House Foreign Affairs Committee
Hearing on Holocaust Survivor Care Needs
September 18, 2014

Prepared and Submitted by Barbara Paris, MD

Chairman Ros-Lehtinen, Ranking Member Deutch and members of the subcommittee.

I am grateful for the opportunity to speak before you today.

" Doctor, I cannot sleep because every time I close my eyes, I am in Auschwitz". During each home visit to my demented elderly patient those were her words. I cannot get them out of my head.

Can you, Committee members, imagine the trauma of a child, a teenager, a parent being brutally shoved into a cattle car, with no air, no bathroom and no food for days? At that was just the beginning. Lined up for hours in the bitter cold with no shoes or coats, shaved heads, smelling the burning bodies of there loved in the crematoria.

I am privileged, as a physician whose career has been devoted to caring for survivors and their family members, to provide a few important observations. Time does not permit me to adequately address the multitude of obstacles that currently prevent Holocaust survivors from receiving the resources and care they need for dignity in their final years. By this I refer to everything from the simple failure of Germany to acknowledge and commit to providing to address all survivors' physical and emotional needs, to the horrific maze of opaque guidelines and ludicrous paperwork demands and deadlines imposed by Germany and the Claims Conference in various programs.

Does the German Government really need to spend their money interviewing anyone who could possibly survive Hitler's dehumanization, torture, rape, medical experiments, starvation and death marches to determine if they have been psychologically and physically harmed enough to deserve reparations? Even when the German psychiatrist acknowledges damage, these patients are not physically or emotionally capable of completing highly formalistic, complicated and overly bureaucratic correspondence requiring yearly physician input, notarization and more. As a physician, I am challenged to complete forms written in German and asking for a level of detail about past events that I cannot ascertain from a demented patient and for other patients it is traumatizing to have to relive these details and be forced to " re-justify" their right to reparations every year. It is a clever way of withholding money from disabled people.

Thankfully, many survivors are well in their nineties and I have the honor and the privilege to be their doctor. While they have exhibited tremendous vitality in building new lives and families in America, they sublimated their losses into flawed parent - child relationships, night terrors, and silently replayed their living hell to themselves. One second generation survivor poignantly told me, "although I did not realize this a child, I understand now that the holocaust was playing out in our living room everyday." Make no mistake, every survivor suffers from PTSD. The German government needs to face this crystal clear fact and act upon it."

The medical definition of PTSD is as follows;

A disorder that occurs when a person has 'experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and " the person's response involved intense fear, helplessness, or horror." It is characterized by repeated reliving of the life-threatening events in the form of images, thoughts, illusions, flashbacks, dreams or hallucinations.

A close professional colleague has been studying aging survivors in Jerusalem since 1990 and comparing them to non-survivors of the same age residing in Jerusalem. Survivors are less educated, have fewer social supports, greater difficulties with activities of daily living and greater usage of psychiatric medications. This is not surprising and must be addressed. Aging survivors, with time and fewer activities to occupy their day are back in the ghettos and concentration camps, grieving for their dead relatives, hiding food in their beds, depressed that they survived, afraid of doctors, fearful of acknowledging weakness (that was an automatic death sentence) anxious about showers, standing on line, wearing ID bracelets and lots more.

We need resources to manage them in comforting environments designed NOT to trigger these fears. Only now, in their retirement, and facing death of spouses and friends are they beginning to uncover these painful suppressed memories and grieve the death of their own parents, sisters and brothers. For these survivors the year is 1946, not 2014. All Doctors and other health care providers and caregivers are not educated in the unique skill sets needed to respectfully and compassionately help survivors live their final year in relative peace. Caring for survivors really requires fully trained health care professionals who understand this unique population's emotional and medical needs. Well-intended but not well-informed or funded programs that give the appearance of assistance really just divert attention from the vast gulf that exists between survivors' needs and available resources and programs.

What about their children? Most second-generation survivors and their therapists do not understand this trans-generational effect of trauma on their own emotional difficulties including failed interpersonal relationships, depression, and anxiety. Schizophrenia and much more. Their parents, depleted of psychological resources, were often emotionally detached but simultaneously feared any separation from their children in suffocating ways.

One frustrated, lawyer son of survivors tells me" the reparations program totally ignores emotional/mental scarring and financial needs of the offspring of survivors. Growing up in a home with a parent who was incapable of nurturing her children, led me to many years of psychotherapy- yet the Germans refuse to acknowledge any causal connection or obligation to reimburse my therapy expenses. In fact, they exhibited a rigid myopic notion that insisted that the effects of the Holocaust were not passed on to children of survivors, or even if there was some "leakage", Germany maintains that it has no obligation to compensate or assist members of that "select" offspring group.

I am continuously frustrated and bewildered by grandiose announcements from Germany and the Claims Conference concerning new benefit programs. Have they ever taken a measure of the full scope of the needs and simply decided that Germany will now and going forward pay what is needed? Why not? This applies to last year's home care fund announcement, which will fall far short of meeting the actual home care needs of survivors, as well as this month's announcement for child survivors.

I ask you, committee members, how much can $3280 cover in expenses for child survivors?

I set of dentures? I set of hearing aides? Six weeks of a 24-hour home attendant? Home visits with an occupational therapist, a medical doctor, psychiatrist or social worker? Bereavement counseling? Medication costs? Transportation costs? It does not even make a dent in addressing their medical and psychological needs. AMCHA, the National Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation has developed a rich body of unique knowledge in the late effects of Holocaust traumatization an its intergenerational transmission. Resources are needed to implement the wide range of therapies that AMCHA has been utilizing to treat these victims.

The financial needs for care, resources, and education of caregivers and health care providers are many. We must advocate for our citizens who came here physically and emotionally spent, yet managed to rebuild their lives at great personal cost. We must not ignore or minimize their needs and the needs of their offspring. I am very honored to have this opportunity to spell out for the Congress a small part of what the problem is. I struggle daily to creatively piecemeal together and coordinate the far too few resources that can help provide a modicum of relief. The survivors and their families are running out of time, truly. They are depending on this Committee and Congress to step in where others have failed, and use your powers as the elected officials of our country to demand that Germany and other responsible institutions step up and finally do what is morally necessary. You have the power to help. Thank you.

September 18, 2014

Holocaust Survivor Needs

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First Generation – often live alone and either have no family at all or family members do not live in reasonable proximity to assist with finances, day to day needs, transportation, guide decisions, provide oversight or companionship. This raises many issues as survivors age and face increasing frailty, chronic and acute medical illnesses and memory loss:

Home care attendants – private pay help is unaffordable for most, even those who are not sufficiently impoverished to qualify for Home Medicaid. As Medicaid dollars become increasingly scarce, very elderly at-risk patients are denied 24-hour care unless they are bed- bound with bedsores or worse. Many are also caught in the gap of not being sick enough for 24-hour home care, but also not sick enough to be accepted to a nursing home. Most also would prefer to stay at home, but that becomes a challenge when there is no family oversight or back up. Nursing homes often trigger the experience of a "second institutionalization". A simple activity such as "tell us about your 9th birthday" or a shower can lead to uncontrolled panic and fear. All health care workers require training in understanding the special needs of survivors and to make environmental adjustments and learn communication skills that make survivors feel comforted and safe.

Mental Illness – With more time on their hands as they age and no longer work or have primary responsibility for their children, their minds return to the traumas of the war. In addition, with early or moderate dementia and even mild cognitive impairments, the ability to suppress these memories falters. Depression, anxiety and post-traumatic- stress disorder symptoms increase yet are often under-diagnosed and inadequately treated by health care providers, most of whom are not educated about the special issues of aging survivors. Patients' behavior is often misinterpreted as non-compliant, annoying, somatization etc. Patients themselves may also feel stigmatized by the suggestion of a psychiatry consultation. We need more programs that can bring specialized mental health care workers in patient's homes, day care centers and nursing home. Additional therapies including occupational, physical, art, music and relaxation need to be supported and expanded to compliment the work of the psychiatrists and social workers.

Physical Illness- Years of malnutrition, hard physical labor, repeated beatings, frostbite and mental anguish take their toll and catch up with you in old age. Survivors have severe degenerative joint disease, severe osteoporosis causing spinal and hip fractures, dental, vision and hearing problems that require many resources to help preserve dignity and independence.

Companionship – There is a tremendous sense of loneliness and lack of companionship. Children and grandchildren (if they exist) cannot adequately fill the gap – with age, survivors feel the loss of their spouses, parents, siblings, etc., with ever-greater intensity. Home attendants can clean; cook, shop and bathe, but they are not companions. Dorot in Manhattan is a wonderful organization that provides friendly visitors, educational programs without walls etc. – but there are fewer, smaller scale and more difficult to access similar programs in Brooklyn and other places where survivors live.

Goals of Care - As these patients approach the final years and months of their lives and become increasingly debilitated with diminished quality of life, health care providers need to have sensitive discussions with survivors to minimize aggressive and often futile and painful procedures and hospitalizations, often without the benefit of palliative and or hospice care. Court appointed guardians are also often limited in their ability to help set appropriate goals of care in this setting.

Second Generation – This is another area of tremendous unmet need, many of whom are themselves now senior citizens with significant unaddressed physical and psycho-social issues. Families are known to be significantly dysfunctional, have tremendous problems caring for their parents, themselves and their own children. We need to recognize and begin to address and support their needs, and also recognize them as survivors.

Summary points:

1 Coordination of services: Although there are many agencies that provide various "pieces of the pie" (Self-help, JASA, Met council, Bikur Cholim) there is no coordinated effort or umbrella that can help a health care provider, patient or family coordinate all of these agencies, easily access their services and assure that the patient's needs are being met by a combination of these services. There is no central way for a given provider, patient or family to even know what array of services currently exist for survivors in a given neighborhood.

2. Minimize the paperwork: Many providers are hesitant to advocate with these agencies or the Claims Conference due to repetitive and endless forms that follow a request, often without light at the end of the tunnel.

3. Home care/ assisted living/nursing homes: Elderly survivors with multiple illnesses and functional limitations who are isolated at home with no family to assist should be entitled to 24 hour home care and options for low cost assisted living facilities. There are no reasonably priced, subsidized, assisted living care facilities geared towards the dietary and psychosocial needs of survivors. In addition for those who require nursing home, that do not have Medicaid, the rates are unaffordable and should be subsidized for this population.

4. Mental health services: We need to train and have easily accessible mental health counselors, social workers, psychologists and psychiatrists who understand the issues facing both first and second generation survivors, whose services are financially accessible (sliding scale or free). These services are not currently or very minimally covered by health care insurance. Transportation costs need to be covered and in many cases the counselors need to go into the patients' homes.

5. Physical health services - medical doctors need to be educated in identifying survivors among their patients, gaining their trust and fostering healthy doctor- patient relationships. It will ease the survivor's acceptance of appropriate therapies and medications. Survivors need financial assistance to pay for medications, treatments, dentures, glasses, assistive walking devices and hearing aides.

5. Companionship: There needs to be a centralized effort to develop regional availability of both volunteer and paid friendly visitors who are educated in the special issues of both first and second generation survivors.

6. Special Programs: A cadre of special programs around holidays, summertime should be available – a week in the Catskills with dietary laws adhered to Many survivors are all alone on Jewish holidays, have no celebrations or any moments of joy.

7. Advocacy: There needs to be regional access to health care providers, lawyers etc. who are willing to both treat and advocate for survivors and participate in establishing goals of care and act on their behalf . Financial support for these services should be subsidized.

8. Second Generation Plans: This requires an assessment of the scope of the financial, psychosocial and medical needs of this generation. There will need to be programs, support networks and services set up and accessible to address their needs.

Addendum:

Cases:

Case 1

98-year-old widowed survivor with one son who is bed-bound and confused s/p massive stroke. The patient is alert, anxious, has severe degenerative joint disease, unstable gait with frequent falls and hypertension on medications. She lives alone. She is not wealthy but she is not Medicaid eligible. Although she is fortunate to have no skilled nursing needs, she is frail and at risk living alone. Her lack of memory impairment and no skilled nursing needs make her not eligible for full-time home care or nursing home. She is falling through the cracks of all systems. She is unable to afford an assisted living facility, which would be a reasonable option, if it were affordable.

Case 2

96-year-old widowed survivor who has one son in another state and another son who is disabled with chronic mental illness, related to being a second-generation survivor. The patient is currently in a sub-acute setting after having suffered a stroke that left her with right-sided weakness of her arm and leg. Although she is mentally intact, she is unable to perform activities of daily living without assistance due to her stroke. She does not qualify for Medicaid and she cannot afford private pay 24-hour home attendants or the daily nursing home rate.

Case 3

93-year woman survivor brought in by her daughter for management of paranoid aggressive behavior. The patient's regular, familiar home attendant had just left the job and the patient was fearful of the new person. She called the police to her home multiple times, ran down the elevator and tried to exit through the basement of the building. In my office, the patient berated her daughter, complained that her daughter was jealous and wanted nothing to do with her. After the appointment, the patient refused to get into the car with her daughter and we had to arrange for a car service (paid for by the hospital) to get the patient home. The daughter refused to allow us to hospitalize the mother, was quite tearful but wanted to continue to try to help her at home. She also felt very unsupported by her siblings who just wanted me to sedate the mother, even though that would likely make her more confused and at risk of falling. The situation remains unresolved despite a strong team of professionals intervening to support the mother and daughter - including a social worker in my office that is grant funded and a psychiatrist who visits the patient at home, also funded by a grant. The doctor, office and other professionals try to help this family work through the complexities of their interpersonal relationships and be able to keep this patient from being institutionalized, with many hours of phone calls and office visits.

Case 4

Elderly couple, survivors, both over 90 years old had 2 daughters. The husband has Parkinson's disease and the wife has mild dementia. The daughter, who was the primary care giver, died of cancer and this was devastating to the patients and their other daughter who suffers from severe manic depression. There is a high level of anxiety and multiple physical complaints from the patients. The daughter is easily overwhelmed and unable to adequately be emotionally supportive to her parents. She becomes very anxious with ever-minor complaint stating that her parents have suffered enough and she cannot bear to see them in any pain or discomfort.

Case 5

92-year woman survivor with severe anxiety disorder and arthritis. She has been widowed for 35 years but still mourns the loss of her husband as if it happened yesterday. She will only eat on paper plates, as she cannot enjoy a nice meal without her husband. She is very demanding of her daughter and would like her to spend more time with her. Her daughter brings her to every appointment and visits her daily and takes her to her own home for the weekends. The daughter's husband is sick with cancer and she also has multiple grandchildren under her care. The daughter always looks exhausted and never complains about the multiple competing demands she must juggle. The daughters' greatest concern is that despite all of her efforts, the mother still feels that her daughter is too busy to give her the attention that she deserves.

The Long-term Psychological Effects and Treatment of Holocaust Trauma

Natan P.F. Kellermann.

ABSTRACT

The present paper 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." A Holocaust survivor.

The long-term after-effects 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 ageing 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 ever knew. The offspring of both 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 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 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 paper is to describe 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, the National Israeli Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation, a non-profit 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 tries 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 ageing survivor community, many felt the responsibility of bearing witness and preserving memory. In addition, the psychological effects of transgenerational transmission of trauma upon the offspring became more widely acknowledged.

Secondly, 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 their 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 on "The 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 counter-transference 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 2nd 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. For example, 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 these people were traumatized in one way or another, either 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 one million people. Though only a small percentage of these were assumed to be more vulnerable to mental distress, the population at risk still constituted a large number of individuals 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 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 as presented in Table 1.

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1. Holocaust Survivors.

Holocaust survivors clearly differ from one another in a great many ways, in their pre-war personality make-up, in their various traumatic war experiences, and in their post-war readjustment. Of all these differences, their varying vulnerability and resilience to stress are perhaps the most striking in rendering them more or less susceptible to mental ailments. Such variability makes the differentiation between clinical and non-clinical 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 since its establishment), a clinical minority continued to suffer from periods of depression, irrational anxieties, sleep disturbances and psychosomatic symptoms, which clearly lead back to Nazi persecution. Here are some typical examples:

An 80-year-old female Holocaust survivor is referred to AMCHA by her daughter because of exaggerated hoarding of food. Though this had been common practice for years, with the refrigerator always over-packed 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.

Another elderly man consulted AMCHA because of severe sleeping disturbances. He awoke almost every night in a sweat, unable to fall back to sleep. Since being less active, painful memories from the Holocaust had returned with all 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 up 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 it's meaning for him. "Before there was *life*," he said, "now it is just an *existence*."

The following ten characteristics are frequently observed in Holocaust survivors who apply for psychiatric treatment at AMCHA: (1) Massive repression, numbing of responsiveness, amnesia, alexithymia; (2) Intrusive memories, Holocaust-related associations, "shattered assumptions"; (3) Anhedonia, suicidal ideation, depression, chronic state of mourning; (4) Survivor guilt; (5) Sleep disturbances and nightmares; (6) Problems with anger regulation and in dealing with interpersonal conflicts; (7) Excessive worries, anxieties, catastrophic expectancy, fear of renewed persecution; (8) Suspiciousness, paranoia, isolation from the community, lack of trust, loneliness; (9) Utilization of survival strategies "from there"; and (10) 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, as they remind survivors of their immense loss and all 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 utilize 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 them again late in life. Having hitherto done all they could to cover up their pain and to repress their terrifying memories, old traumata 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 over fifty years until the past caught up with him and forced him to re-experience it all over again in his dreams.

The early literature of 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, a lack of words for what they felt). 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 non-representative clinical case reports. Dasberg's (1987) review of some of the later comparative studies conducted on non-clinical populations of Holocaust survivors revealed a more mixed picture of post-war 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 non-clinical 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 non-clinical group continues to function well, but present 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 Post-Traumatic Stress Disorder"* (PTSD) with depression as a frequent associated feature (Kellermann, 1999a).

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 has 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 on the lives of the survivor is emphasized. For this purpose, survivors are invited to recount what they went through during the war already 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 re-experience 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 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 acknowledgement 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 a conscious and intentional activity. Survivors continue to re-experience 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. 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. Re-telling 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 re-educative 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, we 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 respect from that of their younger brothers and sisters as well as from 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 is 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, are often applied. In addition, as the survivors grow older AMCHA attempt 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 also aims to alleviate the anxieties of aging: to help them deal with the 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 to prepare for an approaching death. The 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 tensions and as a means to get the 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 therapists' own counter-responses. 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 some integration of the trauma within one's own and one's family's history (e.g. to pass 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.

2. 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 are. 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 in 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 – 70, depending on their age at the end of the war. Perhaps it would be more correct to divide this population into three subgroups; (1) infant or early childhood survivors who were not older than 6; (2) child survivors who were between 6-12; and (3) 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 their war experiences.

These developmental phases indicate some of the themes that child survivors struggle with; (1) Learned helplessness, (2) Abandonment and isolation, (3) Interrupted mourning of loss, (4) Identity problems, (5) Memory loss and (6) Primitive defenses, which will be further discussed below:

First, since they 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 mindset" in which they feel at the mercy of others. In addition, the lack of safety, predictability and trust, together with overwhelming fear, powerlessness and loss of control become a permanent learning experience which continue 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 which lead 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 longstanding tendency to deny the overwhelming loss therefore continues to be a life-long 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 an 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 presume their original names after the war.

Fifth, loss of memory leaves a void forever 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 traces of the past (and their parents) back. They may look for pre-verbal signs, such as a familiar smell, a sound, or an image that can evoke some fragment of their mothers and fathers and original homes, and thus to re-experience 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 picked him up. After more than fifty 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 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. As adults, 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, to be quiet, obedient and "good." A 13-year-old girl is 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 all 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 sixties, 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 re-experience the painful moments of separation and loss from the past and then suffer from periods of behavioral dysfunction and increased anxiety and depression.

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 in 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 are often added emotional components.

Treatment of Child Survivors

Such emotional characteristics, makes 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 affects. 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, due 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 the child survivor 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 towards 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 their past loss. In addition, such an experience may give him or her new perspectives of life and new sources of identification.

3. 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 fifties (45-55 if they were born between 1945-1955), they themselves continue to ponder about 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, on the one hand, "direct and specific" transmission (a mental syndrome in the survivor parent leads *directly* to the same *specific* syndrome in the child), and on the other hand, "indirect and general" transmission (a disorder in the parent makes the parent unable to function as a parent which *indirectly* leads to a *general* sense of deprivation in the child). While such a differentiation seems to be valid, it confuses aspects of the process of transmission, which are more or less "overt and covert," "manifest and tacit," and "conscious and unconscious." It further fails to clearly separate the aetiology (or assumed *cause*) of the transmission from the manifestation (or assumed *effect*) of the transmission. Apparently, there is as yet no consensus as to how to define the field, some limiting it to its descriptive meaning whereas others include possible explanations of its aetiology.

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

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, childrearing 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 & 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 of 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 impeding 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 over-silence or over-preoccupation, 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 with mourning their immense loss, some parents had difficulties in responding to their children with adequate affect and for many, economic safety was considered more important than emotional well-being. Nonetheless, these "enmeshed" families were described as highly closed systems with parents fully committed to their children, and children overly concerned with their parents' welfare, both trying to shield the other from painful experiences. Through mutual identification, parents were seen as living vicariously through their children and children as living vicariously in the horrific past of their parents. Considering such powerful interpersonal family dynamics, it is not surprising that problems involving individuation and separation and attachment were frequently observed.

Empirical research on the process of transmission in parenting focused largely on over-protection, over-involvement and enmeshment as perceived by the offspring. Contrary to the assumptions of the above descriptive studies, an ambiguous picture of the state of Holocaust survivor parenting evolved. On the one hand, some studies reported a higher degree of intrusion, over-protection, lack of separation and role confusion (enmeshment) that may have hindered the healthy development of independence in the second generation. On the other hand, others did not find significant differences in attitudes towards parents between children of survivors and other children.

In a recent study on Holocaust survivors as parents, Kellermann (1999b) found that Israeli children of Holocaust survivors generally view their parents in a positive light and that differences in childrearing practices between Holocaust survivors and other Israeli parents on such major parenting behaviors as affection, punishing and over-protection, seem to be small, if taken as a whole. However, despite their devotion and largely successful child-rearing behavior, Holocaust survivor parents were perceived as unable to prevent the Holocaust from having a significant impact upon their offspring. According to the findings of this study, their parents' past continued to have a strong influence on the lives of the offspring who felt that they had absorbed the inner pain of their parents. It was as if they had taken upon themselves a kind of emotional burden from their parents that had a major influence on their lives. Described in terms of "role reversal with the parent," as "enmeshment," "parent-child role diffusion," or as "parental/parentified child," this "transmission" factor seems to be one of the characteristics in the parent-child relationships in such families.

Content

What was transmitted from Holocaust survivor parents to their children? What are the manifestations of trauma, if any, that can be observed in children of survivors?

A frequent assumption in the clinical literature was that a "secondary posttraumatic stress disorder" was being transmitted, suggesting that since many Holocaust survivors suffer from PTSD, their offspring will also suffer from a syndrome of similar dimensions with diminished proportions (e.g. Barocas & Barocas, 1973; Baranowsky, et.al, 1998). When vividly associating about the Holocaust, the offspring seemed to be vicariously traumatized by the horrific experiences of the parents, though they themselves had no first-hand experience of it.

Such a direct "transposition" (Kestenberg, 1982) of trauma was thought to have been inherited, absorbed, or contracted by the child, as if the persecution complex of the parents was contagious, infecting offspring across generational lines. As carryovers from the past, this traumatization was perhaps denied or "forgotten" but was assumed to find expression in some emotional distress or irrational behaviour. Thus, when children learned to behave in disordered ways similar to those of their parents, there was a direct transposition of a distinct disorder (such as the KZ-syndrome, PTSD, depression or general anxiety disorder) from the parents to the children. An "anniversary syndrome" can also appear in which offspring might re-experience a trauma of their parents or even grandparents at a similar age, or at the same date as the original trauma.

The existence or non-existence of either specific or general manifestations of psychopathology in the offspring of Holocaust survivors has been the subject of the greatest disagreement between clinicians and researchers. While psychotherapists characteristically observed and described various manifestations of emotional distress in this population, researchers failed to confirm these observations with more objective and reliable instruments. A recent overview (Kellermann, 2000) of the empirical research on the contents of transmission attempts to synthesize earlier findings of the mental state of the children of Holocaust survivors. When summarizing the findings of these studies, most failed to confirm the assumption of increased rates of psychopathology in the offspring of Holocaust survivors as compared to matched control groups. Two-thirds of these studies found no or insignificant differences in the mental health of offspring as compared to controls. Only about a third of the studies found differences on some measures.

It is important, however, to further analyze these overall results through a breakdown of studies that included samples of offspring drawn from non-clinical and clinical populations. As expected, among the non-clinical populations, most studies failed to confirm higher rates of psychopathology in offspring. Among the clinical populations of offspring investigated, it is less surprising to find signs of psychological distress in a large number of the studies reviewed. These studies indicated that clinical populations of children of Holocaust survivors, as compared to other people with emotional problems, seem to have some specific characteristics, more or less centered on difficulties in coping with stress and a higher vulnerability to PTSD. Interestingly, these empirical studies of clinical populations are largely in agreement with the vast number of descriptive studies that reported specific manifestations (and increased rates) of psychiatric symptoms in children of survivors as compared to other populations.

The above differentiation between clinical and non-clinical offspring populations has made the earlier disparity between clinicians and researchers largely redundant. But, although the second generation in general do not differ from others in psychopathology, after additional stress their latent vulnerability will become more manifest (Dasberg, 1987). Thus it seems that offspring seem to experience a contradictory mixture of vulnerabilities and resilience, very similar to their Holocaust survivor parents. Excellent occupational, social and emotional functioning in ordinary circumstances may be interrupted by periods of anxiety and depression, that have a distinct "Holocaust flavor" in times of crisis. Such signs of specific vulnerabilities in the offspring of Holocaust survivors have been found in a number of studies over the last decade.

Treatment of the Second Generation.

A wide range of treatment procedures are presented in the literature and offered at AMCHA to alleviate the mental difficulties of children of Holocaust survivors. Most of these include ways to encourage free expression of feelings, thoughts and associations that were hitherto largely covered up. Being vaguely aware of the impact of the Holocaust on their lives, many children of survivors are unable to find a suitable expression to their seemingly unwarranted anger, anxiety and depressions. Frequently, psychoanalytically-oriented psychotherapy is therefore offered to help them become more aware of the unconscious or preconscious processes that continue to propel the transmission of trauma from one generation to another.

Sometimes such individual therapy is combined with analytic group psychotherapy, or group therapy is provided by itself with various orientations, including expressive forms of music, art, psychodrama and bibliotherapy. The common aspect of these approaches is to provide the child of survivors with opportunities to gain some insight into the roots of their problems, followed by a gradual process of working through and re-integration. Group therapy approaches provide a suitable setting for children of survivors to compare experiences, to feel accepted as they are and to develop a unique "second generation" identity.

Since so much of the second generation problems are centered on conflicts of enmeshment, it is a major task of therapy to help them separate from their parents and to find their own identities. If the relationship between parents and children is so close that it is impossible to tell the feelings of one from the other, some help in differentiation is required. In short, if children feel that their original Holocaust survivor family environment is too much to handle, they need to be helped to "leave home" both in reality and in fantasy. As we have already pointed out, this is easier said than done in families that have suffered so many traumatic losses and put so much hope and expectations on the offspring. Many second generation clients, therefore, need a lot of support and encouragement to work through such an individuation process step-by-step. At the same time, they will also try to rid themselves from the burdensome dark influences of the Holocaust trauma that often come with being the children of Holocaust survivors.

Conclusion

AMCHA has developed a rich body of unique knowledge in the late effects of Holocaust traumatization and its intergenerational transmission. This knowledge can also be used in treating post-war effects beyond Holocaust traumatization. Whether it is in Cambodia, Rwanda, Bosnia or elsewhere, survivors of atrocities from various parts of the world may benefit from the cumulative experience of AMCHA. This includes not only how to provide survivors with a long-term psychosocial support network but also how to work with their offspring and those secondarily traumatized.

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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 psycho-geriatric) consultations (for clients in therapy)

Services provided to elderly Holocaust survivors

- Home-visits by volunteers
- Documentation through video-recordings of personal and family history
- Psycho-social senior citizen support clubs

Services provided to Child-survivors of the Holocaust

- Counseling for "non-survivor" 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