

CLINICAL HETEROGENEITY IN CHILDREN OF HOLOCAUST SURVIVORS

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▼ Five decades after the worst human-made tragedy in history, there has been a consistent interest in the social, psychological, and medical consequences of the Holocaust. Naturally, such interest has been fueled by the awareness that research data obtained from the study of Holocaust survivors and their offspring can be applied to victims of other massive psychic trauma. Intergenerational transmission of trauma has become an important issues in understanding the consequences of parental posttraumatic stress disorder (PTSD) on offspring.

Early literature on children of Holocaust survivors focused mainly on population of patients that were observed in the consultation room and on conclusions drawn from small clinical samples that were erroneously generalized to the entire population of "second generation" survivors (Solkoff 1992). As a consequence, since the late 1960s there has been a tendency to focus on similarities and common links between major issues presented by children of Holocaust survivors. For unclear reasons, there has been a tendency to ignore clinical and personal heterogeneity. More recent studies (Schwartz, in press; Solkoff 1992) have pointed specifically to the fact that a clear differentiation has to be made between the patient population and the nonpatient population of children of Holocaust survivors. Likewise, the Columbia University Study (Schwartz, in press) has not confirmed early reports that the nonpatient population of adult children of Holocaust survivors may be prone to specific psychopathology. However, there may be a history of minor depression and generalized anxiety disorder in younger offspring (under age 25 years) of Holocaust survivors.

▼ HETEROGENEITY

Different factors of heterogeneity have to be considered in assessing this population of "second generation" survivors.

Definition. In the United States, any individual whose parents fled Europe after 1933 is considered a child of Holocaust

survivors. This is a broad definition. Although all such families are marked by major losses, one can understand that children of concentration camp survivors may be facing different issues than the ones who "escaped" from Europe and may be the only survivors in their family.

Impact of parental trauma (family factors). Danieli (1981) described different family patterns among survivors of the Holocaust. It is noteworthy that in families of Holocaust survivors one can examine the relationship between the victimizers (survivors) and the victims (the children); hence this process has been previously referred to as *secondary traumatization*.

Genetic and temperamental factors. Obviously, as in any expression of human behavior, genetic and temperamental elements are at play. Some individuals may also bear a genetic vulnerability to psychopathology. This has to be differentiated from a possible acquired vulnerability secondary to traumatization.

Psychopathology. The presence or the absence of psychopathology in children of Holocaust survivors as an independent variable has to be stated. As second generation individuals reach middle age, the natural probability of their developing certain psychiatric conditions increases. It is important to study the circumstances of these psychiatric conditions in an already vulnerable host.

Associated traumas.

Sources of additional trauma have to be considered. Immigration is an important factor. Studies should use control subjects whose parents are immigrants. Researchers (Brody 1970; Novac 1986) have shown that immigration is a significant trauma in itself. When referring to immigration, a difference between "acculturation" of individuals in the United States versus families immigrating to Israel can be observed (immigration to Israel after World War II was more likely to result in a more rapid adjustment to a new "homeland"). The

experience of inner cities in the United States is a noteworthy social trauma. At least one study (Breslau and Davis 1992) has revealed that 9.2% of traumatized individuals in inner cities will develop DSM-III-R criteria for PTSD. Thus a child of Holocaust survivors growing up in a American inner city is likely to exhibit secondary traumatization from a source unrelated to the family. Finally, war and the military have to be mentioned. The outcome of some children of Holocaust survivors who have participated in different Israeli wars have been studies. An interesting study by Solomon et al. (1988) showed that Israeli soldiers who were children of Holocaust survivors and developed PTSD during the Lebanese war, were significantly more symptomatic 1 year later in comparison with control subjects. This may suggest a specific nongenetic vulnerability to developing PTSD.

Microcultural heterogeneity. This refers to specific heterogeneous backgrounds of these second generation individuals. Questions about religiosity have to be asked. What is the host culture? For example, children of a more assimilated German-Jewish background may have grown up with different myths and attitudes than those from a Polish Hasidic background. Questions about the degree of assimilation after immigration have to be asked. Many children of Holocaust survivors were raised with the goal of becoming "good healthy Americans." This may be partially related to a tendency of parent survivors to teach a "low profile" to children in the so-called "victim family" (Danieli 1981).

▼ THE IMPACT OF PARENTAL TRAUMATIZATION

The type of survivor parent (concentration camp survivor or not) is important. Studies on subjects whose both parents were survivors of the camps are in fact emphasizing the "concentration camp effect" on the offspring. This, however, may not be the only factor in the traumatization of survivor parents. The following are some of the vehicles of *transposition* (i.e., transmission) of trauma:

- ▼ *The stories presented by the parents.* Were there vivid descriptions with imagery that then created secondary nightmarish memories for children? Were there no stories at all (i.e., blank spots), which then resulted in fantasies? The latter process was also referred to by Danieli (1981) as *traumatization by osmosis*. In a pool of children of Holocaust survivors in the "2-G" organization in the Los Angeles area, approximately 50% of the members stated that they grew up without explicit stories about their parents' experience (*silent parents*).
- ▼ *Nongenetic familial transmission of traits.* This is an important subject that has to be included in this study. Here I would specifically refer to work by Kendler (1988) on "indirect

vertical cultural transmission." (Direct vertical transmission result in similar traits in offspring; indirect vertical transmission may induce complementary, mirrorlike traits.)

- ▼ *The position of the second generation individual within the family.* This is another important factor. In her book *Memorial Candles: Children of the Holocaust*, Wardi (1992) referred to a common phenomenon seen in Holocaust families where one child who is named after a relative who was killed in the camps is usually victimized by additional demands (scapegoating). She referred to these individuals as the *memorial candles*.
- ▼ *The type of survivor family.* Danieli (1981) described four different types of families: victim, fighter, numb, and families of those who made it.

▼ THE PATIENT POPULATION

When referring to patients who are children of Holocaust survivors, numerous "phantom" variables have to be recognized. *Phantom variables* are specific masked characteristics that may be present in children of Holocaust survivors who are seeking treatment for routine psychiatric conditions (e.g., depression, anxiety). Because of such phantom variables, these individuals may present different outcomes than patients who are not children of Holocaust survivors. Our own experience (Andrei Novac and S. M. Broderick, unpublished data) revealed a statistically significant increase of "atypicality" (reversed functional shift) in a population of children of Holocaust survivors who presented chief complaints of anxiety and depression. This same group also showed a definite trend toward comorbidity of anxiety and depressive disorders in comparison with matched control subjects who presented also with chief complaints of anxiety and depression but were not children of Holocaust survivors.

▼ CONCLUSIONS

- ▼ An important difference has to be made between the patient population and the nonpatient population of children of Holocaust survivors.
- ▼ The nonpatient population has not demonstrated significant and specific psychopathology.
- ▼ The issue of heterogeneity in children of Holocaust survivors has been largely neglected until now.
- ▼ The numerous factors of heterogeneity deserve further attention.
- ▼ Self-selection for treatment and help-seeking patterns have to be more closely examined.
- ▼ The factors of heterogeneity should be also considered among the patient population of "second generation."
- ▼ At least in one subgroup (2-G individuals who complained

of anxiety and depression) there seems to be a tendency toward comorbidity of anxiety and depressive disorders. A statistically significant increase of "atypicality" in children of Holocaust survivors was present.

- ▼ The relationship between these findings and the results of the Columbia University Study (Schwartz, in press), according to which nonpatient second generation individuals may have experienced more anxiety and depression before age 25, should be further examined.

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