

# Transmission of Holocaust Trauma

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## **ABSTRACT**

### **Transmission of Holocaust Trauma**

Much has been written about how children of Holocaust survivors tend to absorb some of the psychological burdens of their parents. But many questions remain to be answered regarding such parental transmission of Holocaust trauma. What was in fact passed on from parent to child? How does the transmission occur? Do parents invariably transmit and are children equally susceptible? The purpose of the present paper is to further discuss these issues and present a model in which the process of trauma transmission can be understood more consistently. After a brief description of that which was transmitted, a model is presented of the four prevalent theories of trauma transmission, including the (1)

psycho-dynamic; (2) socio-cultural; (3) family system; and (4) biological points of view. Thereafter, an integrative view is suggested that takes into account the interplay among different levels of transgenerational influence, suggesting that transmission is caused by multiple factors, including biological predisposition, individual developmental history, family influences and social situation. In conclusion, some of the mitigating and aggravating factors are presented that are assumed to decrease and to increase the risk of children to absorb the trauma of their parents and to develop specific second-generation psychopathology as a result.

### Transmission of Holocaust Trauma

During the course of psychotherapy, a man reports fragments of dreams: “I am hiding in the cellar from soldiers who are searching for me. Overwhelmed by anxiety, I know that if they find me they will kill me on the spot... Then, I am standing in line for selection; the smell of burning flesh is in the air and I can hear shots fired. Faceless and undernourished people with striped uniforms march away to the crematoriums. Then, I am in a pit full of dead, skeletal bodies. I struggle desperately to bury the cadavers in the mud, but limbs keep sticking up from the wet soil and keep floating up to the surface. I feel guilty for

what has happened, though I do not know why. I wake up in a sweat and immediately remember that these were the kinds of nightmares I had ever since I was a child. During a lifelong journey of mourning, I have been travelling back to the dead; to the corpses and graveyards of the Second World War with a prevailing sense of numb grief for all those anonymously gone.”

From the content of this dream, the man could have been a Holocaust survivor. But he was not. He was the *child* of a survivor. His mother had survived the Auschwitz-Birkenau concentration camp. But he, himself, was born long after the war had ended in a country far removed from the horrors of the Holocaust. Why was he dreaming such dreams about half a century after the war? Why are children of Holocaust survivors still experiencing the effects of the Holocaust as if they themselves had actually been there? How do we explain that the so-called “second generation” seems to share the grief and terror of their traumatized parents? Was the trauma of the parents somehow transmitted to them?

The observation that the psychological burdens of Holocaust survivors have been thus passed on to their children is not a new one. Over a period of three decades, more than 400 papers have been published on the transmission of trauma from Holocaust survivor parents to their offspring (Kellermann, 1999a). Despite this vast literature, however, several questions remain to be answered about this complex process of transmission of Holocaust trauma. What was in fact passed on from parent to child? How does the transmission occur? What is the relationship between parental psychopathology and mental distress in the children? Do parents invariably and inevitably transmit and are children equally susceptible? The purpose of the present paper is to further discuss these issues and present a model in which they can be viewed more consistently.

#### Transmission Terminology.

A review of the literature suggests that there are a multitude of different terms that describe trauma transmission. 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 and I have therefore retained it here. In addition, 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. Emphasizing the generational interchange specifically from parent to child, the transmission process is delineated as either *trans-generational* (e.g.

Felsen, 1998); *inter-generational* (e.g. Sigal & Weinfeld, 1987); *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 (Dasberg, 2000).

Earlier literature on the transmission of Holocaust trauma (e.g. Schwartz, Dohrenwend & Levav, 1994; Felsen, 1998) have further differentiated between on the one hand "direct and specific" transmission (a mental syndrome in the survivor parent leads *directly* to the same *specific* syndrome in the child) and on the other hand "indirect and general" transmission (a disorder in the parent makes the parent unable to function as a parent which *indirectly* leads to a *general* sense of deprivation in the child). While such a differentiation seems to be valid, it confuses aspects of the process of transmission, which are more or less "overt and covert," "manifest and tacit," and "conscious and unconscious." It further fails to clearly separate the aetiology (or assumed *cause*) of the transmission from the manifestation (or assumed *effect*) of the transmission. 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.

In order to limit such ambiguity, I will 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) (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 behavior of children of survivors (B) is a function (f) of Holocaust survivor parents' childrearing behavior (P), leading to the formula:  $B = f(P)$ .

However, there is seldom a clear and simple linear connection between P and B. 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.) and it is illustrated in Figure 1.

FIGURE 1

The Transmission of Holocaust Trauma from Parent to Child



In order to more fully describe this complex process, I will here describe some of the contents of that which was transmitted, present an overview of the prevalent theories of trauma transmission and discuss some of the “mitigating” factors that are assumed to decrease and increase the development of specific second-generation psychopathology.

**Content of transmission.**

What was passed on to the child? What are the manifestations of trauma, if any, that can be observed in children of survivors? While the content of transmission has been also described in positive terms as a “legacy” and/or as a capacity for resiliency, it has most often been negatively associated with some kind of psychopathology. Most frequently, the transmission has been assumed to contain some kind of secondary posttraumatic stress disorder, suggesting that since many Holocaust survivors suffer from PTSD, their offspring will also suffer from such a syndrome (Baranowsky, et al, 1998).

The existence or non-existence of any manifestations of psychopathology in the offspring of Holocaust survivors has been the subject of the greatest disagreement. While psychotherapists usually observed and described various kinds of emotional distress in this population, researchers failed to confirm these observations with more objective and reliable instruments. A recent overview (Kellermann, 2000b) of the empirical research concluded that most controlled studies failed to confirm the assumption of increased rates of psychopathology in the offspring of Holocaust survivors compared to control groups. Thus we are no longer asking if children of Holocaust survivors in general are more disturbed than others. Rather than continuing to investigate this question, we should be trying to delineate the specific characteristics of this clinical subgroup of children of Holocaust survivors. According to clinical experience and empirical research, this clinical population, compared to other people with emotional problems, seems to have specific disturbances more or less focused on difficulties in coping with stress and a higher vulnerability to PTSD. Problems are usually centered around the following areas (Kellermann, 1999b):

(1) *Self*. Impaired self-esteem with persistent identity problems, over-identification with parents' "victim/survivor" status, a need to be super-achievers to compensate for parents' losses, carrying the burden of being "replacements" for lost relatives.

Dave Greber (2000), a son of Holocaust survivors, reflected upon what the children of survivors represented to their parents. "Sometimes it was everyone and everything they lost. So I was not David Greber, but my father's brothers Romek and Moishe and Adamek, and his father David; my brother wasn't Harvey, but Herschel, my mother's beloved brother, or Aharon, her father; my sisters were named for our grandmothers and aunts Sarah and Leah and Bella and Molly, loved ones our parents last saw when they were 18 and were being separated for transportation to camps from which they never emerged. Representing six million dead is a grave responsibility, and a terrible burden for a child to carry." (p. 1).

(2) *Cognition*. Catastrophic expectancy, fear of another Holocaust, preoccupation with death, stress upon exposure to stimuli which symbolizes the Holocaust, vicarious sharing of traumatic Holocaust experiences which dominates the inner world.

Chani Kurtz (1995) gave the following example: "In fact, I still have a problem with buying my children clothes with vertical stripes. Silly? Perhaps. But in my parent's photo album is a picture of my father in his concentration camp garb. I carry that photo in my mental album, too. Nor can I forget my father's reaction when I bought myself a pair of those cute little Dr. Scholl clogs that were so in style when I was a teenager. 'Wooden shoes?' He stared at me, not angry, just bewildered. 'Wooden shoes? I've already worn wooden shoes enough to atone for my children, and for my children's children, and for their children after them'."

(3) *Affectivity*. Annihilation anxiety, nightmares of persecution, frequent dysphoric moods connected to a feeling of loss and mourning. Unresolved conflicts around anger complicated by guilt. Increased vulnerability to stressful events.

A daughter of two survivors of Auschwitz who was born in a DP-camp in 1948 suffered from debilitating clinical depression for her entire life. Her parents had lost five children in the camp, including a pair of twins, and were mentally scarred for the rest of their lives, apparently unable to care adequately for their only surviving child. As a result, she endured severe deprivation during most of her childhood and her life remained a constant struggle of survival against suicidal ideation and dreams of the horrors her brothers and sisters had endured before being killed. Anti-depressant medication and a supportive family of her own were of little substantial help.

(4) *Interpersonal functioning*. Exaggerated family attachments and dependency or exaggerated independence and difficulties in entering into intimate relationships and in handling interpersonal conflicts.

Helen Motro (1996) shared some of the contents of a group for children of Holocaust survivors that used to meet on Holocaust Memorial Day; “We gather to talk about our ability and our inability to love, to be lovable, to deserve love. We hardly mention the war at all. We don’t have to; it’s always there in the background, axiomatic. After all, the war is our template. One of us might say, ‘when I was 6 and wouldn’t eat enough, my mother shouted at me: “Mengele I survived – but having you will kill me!”’ And we others listening will nod and know what our friend means. Not all of our fathers beat their sons when the boys came into the house wearing black boots. Not all of our mothers froze us out as teenagers because they themselves survived by abandoning their own mothers at 15 in the camps. No, most of us had parents who loved too much, who smothered us with their care, their solicitude, their ever-present, all-enveloping anxiety.”

### **Models of trauma transmission.**

How does transmission of trauma occur? How can a trauma be transmitted from one generation to another? At first glance, the concept of transmission is difficult to grasp. It is as if saying that someone’s headache is caused by the fact that his father was hit on his head by a stone some 50 years ago. Or, that a woman is afraid of becoming pregnant because her mother had lost a child during the war. 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.

Most people, however, would agree with popular folk wisdom that “an apple does not fall far from the tree,” and with the notion of “like father, like son.” In addition, bacteria may be transferred from one person to another in the spreading of disease and various physical forms of passing something over from one body to another, or from one place to another, are parts of our daily

experiences. The transmission of sound waves in telecommunications is a commonly accepted phenomenon and may serve as a suitable analogy that also illustrates the process of trauma transmission. Thus, in the same way as heat, light, sound and electricity can be invisibly carried from a transmitter to a receiver; it is possible that unconscious experiences can also be transmitted from parents to their children through some complex process of extra-sensory communication. In fact, such quasi-naturalistic terminology is frequently applied when describing how the “vibrations” within a Holocaust family “atmosphere” may affect the offspring in a variety of indirect and subtle ways.

Four major theoretical approaches to understanding trauma transmission have been suggested: (1) psychodynamic; (2) sociocultural; (3) family system; and (4) biological models of transmission. These are summarized in Table 1.

Table 1.  
Models of Trauma Transmission.

	<b>Theory</b>	<b>Medium</b>	<b>Main Transmission Factor</b>
1	Psychodynamic	Interpersonal Relations	Unconscious displaced emotion
2	Sociocultural	Socialization	Parenting and Role Models
3	Family Systems	Communication	Enmeshment
4	Biological	Genetic	Hereditary vulnerability to PTSD

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### 1. Psychodynamic and relational models of transmission.

The field of Holocaust transmission has long been dominated by psychoanalytically-oriented theories. According to these theories, emotions that could not be consciously experienced by the first generation are given over to the second generation. The child thus unconsciously absorbs the repressed and insufficiently worked-through Holocaust experiences of survivor parents.

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 (Volkan, 1997, p. 43).

Psychoanalytic authors further emphasized the transmission of Holocaust traumatization through an unconscious process of identification and a failure in achieving self-object differentiation. Specifically, Rowland-Klein & Dunlop (1998) propose a form of projective identification as an explanatory mechanism to the transmission of trauma that “brings together diverse aspects of the observed phenomena: projection by the parent of Holocaust-related feelings and anxieties into the child; introjection by the child as if she herself had experienced the concentration camps; and return of this input by the child in the form of ... problems” (p. 358). As a result, the children would feel the need to live in their parents’ Holocaust past (Kogan, 1995, p. 26). Auerhahn & Laub (1998) described how “the massive psychic trauma shape the internal representations of reality, becoming an unconscious organising principle passed on by parents and internalised by their children” (p. 22). Throughout this process parents tended to displace their own repressed grief upon their children who would then be seen as “memorial candles in Holocaust cape” (Vardi, 1992, p.40).

For example, a daughter of a Holocaust survivor remembers how she was buying a dress with her father as a child. Looking at herself in the mirror with her new dress, she caught a glimpse of the reflection of the face of her father behind her. He suddenly looked pale with grief and bewilderment. Asking him what was going on, he told her for the first time that he had had a daughter before the war and that he recognized the remarkable resemblance between her and his first daughter who had died at about the same age as she was now. From that point on, the woman understood why her father had always looked at her with some amount of sadness and why she herself had felt a kind of unexplainable grief throughout her life.

Adding to the above formulations, relational psychoanalytic models of trauma transmission described children of survivors as also being shaped by a matrix of unhealthy relationships with their parents with whom they struggle to maintain their ties and from whom they try to differentiate themselves at the same time. Repetitive patterns of interpersonal behavior, based largely on internalized self and object representations, continue to control their lives. Such undifferentiated relations have been described in various case studies (Barocas & Barocas, 1980) and in empirical research reports (Kellermann, 2000b).

## 2. Sociocultural and socialization models of transmission.

Transmission in culture (Heller, 1982) 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. Social learning and socialization models of transmission focus on how children of survivors form their own images through their parents’ childrearing behavior, for example their various prohibitions, taboos and fears. Numerous studies indicate that

abused children often grow up to be child abusers themselves (Blumberg, 1977), that teenage motherhood and early marriage seems to be passed on from mothers to their daughters and that an inclination for gambling and alcoholism seems to be passed on from parent to child.

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. The exaggerated worries of such anxious parents may have conveyed a sense of an impending danger that the child may have absorbed.

Countless studies have confirmed the relationship between childrearing practices and behavioral traits in the child (Sears, et al. 1957). Patterns of parental rejection, over-protection, over-permissiveness, and harsh, inconsistent discipline upon the developing child have been regarded as most influential. 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 (2000a) 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.

We may assume, however, that Holocaust survivor parents influenced their children not only through what they *did* to them in terms of actual childrearing behavior, but also through who they *were* in terms of inadequate role models. As pointed out by Bandura (1977), children learn things vicariously by observing and imitating their parents. Children of Holocaust survivors may be assumed to have taken upon themselves some of the behaviors and emotional states of their parents.

A middle-aged child of two Holocaust survivors with a very low tolerance for stress described her parents in the following manner: “My father used to scream during the night and my mother screamed during the day. Both were highly disturbed and could not tolerate anything that might upset them. I had to be careful always as a child not to come home late, not to be ill, not to show any signs of distress, and to be as quiet as I possibly could be.”

Growing up with such tormented parents must in itself have been a kind of cumulative trauma for the woman, but some of her own anxious behavior was clearly learned through modeling.

### 3. Family systems and communication models of transmission.

Unconscious and conscious transmission of parental traumatization always takes place in a certain family environment, which is assumed to effect 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 live vicariously in 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) and attachment (Bar-On, Eland, Kleber et al (1998) were often observed.

A 43-year-old man, a lawyer by profession, brought his disturbed mother for consultation. His appearance was candid and strong, but when he spoke, one could immediately notice a sense of insecurity and low self-esteem. He was single and had never built a life of his own. His eighty-year-old mother, on the other hand, was a strong-willed, dominant lady whose hysterical personality and anxieties were all too obvious. She was fully self-centered without any real concern for her son. One had to see both of them together to realize that the mother had bound her son to herself with an invisible, yet unbreakable bond. She cursed him and praised him and demanded that he take care of her forever. Like a small boy, he did not know how to respond.

Parents like this, who care too much and who become overly involved and intrusive, tend to enmesh their offspring in the crossfire of their own emotional problems and bind their children unto themselves in a manner that makes it difficult for the children to gain independence. When such parents grow older and become more dependent upon their children, an impossible situation is created for everyone involved.

When neither a nurse nor a spouse was available, a daughter had to take care of her frail Holocaust survivor mother who had become ill. Because of the daughter's earlier ambivalent feelings towards her mother, she had great difficulties taking such a role upon herself, feeling both angry and guilty towards her mother who had endured so much during the war. Occasionally open expression of hostility toward her mother led to self-reproach, and she tried unsuccessfully to resolve the conflict by taking care of her mother even more, neglecting her own children for a long period. She said: "I could not stand being with her, but I kept nursing her until she died. I had no choice. My mother had lost her mother in the war and I had to make it up to her!"

Children like these take upon themselves the role of being parents to their own parents. Helen Motro (1996) explains: “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 caretaking,” (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.

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 says: “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. In fact, much of the family influence of trauma transmission may be explained as occurring through non-verbal, ambiguous and guilt-inducing communication (Lichtman, 1984; Klein-Parker, 1988) and especially through the widespread “conspiracy of silence” (Danieli, 1998). The subliminal mediating influence of parental communication style, through either over-silence or over-preoccupation (Sorscher & Cohen, 1997), may be a major reason for the difficulty many children of Holocaust survivors have when trying to connect their vague sensations of fear, sadness and vulnerability with actual memories of the experience of growing up with Holocaust survivor parents.

#### 4. Biological or genetic models of transmission.

Biological models of trauma transmission are based on the assumption that there may be a 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. Holocaust traumatization may be similarly passed on “almost as if psychological DNA were planted in the personality of the younger generation through its relationships with the previous one” (Volkan, 1997, p. 44). Memories of fear can thus be carried across generations through physiological processes and get “picked up” by another

mind and elements of the collective experience of the species are thus reflected in the genome (Perry, 1999).

While the genetic model of transmission may evoke resistance because of its similarity with the Nazi ideology of purifying the gene pool of the German race, it 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 may thus 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. hyperalertness) 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.

In an attempt to investigate such assumptions, 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 conclude: “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).

### An Integrative View of Trauma Transmission.

The investigation of genetic models of transmission is complicated by the fact that genes interact with environmental influences to increase or decrease susceptibility to a specific disorder. Those who believe that there is some genetic predisposition also assume that subsequent factors (psychological, social or experiential) are necessary for the onset of a disorder. As a consequence, trauma transmission cannot be understood only from the point of view of biological predisposition, but from a broader and more integrative point of view. Such a view must acknowledge the intricate interplay among different levels of transgenerational influence, suggesting that trauma transmission is caused by a complex of multiple related factors, including biological predisposition, individual developmental history, family influences and social situation. Whether hereditary or environmentally inflicted, trauma transmission can thus

be explained as being influenced by any or all of the above mentioned psychodynamic, sociocultural, family system and biological factors or by an “ecological” combination of these.

Such an integrative view of trauma transmission explains a specific symptom in a child of survivors as being caused by a multitude of influences. For example, the Holocaust nightmares reported by the child of survivors above may be interpreted, first, according to psychoanalytic theory, as a manifestation of the displaced unconscious fears of the parents. The child is experiencing what the parents themselves cannot perceive and express. Second, according to social theory, it may be explained as a specific kind of parenting. The child responds to the anxieties indirectly expressed in deleterious childrearing behavior. Third, according to family systems theory, it may be the result of enmeshment and tacit communication. The child is trapped in a closed environment in which the shadows of the past are ever present. Finally, according to biological theory, the stress disorder of the parent may be biologically transferred to the child who also becomes more vulnerable to stress. Since these models of understanding trauma transmission has a great influence on the suggested treatment strategy of the second generation it is important to clarify them as much as possible.

### **Mitigating and Aggravating factors.**

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

Several other circumstances may be assumed to influence the process of trauma transmission except the ones described above. For example, Keinan, Mikulincer & Rybnicki (1988) suggested that some children of Holocaust survivors developed unique coping mechanisms that better enable them to deal with their parents' psychological burden. Even if the parents were deeply traumatized, these children might not have absorbed the trauma because of certain "mitigating effects" that may have helped them to withstand the stress despite everything. According to Sorscher & Cohen (1997);

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

Similarly, Axelrod, et al (1980) observed that a major difference between functional children and their hospitalised patients seemed to be that the children, while growing up, were exposed to fairly open discussion of parents' camp

experiences in "non-frightening" ways. In addition, far from being social isolates, such more well-adjusted families were involved in survivor organisations that may have provided support and a sense of extended community that gave perspective to the close-knit Holocaust survivor family. The acceptance of a Jewish or a specific immigrant identity in such close sympathetic communities, as well as the lack of renewed anti-Semitism may also have played a mitigating role.

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

1. 1. Offspring were born early after the parents' trauma (between 1945-1955);
2. 2. Offspring were the only, or the first-born child;
3. 3. Both parents were survivors;
4. 4. Offspring were "replacement" children to children who had perished;
5. 5. Parents had endured extraordinary mental suffering and significant loss of close family and were highly disturbed as a result;
6. 6. Symbiotic relations were dominant between parents and children, and family relations were characterized by enmeshment without sufficient "corrective periods of disengagement" and without a supportive peer-group;
7. 7. The trauma was talked about too little or too much.

It will be the purpose of future research to investigate this assumption.

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