocaust experiences while they were growing up. Various kinds of identification processes further strengthened this socialization process (deGraaf, 1975). During specific phases of child development, including adolescence, children commonly ask themselves if they are like their parents or if they are 'different' (Keinan, Mikulincer & Rybnicki, 1988). This is of course the essence of the process of identification and of individuation and, later, of inner separation. One young woman, for example said: "In some ways I am like my mother but in other ways I have done things quite differently and far better than she did. Sometimes, I learned from my parents' mistakes. Other times I repeated them."

Such theories of socialization, together with theories of role modeling (Bandura, 1977) and repetition compulsion applied to parenthood further exemplifies how parents treat their children in the same way as they were treated by their own parents. For example, after having been hit by his father all through early childhood, a man swore that he would never hit his own children. But one day, he got furious with his son and gave the child a box on the ear. Realizing that he had lost control, he asked himself: "What made me do that?" "What made me repeat the exact behavior of my father that I had earlier found so repulsive and humiliating?"

In comparison with psychoanalytic theories that focus on unconscious and indirect influences, social learning theories emphasize conscious and direct effects of parents on their children. In much of this literature, Holocaust survivors have been described as inadequate parents. Their multiple losses were assumed to create childrearing problems around both attachment and detachment. For example, overt messages conveyed by Holocaust survivor parents, such as "Be careful" and "Don't trust anybody!" were assumed to have left their indelible marks on the child. The exaggerated worries of such anxious parents may have conveyed a sense of an impending danger that the child may have absorbed. For example, Scharf (2008) found that adolescents in families where both parents were HS perceived their mothers as less accepting and less encouraging independence, and reported less positive self-perceptions than their counterparts.

Empirical research on children of Holocaust survivors, however, has yielded contradictory evidence regarding the parenting behavior of Holocaust survivors when investigated with classical parenting instruments. Kellermann (2001a) investigated parental behavior with a new self-report instrument that also included salient Holocaust dimensions and found four major kinds of parental rearing behaviors: transmission; affection; punishing and over-protection. While the second-generation group rated their parents higher on transmission, other differences in

childrearing practices were small, if taken as a whole. These findings largely support the descriptive literature on trauma transmission, while at the same time refuting the view that Holocaust survivors function more inadequately than other parents do.

Many questions remain as to how much of the 2G effects are in fact influenced by family upbringing. In addition, there is significant influence from peer groups and random environmental factors also. While originally, the '*Yiddishe Mammeh*' seems to have been made responsible for all deleterious effects in the child, it is perhaps more common today to look for additional factors, especially the family environment, to explain such effects.

### **3. Family system and communication models of transmission**

Direct and indirect transmission of parental traumatization always takes place within a certain family environment, which is assumed to have a major impact on the children. Though Holocaust survivor families certainly differ from one another in many ways (Danieli, 1981), the more pathological families are described as tight little islands in which children came into contact only with their own parents, with their siblings and with other survivors. In such highly closed systems parents are fully committed to their children and children are overly concerned with their parents' welfare, both trying to shield the other from painful experiences (Klein-Parker, 1988). Through mutual identifications, parents live vicariously through their children and children experience vicariously the horrific past of their parents. Considering such powerful family dynamics, it is not surprising that problems around individuation and separation (Klein, 1971; Barocas & Barocas, 1980; Freyberg, 1980; Brom, Kfir & Dasberg, 2001) and attachment (Bar-On, Eland, Kleber et al (1998) were often observed.

Repeated research has found that communication patterns have a profound effect on the process of intergenerational transmission of trauma. Studies on communication styles within Holocaust survivor families have found mainly two main patterns. While some survivor-parents excessively exposed their children to their horror stories, others were fully silent and secretive about their trauma. Some of these latter parents apparently practiced a wide variety of guilt-inducing styles of communication with their children. These types of communication often scared the children (Bar-On et al., 1998), leading them to engage in frightening fantasies, or to develop other disturbed psychological states (Lichtman, 1984).

Family systems models of transmission assumed that such hidden communication patterns, often described as 'conspiracy of silence' were a primary factor of transmission between parent and child. Two recent papers on parental communication of Holocaust experiences and interpersonal patterns in offspring of Holocaust survivors (Wiseman, et al, 2006; Wiseman, et al, 2007) found that the lack of communication about trauma-specific events like the Holocaust

has caused a mix of anger and guilt in both parties. Survivors tended to be silent on the subject, not wanting to relive it, a pattern that left the Holocaust distant and detached, not only for themselves, but also for their children. They believe that their children would grow up normal without knowing of the horrors. The children don't ask, and thus the subject is never brought up.

The kids who 'heard too much' - Such children seem to have been secondarily traumatized by hearing parental stories of the Holocaust and witnessing the chronic suffering of their parents. Children who were directly exposed to the parents' trauma —nightmares, psychotic breakdowns, crying, depression, and preoccupation were more easily affected. These experiences were too frightening for the child, in particular when no other caregiver was there to assist the parent and to buffer the psychological experience of the child.

A specific kind of "double-bind" family communication may also account for trauma transmission. The child is fixed in an intense emotional relationship with a parent who, by the contradictions between the parent's verbal remarks and behavior, makes it impossible for the child to respond adequately. For example, a son may be encouraged by his mother to use initiative in his schoolwork. Yet when he wants to go to the library, his mother said: "Why do you leave me? I need you here and will become ill if you leave me alone." Such a double bind restricts the emotional development of the child and further confuses the communication that is already very complicated. Miller's (1981) description of parents who unintentionally damaged their children by not recognizing their emotional needs fits well within this picture.

Much of this family influence results in a tendency in the children to take upon themselves the role of being parents to their own parents. Motro (1996) wrote: "We are older now than our parents were when they survived. And yet they in their old age still feel like orphans, and we often feel like their parents. It is our duty to fill all voids." This kind of role reversal with the traumatized parent may be conceptualized as "defensive care taking," (Metzger-Brown, 1998), "narcissistic parenting" (Rosenberger, 1973), "enmeshment," (Zlotogorski, 1985; Seifter-Abrams, 1999), "engagement" (Podietz, et al., 1984) or "parent-child role diffusion" (Zilberfein, 1996). Through "invisible loyalties" (Boszormenyi-Nagi & Spark, 1973), children adopt the role of parental and/or parentified child, and they thus sadly become orphans themselves with unfulfilled dependency needs of their own.

#### **4. Biological and genetic models of transmission**

Biological models of trauma transmission are based on the assumption that there may be an inherited, genetic and/or a biochemical predisposition to the etiology of a person's illness. Genes transmit constitutional elements from parent to child and some mental illnesses seem to

have a clear hereditary etiology. For example, studies indicate that children of schizophrenic parents are much more likely to develop the disorder than the general population.

This kind of research started immediately after the 2<sup>nd</sup> World War when physicians observed that newborn children of Holocaust survivors suffered from a number of birth defects. Eitinger (Eitinger & Krell, 1985) mentioned one of the very first studies concerning the children of concentration camp survivors published as early as 1948 by a gynecologist in Munich who found that of the 1430 Jewish newborn at his department, one out of 25 (4%) had congenital malformations. The average percentage of malformations in newborn at the same department had earlier been only one in hundred (1%). Such findings naturally support the assumption that there is validity in the biological model of transmission, which normally is studied exclusively on animals. For example, a recent animal study conducted by Bertram, et al. (2008) found that the prenatal environment is a powerful determinant of risk for developing disease in later life. Specifically, they showed that maternal under-nutrition caused dramatic changes in heart structure across two generations of guinea pigs. Similar profound biological effects on the offspring of undernourished Holocaust survivor mothers can thus also be expected.

The genetic model of transmission provides a clear theoretical basis for future research. Primarily, it suggests that parental traumatization may be transmitted in the same manner as some hereditary diseases are passed on from one generation to another. Genetic memory code of a traumatized parent would be transmitted to the child through some electro-chemical processes in the brain. The neural organization of various memory systems in the parent (e.g. hyper alertness) would lead to a similar organization and constitution in the child. Since psychic trauma is assumed to have long-term effects on the neurochemical responses to stress in traumatized parents (Van der Kolk, et al, 1996), it may also lead to the same enduring characterological deficiencies and to a kind of biological vulnerability in the child. Children of Holocaust survivors, who are born to severely traumatized Holocaust survivor parents, would then be "predisposed" to PTSD.

The research by Yehuda et al, (summarized in Yehuda, 2006) has further investigated such assumptions, raising questions of the 2G child's innate qualities, versus his or her personal experiences in causing the observed 2G effects. In a long series of studies over many years, Yehuda, et al (2000) found that low cortisol levels were significantly associated with both PTSD in parents and lifetime PTSD in offspring, whereas having a current psychiatric diagnosis other than PTSD was relatively, but non-significantly, associated with higher cortisol levels. Offspring with both parental PTSD and lifetime PTSD had the lowest cortisol levels of all study groups. They concluded: "Parental PTSD, a putative risk factor for PTSD, appears to be associated with low cortisol levels in offspring, even in the absence of lifetime PTSD in the offspring. The findings suggest that low cortisol levels in PTSD may constitute a vulnerability marker related to parental

PTSD as well as a state-related characteristic associated with acute or chronic PTSD symptoms" (p. 1252). These studies indicate that children of trauma survivors constitute a high-risk group for posttraumatic stress disorder (PTSD) because they have a greater prevalence of lifetime PTSD compared to demographically similar persons who have experienced equivalent numbers and types of DSM-IV traumatic events.

### **Manifestations of Trauma Transmission**

Having discussed the prevalent theories of trauma transmission, and emphasized the various ways in which parents might have passed on their Holocaust trauma, we will now review some of the manifestations of such transmission, and focus on the various effects of this transmission upon the child. What did the child in fact absorb? While the main assumption was that the child absorbed the Holocaust traumatization of the parent in general, the main question concerning the 2G would then be if they suffer from more psychopathology than comparative groups (e.g. children of immigrants). If the Holocaust survivors suffer from PTSD, their offspring would also suffer from such a syndrome (Baranowsky, et al, 1998). The 'content' of trauma transmission would therefore be some kind of secondary posttraumatic stress disorder.

The existence or non-existence of psychopathology in the offspring of Holocaust survivors has been the subject of the greatest disagreement. While clinicians observed various kinds of emotional distress in this population, empirical research failed to confirm these observations when investigated with more objective and reliable instruments. An overview (Kellermann, 2001b) of the empirical research concluded that most controlled studies failed to confirm the assumption of increased rates of psychopathology in the general populations\_of offspring of Holocaust survivors compared to control groups. This finding was repeated in the only controlled double-blind study of a random sample of female children of Holocaust survivors (Brom, Kfir & Dasberg, 2001), and in numerous other studies (cf. Schwartz, Dohrenwend & Levav, 1994). Most recently, this finding was also confirmed in a recent Israeli National Health survey (Levav, et al., 2007) in which 430 offspring of Holocaust survivors were compared with offspring of parents who did not reside in Nazi occupied territories. No statistical differences in psychoapthology and other health dimensions were found between both groups. They concluded that the generation of HS parents, even though they had suffered maximum adversity in their lives, apparently had been able to protect their children's mental health up to adulthood.

With a fair amount of certainty, we are therefore able to conclude that 2G in general are not suffering from emotionally disorders than others since empirical research has been unable to substantiate the claim that there is more psychopathology in children of survivors than in comparable populations (Van Ijzendoorn, Bakermans-Kranenburg & Sagi-Schwartz, 2003).

Thus, we are no longer asking if children of Holocaust survivors in general are more disturbed than others. We know that they are not. However, many 2G still turn to psychotherapists with a variety of complaints. This clinical subpopulation of 2G apparently suffers from specific symptoms, which are connected to the trauma of their parents. Some practitioners estimate that about 15% of this population presumably suffers from a specific kind of "Second Generation Syndrome". Rather than continuing to investigate the more general comparative question, we should try to delineate the specific characteristics of this clinical subgroup of 2G and define what we mean by a '2G Syndrome'. From the descriptive literature and clinical practice, I suggest that this syndrome includes a predisposition to PTSD, difficulties in separation – individuation, a contradictory mix of resilience and vulnerability when coping with stress, a personality disorder or various neurotic conflicts, periods of anxiety and depression in times of crisis, and a more or less impaired occupational, social and emotional functioning with problems centered on the self, cognition, affectivity and interpersonal functioning (Kellermann, 1999b; 2001b, 2001c).

One of the most apparent characteristics in this sub-population is that they constitute a high risk group for PTSD. Though they may not show any overt signs of psychopathology in ordinary situations, when diagnosed with cancer (Baider, et al., 2006), or when being exposed to combat stress (Solomon, Kotler, & Mikulincer, 1988), they seem to respond with a higher degree of psychological distress than others. It is therefore possible to assume that such 2G children have a kind of inherent and inherited 'vulnerability marker' (Yehuda, 2006), which is threatening to be activated at the occurrence of any new trauma.

Clinical impression and qualitative studies based upon deep interviews and content analysis has further identified specific intergenerational themes that may be frequently observed in this clinical group of 2G. These include subjective feelings of guilt, anxiety and depression, which have a definite 'Holocaust flavor'. It is as if the 2G are carrying a heavy burden which is loaded with the emotional pain of the parent. When asked about the content of this burden, such 2G would frequently be able to share common Holocaust associations, indicating that much of their inner worlds is filled by images of persecution, annihilation, loss, escape and other common images of from the 2<sup>nd</sup> World War. Apparently, such traces of the Holocaust have 'rubbed off' on them and have come to dominate their inner lives. Most obviously, this preoccupation with the Holocaust frequently tends to exacerbate their latent sense of catastrophic expectancy. This is one of the most common, if not *the* core symptom of traumatization. Since it has happened before, 2G think that it can happen again. It's not a question of 'if', but of 'when' it will happen again (and again and again). So they live 'on the edge' all the time, jumping at every knock at the door, sudden telephone signal or impending news. Such a startle reaction is of course familiar to all trauma survivors.



In addition, and perhaps in a futile effort to 'work through' the trauma of their parents, 2G are constantly trying to imagine how it was 'there and then'. For example, they may be searching for the remnants of the old village where their parents used to live, and from where they were sent to the camp. Then, they will try to imagine the horrors of mass dehumanization; to reconstruct the scenes of prisoners marching into the camp, and to envision how the victims were murdered. In a vicarious manner, they try to 'join' their parents' in that place, as it were, to revisit the landscape of death and they wove to remember and to keep the fire alive. Carrying the memory of the murdered victims may in itself become an overwhelming responsibility and a suffocating duty.

In several recent qualitative studies, a variety of such issues in the 2G were investigated. For example, Bar-On, et al (1998) applied an attachment perspective for understanding the developmental sequelae of trauma across generations. A few years later, Chaitin (2002) looked at how three generations in Israeli families of Holocaust survivors work through the past. Fifty-seven people from 20 families told their life stories and the interviews were analyzed for central themes and values. These studies showed that the working through process posed different problems for each generation. Finally, Gottschalk (2003) proposed an alternative 'listening model' to the previously utilized psychiatric and psychological models. In his extraordinary illuminating analyses of many profound in-depth interviews, he succeeded to highlight the experiential inner worlds of the 2G. For example, in one such case, he describes how Diane was trying to imagine what her mother felt: "...the fear, the cold, the lice, the constant fear of the shower, the terrible train rides and not knowing what will happen...Today I tell myself that I live a luxurious life...Everything is in comparison to my mother. I tell myself that to have cancer is nothing as compared to being in a concentration camp".

Such qualitative interviews reveal that there are important differences in the ways that different 2G cope with being children of Holocaust parents. Some children grow up with terrible anxiety-provoking Holocaust associations that haunt them day and night. Others experience their heritage as a powerful legacy that gives them a sense of purpose and meaning in life.

Apparently, the child may perceive the trauma of their parents both as a curse and as a legacy. In addition, these various 2G-identifications may go through constant transformations during an ongoing process of working through. For example, it might start as a great burden and then be transformed to become an important and valuable part of a person's life. Earlier, the 2G children might have been ashamed of the fact that their (victim) parents had numbers on their arms. Today, they might be proud of being children of Holocaust survivors (now viewed as heroes) who, despite everything, have succeeded to overcome so much adversity in their lives.

Many of these latter 2G have been able to transform such parental identifications into creative and artistic expression, through the medium of music, literature, drama or art. For example, in the book "Children of Job," Berger (1997) presents a comprehensive study of 2G writing in what he calls an attempt to cope with "the presence of absence." Other 2G have used their Holocaust 'legacy' to contribute to other aspects in life and to society in general.

### **Vulnerability and Resilience**

Thus we are left with the finding that the 2G seem to carry within themselves the contradictory forces of both vulnerability and resilience (Sigal, 1998). While the 'transmitted trauma' that they have inherited from their parents might increase their suffering, the very fact that they have vicariously experienced so much tragedy also provides them with ability for adaptive coping and with 'survival skills', which usually are insufficiently developed in other people.

Helmreich (1992) delineated ten such general traits that enabled Holocaust survivors to lead positive and useful lives following the war, despite their earlier trauma: (1) to be able to adapt in a flexible manner to new environments, (2) to be assertive and take initiative, (3) to refuse to take 'no' for an answer, (4) to have an optimistic and future oriented approach to life, (5) to utilize intelligence and professional skills, (6) to be able to remove the trauma from consciousness, (7) to belong to a helpful support group, (8) to assimilate the knowledge that they survived, (9) to find meaning and a sense of coherence in one's life, and (10) to muster courage. If many of these resilient traits were predominant in the survivors, we may assume that some of them were also passed on to their offspring. As a result, and because of their close affinity with the tragedy of their parents, traits such as compassion, empathy and a deep understanding of human suffering may be assumed to be highly developed in the 2G, giving them a special interest and ability to work in the helping and teaching professions.

It would be a simplification, however, to describe the two forces of vulnerability and resilience as two separate forces struggling to take hold of the inner personality of the 2G. Rather, offspring of Holocaust survivors seem to simultaneously struggle with both forces at one and the same time, and probably, there will be periods in their lives when one or the other is more dominant. Some might suffer from life-long debilitating psychopathology with periods of tranquility, while others may function excellently most of the time with shorter periods of severe anxiety and depression. It is important, therefore, not to view this client population as a homogenous group, which either suffers from specific psychopathology or which manifests post-traumatic growth, but to see them as simultaneously struggling with both forces throughout life.

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