Abstract: For children of Holocaust survivors, the trauma of their parents can be perceived both as a curse and as a legacy. On the one hand, it may fill their inner lives with terrible anxiety-provoking associations; on the other, it may be a source of creative inspiration that motivates them to make the world a better place. As a result, most of them struggle with the contradictory forces of vulnerability and resilience that they inherited from their parents. Since there is such a wide spectrum of adaptive reactions to the Holocaust, it is important to identify the various aggravating and mitigating factors that are assumed to increase or decrease the risk of children to absorb the trauma of their parents and to develop specific second-generation psychopathology as a result. In an effort to understand more clearly some of the aggravating factors, a demographic study of a clinical sub-population of the “Second Generation” was conducted. Results indicated that most of this clinical population was born soon after the war ended, to parents who were both Holocaust survivors, and that they were mostly female, married, highly educated, working as teachers or in the helping professions, were the first or the second child, and had parents who were inclined not to share their Holocaust experiences with their children. Parents were mostly rated as fully functioning, without severe mental and physical disease and as not overly preoccupied with the Holocaust.

Over 500 studies have been published on the transmission of Holocaust trauma from Holocaust survivors to their children (1). This literature describes how the psychological burden of Holocaust survivors has been passed on to their children. Though these children seem to have “inherited” some of their parents’ Holocaust trauma, it is important to emphasize that not all children of survivors are emotionally disturbed and in need of treatment. Most empirical research could not substantiate the claim that there was more psychopathology in children of survivors than in comparable populations (2-4). There seems to be sufficient evidence, however, that children of trauma survivors constitute a high risk group for PTSD (5). For example, when diagnosed with cancer (6), or when being exposed to combat stress (7), children of Holocaust survivors seem to be more distressed than comparative populations.

According to data from the Israel National Health Survey (4), 13.6% of the offspring had mental health treatment during the last year and 12.6% reported having an anxiety or mood disorder during their lifetime. This data suggests that there is a clinical subpopulation who suffers from a severe kind of “Second Generation Syndrome.” This syndrome includes a predisposition to PTSD, difficulties in separation — individuation, a contradictory mix of resilience and vulnerability when coping with stress, a personality disorder or various neurotic conflicts, periods of anxiety and depression in times of crisis, and a more or less impaired occupational, social and emotional functioning with problems centered on the self, cognition, affectivity and interpersonal functioning (8, 9). During the last two decades, thousands of these more severely affected clients in Israel have turned to Amcha — the National Israeli Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation — for psychotherapeutic counseling. Mental health professionals working within this treatment center have the impression that these “2G-clients” still suffer tremendously from their tragic heritage, even though they already have reached middle age.

Who are these clients? What made them absorb the Holocaust trauma to a greater extent than their brothers and sisters? What made these clients more
susceptible to emotional problems than their “non-client” peers? Why did these children of Holocaust survivors develop emotional problems, while others adjusted well, even though they all grew up in the same more or less dysfunctional families? What increases and/or decreases the likelihood to develop psychopathology as a result of parental traumatization? It will be the purpose of the present paper to try to answer some of these questions.

Factors that increase the likelihood to develop psychopathology and put offspring at risk are assumed to include any or all of the following: (1) that the children were born early after the parents’ trauma and immediately after World War II; (2) that they were the only, or the first-born child; (3) that both parents were survivors rather than only one (3, 5, 10, 11); (4) that they were “replacement” children for children who had perished in the war; (5) that parents had endured extraordinary mental suffering and significant loss of close family and were highly disturbed as a result (12); (6) that symbiotic relations were dominant between parents and children and that the family relations were characterized by enmeshment without sufficient corrective periods of disengagements; and (7) that the trauma was talked about too much or too little. These factors may be assumed to be universal in increasing the risk of a child to unconsciously absorb the trauma of his or her parents and to develop mental distress as a result (9).

Several other circumstances may be assumed to influence the process of trauma transmission in addition to the ones described above. For example, Keinan et al. (13) 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 thanks to certain “mitigating effects” that have helped them to withstand the detrimental influence of harmful child-rearing, despite everything. Such mitigating factors would include open and age-relevant communication (14, 15) between parents and children about the Holocaust, an extended community that could alleviate some of the worst family influences, a well-integrated Jewish or cultural identity, reparative socialization during formative years, an adequate individuation-separation phase during childhood and adolescence, and an adequate differentiation from the parents and from their trauma in late adolescence or early adulthood.

These aggravating and mitigating factors are based mostly on clinical experience and have not yet been substantiated by empirical research. It is the hope that an analysis of the present data on the clinical population of the “Second Generation” and their Holocaust survivor parents will improve this situation.

Method

In order to learn more about the specific clinical “Second Generation” population, the following study, approved by a Human Subjects Committee, was conducted.

Rather than continuing to investigate the prevalence of psychopathology in this population as compared to others, the purpose of the present study was to identify the demographic factors, beyond individual differences and genetic endowment that increase the likelihood to develop psychopathology as a result of parental traumatization.

General demographic data from a sample of 273 2G clients (C-2G), who applied for therapy in Amcha during the last 5-6 years, was therefore collected. This self-selected client population, obtained through consecutive admissions/referrals to the clinic, was assumed to be a representative sample of the more disturbed children of survivors. In addition, it may be assumed that they were aware of the influence of their parents’ trauma upon themselves and were motivated to deal with this aspect of their lives since they specifically turned to a treatment center for Holocaust survivors and the Second Generation.

Gathering demographic data of a clinical sample of children of Holocaust survivors was assumed to help differentiate this group from other 2G who might be less inclined to come for therapy. Specifically, this sample might corroborate some of the various aggravating and mitigating factors that are assumed to increase or decrease the risk of children to absorb the trauma of their parents and to develop specific second-generation psychopathology as a result.

A 25-item questionnaire was constructed to
cover different demographic aspects of the subjects themselves and their parents. The C-2G subjects were asked to rate some of these items on a five-point Likert-scale for mothers and fathers separately. Three sets of data were thus collected: (1) demographic variables of the “Second Generation” themselves; (2) Holocaust survivor parent demographic data; and (3) an evaluation of Holocaust survivor parents’ state.

Results
The responses of these three sets of data are presented in Tables 1 and 2.

The following demographic data of C-2G will be presented below: (1) Year of birth; (2) Country of birth; (3) Gender; (4) Marital Status; (5) Education; (6) Number of Children; (7) Occupation; (8) Number of Siblings; (9) Birth order and (10) if there were only one or two Holocaust survivor parents.

1. Year of birth
Three groups of C-2G could be differentiated according to their year of birth after the war: (A) those born immediately after the war, between 1945–1954: 130(48%); (B) those born between 1955–1964: 102(37%), and (C) those born between 1965–1974: 41(15%). Since most of C-2G were born within the first 10 years after the war, we may assume that this is a relevant variable when predicting psychopathology in this population.

2. Country of birth
Since the sample of C-2G was collected in Israel, most clients were obviously born in this country: 160(59%). But there were also others who were born in East Europe 41(%), West Europe 24(%); U.S./Canada/Australia 19(%) and in South America 12(%).

3. Gender
Within the present sample, 86(31%) male and 187(69%) female clients applied for counseling.

4. Marital status
Most C-2G were married 151(61%) and a similar percentage where either single or divorced (18%).

5. Number of Children
The sample of C-2G had an average of 2.5 children/person.

6. Years of study
This was a highly educated group of academics with more than 16 years of study.

7. Occupation
Over half of this population worked either as teachers (25%) or in a helping profession (social workers, counselors, physicians, therapists, psychologists, occupational therapists, etc.). The rest worked in various other professions, including 10% artists.

8. Number of siblings
Most of the C-2G had only one or two siblings, which puts the average to about 1.5 children per Holocaust survivor family, fewer than their own children.

9. Birth order
Most of the C-2G were either first born (42%) or the second child (38%). Only 20% of them where the third child or longer down the birth order, which may have made them less influenced by parents’ Holocaust trauma. Among those born during the first five years after World War II (incl. 1951), 60% were first born children, 30% were second child, and only 9% were third or later child.

10. One or two Holocaust survivor parents
It was difficult to determine if only one or both parents were Holocaust survivors since almost all parents were born in Europe during WWII and all had difficult war-experiences. Some were in ghettos, others in hiding, in working camps, were fighting with the partisans or a combination of all of the above. Without going into the difficult issue of defining who is a “real” Holocaust Survivor (16), we must assume that everybody who was “there” was affected. Consequently, we will answer the question by excluding those who were not there, which are those with one parent born “in an unoccupied country,” for example in Israel, in the U.S., or elsewhere. Within the sample population, 9% of the fathers and 14% of the mothers were not Holocaust survivors according to this definition. Of a total of 546 parents, only 64(12%) were categorized as such. Thus we may conclude that the overwhelming majority (88%) of the C-2G grew up in families in which both parents were Holocaust survivors.
<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
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</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
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<td>1905–1945</td>
</tr>
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<td>23</td>
</tr>
<tr>
<td><strong>Country of Origin</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poland</td>
<td>100 (37%)</td>
<td>86 (31%)</td>
</tr>
<tr>
<td>Czechoslovakia</td>
<td>23 (9%)</td>
<td>29 (11%)</td>
</tr>
<tr>
<td>Hungary</td>
<td>33 (12%)</td>
<td>25 (9%)</td>
</tr>
<tr>
<td>Romania</td>
<td>34 (12%)</td>
<td>37 (14%)</td>
</tr>
<tr>
<td>Other occupied countries</td>
<td>52 (19%)</td>
<td>51 (19%)</td>
</tr>
<tr>
<td>Other unoccupied countries</td>
<td>25 (9%)</td>
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<tr>
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<td>6 (2%)</td>
<td>6 (2%)</td>
</tr>
<tr>
<td><strong>Year of Immigration</strong></td>
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<td></td>
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<td>1920–2004</td>
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<td>66</td>
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<td></td>
</tr>
<tr>
<td>Range</td>
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<td>1926–1975</td>
</tr>
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<td>11 (4%)</td>
<td>11 (4%)</td>
</tr>
<tr>
<td>During the war</td>
<td>25 (9%)</td>
<td>25 (9%)</td>
</tr>
<tr>
<td>Immediately after the war</td>
<td>82 (30%)</td>
<td>82 (30%)</td>
</tr>
<tr>
<td>More than 10 years after</td>
<td>58 (21%)</td>
<td>58 (21%)</td>
</tr>
<tr>
<td>Missing value</td>
<td>97 (36%)</td>
<td>97 (36%)</td>
</tr>
<tr>
<td><strong>Previous Marriage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>210 (77%)</td>
<td>202 (74%)</td>
</tr>
<tr>
<td>Yes</td>
<td>44 (16%)</td>
<td>43 (16%)</td>
</tr>
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<td>19 (7%)</td>
<td>28 (10%)</td>
</tr>
<tr>
<td><strong>Places of war confinement</strong></td>
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<td></td>
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<tr>
<td>Ghetto</td>
<td>52</td>
<td>73</td>
</tr>
<tr>
<td>KZ or working camp</td>
<td>101</td>
<td>116</td>
</tr>
<tr>
<td>Hiding</td>
<td>51</td>
<td>54</td>
</tr>
<tr>
<td>Partisans</td>
<td>21</td>
<td>6</td>
</tr>
<tr>
<td>Unoccupied country</td>
<td>36</td>
<td>38</td>
</tr>
<tr>
<td>Other</td>
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<td>7</td>
</tr>
<tr>
<td>Missing value</td>
<td>34</td>
<td>50</td>
</tr>
<tr>
<td><strong>Extent of Family Loss</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everybody</td>
<td>52 (19%)</td>
<td>48 (17%)</td>
</tr>
<tr>
<td>Most</td>
<td>115 (42%)</td>
<td>106 (39%)</td>
</tr>
<tr>
<td>Some</td>
<td>61 (22%)</td>
<td>53 (19%)</td>
</tr>
<tr>
<td>Nobody</td>
<td>13 (5%)</td>
<td>14 (6%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>17 (6%)</td>
<td>19 (7%)</td>
</tr>
<tr>
<td>Missing value</td>
<td>15 (6%)</td>
<td>33 (12%)</td>
</tr>
<tr>
<td><strong>Other traumatic experiences</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>82 (30%)</td>
<td>75 (27%)</td>
</tr>
<tr>
<td>No</td>
<td>183 (67%)</td>
<td>183 (67%)</td>
</tr>
<tr>
<td>Missing value</td>
<td>8 (3%)</td>
<td>15 (6%)</td>
</tr>
<tr>
<td><strong>Deceased (yes or no)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>117 (43%)</td>
<td>144 (53%)</td>
</tr>
<tr>
<td>Yes</td>
<td>125 (46%)</td>
<td>58 (21%)</td>
</tr>
<tr>
<td>Missing value</td>
<td>31 (11%)</td>
<td>71 (26%)</td>
</tr>
<tr>
<td><strong>Year of death</strong></td>
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<td></td>
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<tr>
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<td>220</td>
</tr>
<tr>
<td><strong>Years of living</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>70</td>
<td>73</td>
</tr>
</tbody>
</table>
Holocaust Survivor Parents’ Demographic Variables

Table 1 shows a summary of demographic data of the Holocaust survivor parents of these C-2G and a summary of its main details: The range of birth of fathers and mothers was similar, with most parents being born between the years 1920 and 1936 in Poland.

Both parents immigrated to Israel immediately after the war 1946–1950, most (57%) of who married within 10 years after the war. Only 17% of these parents were married before, suggesting that the majority of these C-2G were not replacement children. Most of these parents had been exposed to severe Holocaust experiences in a ghetto, concentration and/or work camps, in hiding, or among the partisans; 61% of the fathers and 56% of the mothers had lost everybody or most of their family in the Holocaust. However, only about a third of them had also been exposed to other traumatic experiences in their lives. Such other stressful events would have made Holocaust traumatization less influential as a single factor.

As expected, mothers outlived the fathers, with 46% of the fathers being deceased and only 21% of the mothers. The average life span of these parents was 70 years for the fathers and 73 for the mothers. These numbers were calculated by subtracting the birth year of the parents from their year of death, among those who had died. However, since these numbers were based on a relatively small sample of the general population, they cannot be considered as a valid life-expectation prediction for Holocaust survivors.

Table 2 presents five variables concerning the preoccupation, sharing, physical and mental state, and functioning of the Holocaust survivor parents.

(1) To what extent where parents occupied with Holocaust experiences? Fathers and mothers seem equally preoccupied with the Holocaust, most showing less rather than more preoccupation.

<table>
<thead>
<tr>
<th>Table 2. 2G Evaluation of HS Parents’ State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Preoccupation</td>
</tr>
<tr>
<td>A lot</td>
</tr>
<tr>
<td>Some</td>
</tr>
<tr>
<td>A little</td>
</tr>
<tr>
<td>Missing value</td>
</tr>
<tr>
<td>Sharing</td>
</tr>
<tr>
<td>A lot</td>
</tr>
<tr>
<td>Some</td>
</tr>
<tr>
<td>A little</td>
</tr>
<tr>
<td>Missing value</td>
</tr>
<tr>
<td>Physical illnesses</td>
</tr>
<tr>
<td>Frequently</td>
</tr>
<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>Seldom</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Missing value</td>
</tr>
<tr>
<td>Mental health</td>
</tr>
<tr>
<td>Difficult</td>
</tr>
<tr>
<td>Middle</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Missing value</td>
</tr>
<tr>
<td>Functioning</td>
</tr>
<tr>
<td>Fully</td>
</tr>
<tr>
<td>Partly</td>
</tr>
<tr>
<td>Impaired</td>
</tr>
<tr>
<td>Missing value</td>
</tr>
</tbody>
</table>
To what extent did parents share their Holocaust experiences with their children? Generally both parents shared only a little with their children, but mothers shared much more than fathers.

What was the physical state of parents when the 2G were children? Mothers seemed to be more ill than fathers, but except for 53 mothers and 24 fathers, this population of Holocaust survivors seemed to be in general good health.

What was the mental state of parents during 2G’s childhood? Their children considered their mental state neither difficult nor good, but “average.”

How was the general functioning of parents during 2G’s childhood? Most were functioning fully, with only a few functioning partially and a minority being impaired.

Discussion

According to data from the present study, the clinical sample of children of Holocaust survivors were born early after the war, were female, married, highly educated, working as teachers or in the helping professions and were the first or the second child. Their parents did not share their Holocaust experiences with them. These variables seemed to be the main “aggravating factors” of Holocaust transmission among children of trauma survivors.

As a whole, it is interesting to note that this clinical group of respondents rated their Holocaust survivor parents as fully functioning and not suffering from serious mental or physical disease. In addition, these parents were not perceived as overly preoccupied with the Holocaust, nor did they share much about their traumatic experiences. This data suggests that even a relatively balanced group of Holocaust survivors, such as the present one, still appeared to have transmitted their trauma upon their offspring, who felt a need to come for treatment.

The present sample confirms demographic data collected by Levav et al. (4) and many others, indicating that offspring of Holocaust survivors have more years of schooling than comparison groups. Some have explained this tendency to become high achievers with the high expectations of survivor parents who demanded from their children to “become something” which would make their own survival and their enormous sacrifices more worthwhile.

The data collected was assumed to reflect a clinical population of children of Holocaust survivors. However, since there was no diagnostic evaluation attached to these questionnaires, the extent of their psychopathology remains unclear. Obviously, this is a major limitation of the validity of this study. In addition, we do not have sufficient information of the indication for psychotherapy since we only used the data from the routine demographic intake questionnaire, which might have been a one-time occurrence. Possibly, some of these subjects might not even have suffered from any severe emotional disorder. For our present purposes, however, we utilize our clinical experience from such intake procedures, which repeatedly showed that this population suffers from a variety of psychological problems (delineated above). From this experience, it is possible to assume that this was also the case as to why this population of children of survivors came to Amcha.

An additional limitation was the lack of a suitable control group to measure the differences between this population and other comparable ones. Though these findings may hold some intrinsic value in themselves, they would probably convey additional information with such a suitable control group. But which group could really be a comparable match to this population? Could it be a general population of treatment seekers in Israel? Or, should it rather be children of immigrants? Or, a group of subjects with parents who had endured some other trauma? Or, some other “non-clinical” group of children of Holocaust survivors? Since no suitable control group was found, it was decided to publish the present findings in their present form, hoping to add additional comparative information in the future.

Upon further analysis of these results, we may assume that country of birth has only a small influence on the development of specific “Second Generation” psychopathology, though the countries mentioned obviously represent the main locations where survivors fled after the war. Regarding gender, however, the higher number of women in this sample might indicate either that female clients are more prone to develop 2G-pathology than males, or that women simply are more psychologically-minded than men and therefore more motivated to seek counseling.
Finally, since there could be no objective evaluation of the mental and physical state of the parents, the present study had to rely solely upon the subjective impressions of their children. This obviously cannot be considered a sufficiently reliable and valid measure of Holocaust survivor parents’ general functioning. For example, the parents may have been comparatively dysfunctional and suffering from severe traumatization while their children, for their own reasons, viewed them as extraordinary resilient and as perfect parents. It is our impression, however, that the perception of offspring has important face value for our present purposes, especially since we learned from an earlier study (17) that children of Holocaust survivors tended to view (and evaluate) their parents as equally affectionate, punishing and over-protective as other (non-survivor) parents, but as more prone to trauma transmission.

Conclusion

For children of Holocaust survivors, the trauma of their parents may be perceived both as a curse and as a legacy. Some children grow up with terrible anxiety-provoking Holocaust associations that haunt them day and night. Others experience their heritage as a powerful legacy that gives them a sense of purpose and meaning in life.

This paradoxical learning experience has bewildered trauma therapists for generations.

The contradictory forces of vulnerability and resilience (18) may be assumed to continue to accompany the “Second Generation” for their entire life span. While the “transmitted trauma” that they have inherited from their parents might increase their suffering, the very fact that they have vicariously experienced so much tragedy also provided them with adaptive coping ability and with “survival skills,” which usually are insufficiently developed in other people. Helmreich (19) delineated ten such general traits that enabled Holocaust survivors to lead positive and useful lives following the war: (1) to be able to adapt in a flexible manner to new environments, (2) to be assertive and take initiative, (3) to refuse to take “no” for an answer, (4) to have an optimistic and future oriented approach to life, (5) to utilize intelligence and professional skills, (6) to be able to remove the trauma from consciousness, (7) to belong to a helpful support group, (8) to assimilate the knowledge that they survived, (9) to find meaning and a sense of coherence in one’s life, and (10) to muster courage. If these resilient traits were predominant in the survivors, we may assume that they were also passed on to their offspring. In addition, because of their close affinity with the tragedy of their parents, traits such as compassion, empathy and a deep understanding of human suffering may be assumed to be highly developed in the “Second Generation,” giving them a special predisposition to work in the helping and teaching professions.

It would be a simplification, however, to describe the two forces of vulnerability and resilience as two separate forces struggling to take hold of the inner personality of the “Second Generation.” Rather, offspring of Holocaust survivors seem to simultaneously struggle with both forces at one and the same time, and will have periods in their lives when one or the other is more dominant (10). Some might suffer from life-long debilitating psychopathology with periods of tranquility, while others may function excellently most of the time with shorter periods of severe anxiety and depression. It is important, therefore, not to view this client population of children of Holocaust survivors as a homogenous group, which either suffers from specific psychopathology or which manifests post-traumatic growth, but to see them as simultaneously struggling with both forces throughout life.

Acknowledgement

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References


