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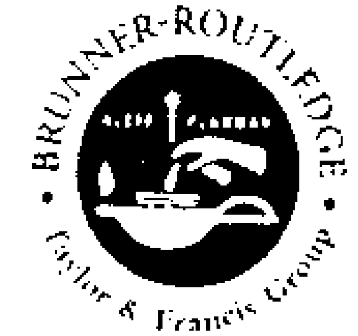

THE LONG-TERM PSYCHOLOGICAL EFFECTS AND TREATMENT OF HOLOCAUST TRAUMA

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The present article gives an overview of the long-term psychological effects of Holocaust traumatization on survivors and their offspring and suggests possible treatment strategies for these client populations. Based on interviews with and treatment of hundreds of such clients and on an extensive review of the literature, it also represents some of the cumulative experience of AMCHA, an Israeli treatment center devoted specifically to this issue.

For me, the Holocaust has not ended (Holocaust survivor)

The long-term aftereffects of Holocaust traumatization are far-reaching. More than half a century after the war, the Holocaust continues to make its presence felt on survivor families and others in a variety of ways. Like an atom bomb that disperses its radioactive fallout in distant places, often a long time after the actual explosion, the Holocaust continues to contaminate everyone who was exposed to it in one way or another. When retiring from work or experiencing deteriorating health, terrifying nightmares and flashbacks reappear in aging survivors who over the years had kept themselves excessively busy in order to repress their painful memories. Survivors who were children during the war continue to struggle with their basic insecurities and prolonged mourning for parents they hardly or never knew. The offspring of both of these groups, the so-called "second generation," gain more awareness of the repressed pain that they indirectly have absorbed from their parents. Traces of Holocaust associations may even be found in the third generation who, in their quest for past roots, discover the prematurely

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broken branches of their family trees. Finally, relatives, close friends, and caretakers show signs of having been secondarily traumatized by the plight of the survivors, and then there are certain populations that suffer from bystander guilt.

Thus, it seems that Elie Wiesel (1978) was correct in stating that "time does *not* heal all wounds; there are those that remain painfully open" (p. 222). While Holocaust survivors and their families made every effort to continue their lives without being constantly reminded of the terrible events of the past, traumatic memories kept returning with all of their accompanying emotions. As Judith Herman (1992) pointed out in her book *Trauma and Recovery*, "atrocities refuse to be buried" (p. 1). They keep penetrating the conscious and unconscious minds of the survivors and their offspring until they are properly remembered, mourned, and worked through within a safe, healing relationship.

The purpose of the present article is to describe the long-term psychological effects of Holocaust traumatization on survivors and their offspring and suggest possible treatment strategies for these client populations. Based on interviews with and treatment of hundreds of such clients and on an extensive review of the literature, it also represents some of the cumulative experience of AMCHA, the National Israeli Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation, a nonprofit organization devoted specifically to this issue.

AMCHA

"Amcha" (Hebrew/Yiddish word for "your people") was the code word that helped Jews identify one another in occupied Europe. Since the establishment of AMCHA in 1987, it stands for another kind of support system in Israel, one that attempts to give survivors and their children an opportunity to unburden their hearts.

Why did it take more than 40 years after the end of the war to establish such an organization? Many reasons may be suggested. First, a new social awareness of the Holocaust began to develop in 1960 after the Eichmann trial in Jerusalem. Having been silent for decades, more survivors than ever were ready to speak out and to openly share their memories and their prevailing mental suffering. As younger people grew increasingly curious about their parents' past, asking questions and seeking answers, the legacy of guilt and shame that was bequeathed to the Holocaust generation was embraced and slowly transposed. With time running out for the aging survivor community,

many felt the responsibility of bearing witness and preserving memory. In addition, the psychological effects of transgenerational transmission of trauma on the offspring became more widely acknowledged.

Second, while survivors seemed to live a normal life and looked healthy from the outside, their families knew of their private and largely concealed suffering. Therefore, during the 1980s, there was a sense of urgency to provide emotional support "now or never." The woes of aging, retirement, illness, and death of spouses created new emotional crises that activated the old trauma. As a result, many began to seek professional help, sometimes for the first time in their lives. Thus, the various psychological needs of this population started to become more acknowledged, as manifested, for example, by Professor Haim Dasberg's (1987) pioneering paper "Psychological Distress of Holocaust Survivors and Offspring in Israel, Forty Years Later."

However, services that were heretofore provided were found to be insufficient and largely inadequate. Mental health professionals seemed to avoid this chronic patient population and showed signs of "Holocaust victimophobia" as well as various countertransference responses that reinforced the conspiracy of silence that had prevailed for so many years.

A "Holocaust survivor" may be defined broadly as any persecuted Jew who lived under Nazi occupation during the Second World War and who was thus threatened by the policy of the "final solution" but managed to stay alive. According to this definition, clients eligible for treatment in AMCHA include persons with widely different Holocaust experiences: those who were confined to a ghetto, experienced forced labor in work camp and/or incarceration in a concentration camp, were in hiding or lived under false identities, became refugees who left their families behind, fought with the partisans, were sent away in the "Kindertransport," etc. All of these people were traumatized in one way or another, having been under constant threat of being killed, having suffered significant losses, or having lived under the shadow of Holocaust persecution.

With about 350,000 Holocaust survivors living in Israel at the time and when including also their children and their immediate families, a rough estimate of those directly or indirectly affected by the Holocaust would be approximately 1 million people. Though only a small percentage of these individuals were assumed to be more vulnerable to mental distress, the population at risk still constituted a large number of people who were in need of special mental health services hitherto not provided.

Starting modestly in Jerusalem, AMCHA currently (as of this writing) employs about 130 mental health professionals (social workers, psychologists,

expressive therapists, psychiatrists, and occupational therapists). These individuals provide services to thousands of clients in four major cities (Jerusalem, Tel-Aviv, Haifa, and Beer Sheva) as well as in affiliated locations.

AMCHA has become a pioneer in the field of lifelong suffering of post-traumatic stress. Much of its experience and research on the mental health of Holocaust survivors is by and large unique. As a result of this unique experience, a rich selection of services are regularly provided by AMCHA (see Table 1).

Holocaust Survivors

Holocaust survivors clearly differ from one another in a great many ways, in their prewar personality makeup, in their various traumatic war experiences, and in their postwar readjustment. Of all of these differences, their varying

TABLE 1 Services Provided by AMCHA

Services provided to all populations of AMCHA
- Individual counseling (supportive and explorative, long/short-term psychotherapy)
- Group psychotherapy (various verbal and nonverbal approaches)
- Open lecture and discussion sessions and study days
- Referral to and information about other services in the community
- Psychiatric (or psychogeriatric) consultations (for clients in therapy)

Services provided to elderly Holocaust survivors
- Home visits by volunteers
- Documentation through video recordings of personal and family history
- Psychosocial senior citizen support clubs

Services provided to child survivors of the Holocaust
- Counseling for "nonsurvivor" spouses
- Specific groups for actualization of memories
- Self-help activity groups

Services provided to the second generation
- Couple and family counseling
- Open and closed groups for children of survivors
- Advice about caring for their elderly parents

Services provided to the professional community and to third parties
- Study days and guidance for mental health and social service professionals
- Research in the epidemiology and treatment of Holocaust-related mental distress
- Yom Hashoah activities
- Education to bystanders and to the society at large

vulnerability and resilience to stress are perhaps the most striking in rendering them more or less susceptible to mental ailments. Such variability makes the differentiation between clinical and nonclinical Holocaust survivors relevant.

While a majority of survivors showed an unusual degree of psychic strength in overcoming the effects of their traumatic experiences and multiple losses (many fought in Israel's wars and helped shape the state in every area after its establishment), a clinical minority continued to suffer from periods of depression, irrational anxieties, sleep disturbances, and psychosomatic symptoms that clearly led back to Nazi persecution. The following are some typical examples.

An 80-year-old female Holocaust survivor was referred to AMCHA by her daughter because of exaggerated hoarding of food. Though this had been common practice for years, with the refrigerator always overpacked with food, the compulsion had increased since the woman had become a widow. The situation had further deteriorated when she refused to discard spoiled food and accused her daughter of stealing. "*There and then,* we had nothing to eat!" she exclaimed. "How can you throw out food now?" The daughter was perplexed, not knowing what to do.

An elderly man consulted AMCHA because of severe sleeping disturbances. He awoke almost every night in a sweat, unable to fall back to sleep. Painful memories from the Holocaust had returned with all of the accompanying affects, and he was overwhelmed with terror. He recounted a recurrent nightmare in which Gestapo soldiers hunted him on motorcycles. It was forbidden for Jews in the ghetto to be out at night, and he ran for his life until arriving at the door of his house, which was closed and locked. Standing in front of the large door, he shouted and called for his father to open the door. He shouted "Papa! Papa!" but nobody opened the door. While shouting aloud, he became aware of his wife trying to wake him, and he realized that it was only a dream. But he was unable to fall asleep again, remembering how his family had been slaughtered and how he had been forced to do things that could never be forgiven. The fact that he was still alive was an absurd accident because life had lost its meaning for him. "Before there was *life,*" he said. "Now it is just an *existence.*"

The following 10 characteristics are frequently observed in Holocaust survivors who apply for psychiatric treatment at AMCHA: (a) massive repression, numbing of responsiveness, amnesia, and alexithymia; (b) intrusive memories, Holocaust-related associations, and "shattered assumptions"; (c) anhedonia, suicidal ideation, depression, and a chronic state of mourning;

(d) survivor guilt; (e) sleep disturbances and nightmares; (f) problems with anger regulation and in dealing with interpersonal conflicts; (g) excessive worries, anxieties, catastrophic expectancy, and fear of renewed persecution; (h) suspiciousness, paranoia, isolation from the community, lack of trust, and loneliness; (i) use of survival strategies "from there"; and (j) low threshold for stress in difficult situations.

Most commonly, Holocaust survivors respond with habitual panic when exposed to triggers that in some way symbolize the Holocaust. Such Holocaust associated triggers may include any or all of the following: crowded trains, train stations, medical exams, a knock at the door, uniforms, extermination (of insects), yellow color, selections, gas, shower, barbed wire, discarding food (especially bread), fences, cruelty, barking dogs, any major disaster or discrimination, separations, the smell of burned flesh, closed spaces, an oven, standing in line, the freezing cold, music by Wagner, the German language, and German products in general. Any of these stimuli may create a violent emotional response in the survivor who at that moment is thrown back to a life-threatening situation during the Holocaust. In addition, happy occasions such as weddings, Jewish holidays, and family celebrations may also evoke sudden grief reactions, since they remind survivors of their immense loss and all of the people who are absent because they were so brutally killed. As a consequence, there is frequently a contradictory effort both to remember and to forget, both to approach and to avoid the traumatic event in a compulsively repeated fashion. Like a broken record that is spinning around and around, intrusive experienced images and painful memories keep coming back while at the same time there is a conscious effort to avoid them and not to think about them.

Such behavior indicates that defenses to ward off anxiety and depression that had been successful earlier in life become harder to use at a more advanced age. The indelible emotional scars created by the impossible choices of life and death during the Holocaust gradually or suddenly burst open, and a mixture of survival guilt and repressed aggression start to torment these individuals again late in life. Having hitherto done all they could to cover up their pain and to repress their terrifying memories, old traumas come back to life, and unfinished emotional business presses for resolution. "When I was released from Buchenwald," one survivor said, "I felt that the only way for me to continue my life was to leave the past behind. I made every effort to stop thinking about it, to stop talking about it, and thus I hoped to be able to cope better. I became *busy* with other things." This seemed to work for more than 50 years until the past caught up with him and forced him to reexperience it all over again in his dreams.

The early literature on Holocaust survivors who were being evaluated for psychiatric treatment and/or compensation presented a gloomy picture of severe symptomatology with considerable affective, cognitive, and behavioral impairments. The usual complaints of such survivors included persistent anxieties, fear of renewed persecution, chronic depression, psychosomatic symptoms, concentration and memory difficulties, maladjustment, sleep disturbances with terrifying nightmares, and a general difficulty to verbalize their traumatic emotions (or alexithymia). In papers by Niederland, Chodoff, Eitington, Krystal, and others, a specific KZ syndrome was suggested to describe such specific psychopathology. This early literature was frequently criticized for being based on nonrepresentative clinical case reports. Dasberg's (1987) review of some of the later comparative studies conducted on nonclinical populations of Holocaust survivors revealed a more mixed picture of postwar adaptation. This included a description of a "hardening" effect that sometimes demanded a high price in terms of emotional restriction.

The psychopathology of Holocaust survivors remains a controversial issue. Any statement describing this population in general as emotionally disturbed will evoke intense protest, since it would in fact stigmatize already-disempowered people (Herman, 1992). Contrary statements that this population is *not* emotionally disturbed will evoke equal protest on the grounds that nobody who went through the Holocaust could remain insulated from emotional scars. The arguments seem to be more affective than informative.

Clearly, we must differentiate not only between clinical and nonclinical populations but also between survivors who may suffer from a variety of mental ailments. The chronic clinical group may have had a pre-Holocaust predisposition for severe mental disorders and continue to present emotional problems all through life. The nonclinical group continues to function well but presents specific Holocaust-related ideation when undergoing psychological evaluation. Clearly, all survivors seem to be "at risk" of mental disturbances, especially at times of renewed stress and traumatization. At these points in life, the most suitable diagnostic label seems to be *chronic posttraumatic stress disorder* (PTSD) with depression as a frequent associated feature (Kellermann, 1999).

Treatment of Holocaust Survivors

Holocaust survivors do not want to be treated as psychiatric patients and show little interest in counseling or psychotherapy. Most apply for help hesitantly and with significant doubts. When they do, however, their need for symptom alleviation is often pressing and urgent. It is therefore important to quickly establish a trusting relationship and to give some hope that the efforts

in overcoming their resistance to seeking help have been worthwhile. Obviously, a major way of doing this is to make them feel understood and accepted as they are within a framework of fellow survivors. Entering into the private world of the client and becoming thoroughly at home in it seems to be a basic prerequisite for such a relationship. This is a central starting point of all treatment interventions at AMCHA.

After establishing safety and trust, the central importance of Holocaust experiences in the lives of survivors is emphasized. For this purpose, survivors are invited to recount what they went through during the war at the beginning of their contact with AMCHA. Survivors who have repressed their painful memories commonly respond ambivalently to such an invitation to retell their stories. "Why open old wounds and reexperience the pain? Why bring out the frightening ghosts from the past? Why not let them sleep? What good does it do to meddle in those terrible memories that happened so many years ago? Let's try instead to forget and go on with life as it is today!" This ambivalence is based in part on the difficulties involved in verbalizing traumatic memories, as expressed by Elie Wiesel (1978): "How is one to speak of such things and not lose one's mind, and not beat one's fists against the wall? It is as impossible to speak of them as not to speak of them. Too many corpses loom on our horizon; they weigh on every one of our words, their empty eyes hold us in check. One would have to invent a new vocabulary, a new language to say what no human being has ever said" (p. 236). Despite such resistance, however, most survivors today want to retell their stories if they feel that there is somebody who is willing to listen to them.

While it is impossible to give any general recommendation about talking or keeping quiet, from the perspective of healing trauma, it is generally agreed that letting out what was hitherto kept in is better than attempting to repress and forget painful memories (Herman, 1992). In other words, memorialization takes precedence over amnesia. Thus, the commemoration of the Holocaust and the acknowledgment of its legacy are surely an essential part of collective working through.

On an individual basis, however, the balance between forgetting and remembering is usually not conscious and intentional. Survivors continue to reexperience the trauma (in vivid recollections and nightmares) while they desperately try to regain some kind of inner balance and emotional equilibrium. Talking about their Holocaust experiences in therapy may, in a paradoxical fashion, provide some emotional relief. For example, a woman had insomnia and nightmares for many years. She would dream that she was back in the camps and that she was going to die. Once she gave testimony and

began writing her memoirs, the nightmares subsided and she slept better. Retelling her story again and again seemed to have helped her. The mere verbalization of memories and the very act of translating feelings into words may thus help to reorganize experiences and make them easier to digest (Freud, 1958).

However, while we may agree on the benefits of talking about the Holocaust with survivors, many questions remain regarding suitable treatment approaches for this population. For example, which therapy approach should be recommended? What works best for whom in which context? Do we recommend long-term, medium, short, or time-limited treatment? In which cases do we suggest individual, group, family, milieu, and/or psychopharmacological treatment? Should psychotherapy be supportive and reeducative or explorative and reconstructive? Obviously, with such a wide variety of presenting problems, it is impossible to give any specific recommendations. Furthermore, while there is a rich literature on the manifestation of Holocaust traumatization, comparatively little is written about actual treatments with this population (Chodoff, 1980). Therefore, this article will only be able to describe some of the general guidelines of treatment developed at AMCHA and list some of the approaches offered.

The treatment of elderly Holocaust survivors differs in some respects from that of their younger brothers and sisters as well as from that of other, more recently traumatized people. Loss of family and the companionship of children, diminished strength, and decreasing physical ability combine with the recurrence of Holocaust memory to accelerate mental distress. In order to suit their personal requests and their individual therapeutic needs, a wide range of treatment alternatives are offered to survivors who come to AMCHA. A combination of psychological, social, and occupational approaches, including individual and/or group psychotherapy, psychosocial milieu therapy, and social casework, is often applied. In addition, as the survivors grow older, AMCHA attempts to develop more innovative treatment approaches and/or psychosocial services to meet the new needs that arise.

Modest treatment goals and limited therapeutic objectives are proposed with this elderly, usually chronic, traumatized population. Except for the obvious focus on mitigating the wounds of the Holocaust, therapy aims to alleviate the anxieties of aging: to help them deal with depression and grief for the death of family members and friends, problems of retirement and inactivity, difficulty in living alone and becoming dependent on others, and approaching death. A social club, home visits by volunteers, and various group activities are provided to brake some of the interpersonal isolation, to

increase morale, and to counteract withdrawal and mental deterioration. Specific rehabilitation activities are suggested, such as suitable voluntary work for an active older retired person and the development of appropriate recreational facilities, such as hobbies, lectures, and discussions. Physical exercise classes are offered both as a release of muscle tension and as a means to get one's mind off whatever is bothering it. Social casework aims to help resolve problems of housing, health, occupation, socialization, and recreation on a more practical basis. Proper information and guidance is sometimes all that an older person requires to continue to maintain self-respect and self-sufficiency. Frequently drugs are added as an adjunct to psychotherapy in cases of major depression, severe anxiety, and chronic sleeping disturbances.

The following phases can often be delineated in the psychotherapeutic treatment of Holocaust survivors. The first stage of therapy is to establish a safe and trusting relationship in which survivors feel accepted and understood. This demands specialized understanding and experience on the part of the psychotherapist as well as considerable attention to the therapist's own counterresponses. Survivors are thereafter encouraged to tell their personal life story, including memories of experiences happening before, during, and after the Holocaust, and relate these to the present. Traumatic incidents are addressed directly, and, if possible, the accompanying emotions, thoughts, and physical sensations are explored in depth. The emotional working through of the personal meaning of these events (as remembered) thus follows the reconstruction of the actual events. This invariably involves a phase of emotional ventilation and mourning the multiple losses of the past and the present within the confines of a safe, holding environment.

Finally, an attempt is made to reach some degree of resolution or transformation of the traumatic past. This may involve some reconnection with the hitherto neglected traumatic past (e.g., in terms of commemoration), a transformation of the personal meaning of the Holocaust (e.g., in terms of finding a profound personal meaning of survival that replaces guilt), or integration of the trauma within one's own and one's family's history (e.g., passing on the legacy of the Holocaust to the next generations). Frankl's "logotherapy," in which survivors are encouraged to work through existential issues around the meaning of life and death, may be suitable in this stage. Naturally, resolution of Holocaust traumatization is never complete. There will always remain a considerable amount of anger, sorrow, fear, and yearning for another reality. But there may also be a sense of completion and of pride for having done so much of what was possible under the specific circumstances.

Child Survivors

Surviving the war as a child seems to be a fundamentally different experience than surviving as an adult. Children are at the same time more vulnerable and more malleable than adults. They experienced the horrors of war at various stages of their cognitive, emotional, and personal growth and seem to have suffered impairment and developmental arrest during the long years of confinement and/or family separation. In addition, they adopted a variety of different and extraordinary survival strategies in coping with extreme deprivations and traumatizations. It is therefore not surprising to find a somewhat different clinical picture among survivors of the Holocaust who were less than 16 years old when the war ended (Durst, 1995). 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.

Most obviously, child survivors feel that they were prevented from having a normal childhood. As a result, there seems constantly to be an alter ego "child" within them that searches for (infantile) need satisfaction. Because of the circumstances in which they grew up, they became "little adults" with premature responsibilities. A female child survivor exclaimed:

> I had no real childhood. As a child, I had to be an adult. It was dangerous to be a child. I had to hide the child within me and pretend to be someone else. Therefore, the child inside me is still yearning to be acknowledged and taken care of. But people find it strange to meet an old woman who is really only a child, and I am careful not to disclose this secret of mine. But when I'm around children, they feel it immediately.

Child survivors are now between the ages of 55 and 70, depending on their age at the end of the war. Perhaps it would be more correct to divide this population into three subgroups: (a) infant or early childhood survivors who were not older than 6, (b) child survivors who were between 6 and 12, and (c) adolescents who were between 12 and 18 at the end of the war. Obviously, age made a big difference in terms of the developmental phase in which the traumatization occurred, for example in achieved cognitive ability to comprehend what was going on and in terms of fixations in specific stages of trust-mistrust, autonomy-doubt, guilt, and identity. Apparently, the younger the survivor, the more traumatic the circumstances and the more damaging the impact of his or her war experiences.

These developmental phases indicate some of the themes that child survivors struggle with: (a) learned helplessness, (b) abandonment and isolation,

(c) interrupted mourning of loss, (d) identity problems, (e) memory loss, and (f) primitive defenses. These are discussed further in the following.

First, since child survivors learned early in life that their destiny was shaped by external forces by which they had no control, there is a strong sense of learned helplessness and a "victim mind-set" in which they feel at the mercy of others. In addition, the lack of safety, predictability, and trust, together with overwhelming fear, powerlessnes, and loss of control, becomes a permanent learning experience that continues to limit their sense of independence and autonomy.

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

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

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

Fifth, loss of memory leaves a void in the inner world of the adult child survivor. The absence of any childhood memories creates a breach in the natural flow of the life narrative. Infant child survivors therefore continue to

search with fervor for something within or outside of themselves that can bring back traces of the past (and their parents). They may look for preverbal signs, such as a familiar smell, a sound, or an image that can evoke some fragment of their mothers and fathers and original homes, to reexperience and feel again something from their lost childhood. A child survivor who was separated from his parents, of whom he has no memories before the age of 5, remembers only one thing from his childhood: how he was walking in mud with soldiers all around. Someone was holding his hand, but he doesn't know who it was. He only remembers that he would fall and that someone would pick him up. After more than 50 years, he still feels that he is walking deep in mud and needs someone to hold his hand and lead the way.

Finally, as a result of overwhelming pain, powerlessness, and isolation, primitive defenses were frequently developed by child survivors in order to survive emotionally. Such defenses served to help them not to feel anything as children, and certainly not to express their feelings, because "children who cried, died." But when perception of reality became too threatening and overwhelming, "speechless terror" left experiences beyond words. Thus, affects were often dissociated and totally forgotten. In adulthood, this is sometimes manifested in a kind of emotional encapsulation, psychic numbing of responsiveness, and total amnesia of the past. Less dramatic survival strategies that also continued throughout adulthood include not being seen, not standing out, and being quiet, obedient, and "good." A 13-year-old girl was sitting in a windowsill, apparently detached from the outside world after a pogrom in which her father had been taken away and beaten at the police station. He was later shot and thrown in a mass grave, and she never saw him again. As if encapsulated from all affect, she was reading a book, keeping her overwhelming emotions locked in. But the emotional development of her life had stopped at that moment. She never created a family of her own and, now in her late 60s, it is as if she is still sitting on the windowsill waiting for her father to return.

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

The clinical picture of the child survivor of the Holocaust seems in many ways similar to the above-mentioned "complex PTSD" that includes a series of traumatic experiences over a long period of time. Typically, however, developmental arrest at early ages manifests itself as various forms of personality disorders, with the adult personality structure being dominated by unfulfilled needs of the traumatized child from the past. Distrust in relations is often an added emotional component.

Treatment of Child Survivors

Such emotional characteristics make the treatment of adults who were traumatized as children a very delicate matter. Beyond the obvious focus on supportive therapy, there are great variations in directiveness, time span, and overall therapeutic strategy. Initially, brief sessions may be suggested to hesitant clients in order to provide a setting in which memory processing, problem solving, and symptom alleviation may occur. The aim of such sessions is to bring the client to an emotional equilibrium and adequate functioning as rapidly as possible. For this purpose, existing defenses and coping mechanisms are strengthened within a framework of positive thinking and cognitive reframing. In addition, the client is encouraged to identify sources of stress in the present, to observe his or her physical reactions to such stress, and to find ways to control overwhelming affect. Relaxation training, meditation, guided daydreaming, desensitization procedures, and similar techniques may be used for this purpose. Since much emotionally painful material is out of the reach of words, it may be more easily uncovered and contained within expressive therapies such as art, creative writing, music, and/or movement therapy. Group interaction and communal sharing may provide further resources for coping with the stressors of life.

While the purpose of such initial sessions is symptom alleviation and/or resolution of concurrent family issues, treatment of child survivors will ultimately have to deal also with the experience of Holocaust trauma itself. A more explorative psychotherapeutic approach may therefore be suggested to work through some of the repressed or dissociated material of their traumatic childhood. However, owing to the doubtful efficacy of classical psychoanalytic psychotherapy with this population, long-term explorative psychotherapy is often based on some kind of psychology of the self rather than on insight-focused interpretation of unconscious conflicts. Step by step, such therapy aims to strengthen the self in terms of making it more caring and able to regulate overwhelming affect. This may help child survivors to finally face the terrible experience of having been abandoned and often violently torn from

their close families. Moving back and forth between grief/sadness and anger/fear, this process invariably stands at the center of trauma (Shoshan, 1989, p. 193). Until such memories are brought to the surface, progress toward assimilation of the images indelibly etched in the minds of child survivors is stalled. Traumatic experiences may thus be slowly worked through within a holding relationship of dependence in which the therapist functions like a good mother figure that protects, reassures, and encourages the client. Through vicarious identification with the parental figure of the therapist, the child survivor is thus provided with a kind of "corrective emotional experience" in which he or she can draw new strength to cope with past loss. In addition, such an experience may give him or her new perspectives of life and new sources of identification.

Children of Survivors

The transgenerational effects of the Holocaust on the offspring of survivors remain 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. As descendants of Holocaust survivors are approaching their 50s (45–55 if they were born between 1945 and 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 some 400 publications. This knowledge has developed in a cumulative fashion similar to that of most psychological research: from observation to generalization to theorizing that stimulated empirical research.

Reviews on the transgenerational transmission of Holocaust trauma from survivor parents to their offspring have differentiated between "direct and specific" transmission (a mental syndrome in the survivor parent leads *directly* to the same *specific* syndrome in the child) and "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 etiology (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 and others including explanations of its etiology.

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 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 response is essential for making sense of the complex theories and available research findings.

Process

How does transgenerational transmission of trauma occur? How is a trauma assumed to be transmitted from one generation to another? The intergenerational mechanism of transmission in culture has always been a central postulate of anthropology, and the passing down of social norms and beliefs from generation to generation is well described in social psychology. The mechanism of transmission of trauma, however, is assumed to be a more multifaceted process, involving various overt and covert kinds of parent-child learning experiences, including internalization, projective identification, modeling, socialization, and vicarious learning. Apparently, it seemed to occur both indirectly through the implicit influences of early childhood and more directly through the communication styles, child-rearing practices, and family interactions of parents later in life. The transmission of trauma may thus be seen as a kind of subtle parental mediating process through which the psychological burdens of survivors are somehow transferred to their children from early infancy on, continuing to reverberate throughout childhood, adolescence, adulthood, and beyond.

Such *indirect* and often unconscious transmission of Holocaust trauma has been described in various psychoanalytic terms as "remembering the unknown" (Fresco, 1984), as a "cry of mute children" (Kogan, 1995), or as the experience of being seen as "memorial candles in Holocaust cape" (Wardi, 1992, p. 40). The Holocaust trauma was thus assumed to be transmitted through an unconscious process of identification and a failure in achieving self-object differentiation. As a result, the children would feel the need to live in their parents' Holocaust past (Kogan, 1995, p. 26). Similarly, Auerhahn and Laub (1998) explained how "the massive psychic trauma shapes the internal representations of reality, becoming an unconscious organizing principle passed on by parents and internalized by their children" (p. 22).

Interestingly, various tacit influences apparently were thought to comprise not so much what Holocaust survivor parents *did* to their children in terms of actual child-rearing behavior, but primarily who they *were* in terms of inadequate role models. Obviously, socialization involved children learning from parents' actions as well as from their attitudes. Growing up with a tormented parent must in itself have been a kind of cumulative trauma for the child who tacitly absorbed the parents' distress. According to Shoshan (1989), merely by virtue of their living together, "the depression resulting from the parents' trauma and their effort to repress it, was transferred to their children" (p. 198). Similarly, a vague sense of an impending danger may have been conveyed through the exaggerated worries of the anxious parent. Indeed, parents with more or less paranoid survival strategies may have functioned as role models for some children to imitate later in life. Thus, much of the indirect influence of transgenerational transmission of trauma occurred through nonverbal, ambiguous, and guilt-inducing communication and especially through the infamous "conspiracy of silence" (Danieli, 1998). Such subliminal mediating influence of parental communication style, through either oversilence or overpreoccupation, might explain some of the difficulties many children of Holocaust survivors have when trying to connect their vague sense of fear, sadness, and vulnerability with actual memories of the experience of growing up with Holocaust survivor parents.

A more *direct* and manifest process of transmission was observed within the socialization experiences of various family systems. Holocaust survivor homes were often described as being haunted by the ghosts of murdered relatives whose names were given to the newborn children. Marriages between parents were depicted as hastily created after the war between incompatible spouses who needed to make up for their losses. The role of children in such homes was to provide hope for the future and keep the families together. Preoccupied