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Lisa Simson Guthery
Exploration of Intergenerational
Transmission of Trauma in
Holocaust Survivors

ABSTRACT

This study was undertaken to help resolve current debate in the field as to whether or not the traumatic effects of the Holocaust are transmitted intergenerationally. What was preventing or, conversely, enabling the passage of symptomatology from one generation to the next, thereby accounting for the contradiction in research, and clinicians' observations during their work with Holocaust families? Over 200 people received the study through social media and snowball sampling requesting participation in a Qualtrics survey consisting of 3 screening questions, 5 demographic questions, 4 sections of multiple-choice questions, and 2 open-ended questions. The four sections assessed parental PTSD symptomatology, attachment, psychological and social impacts on the children of Holocaust survivors, and community support. The findings of this research confirmed previous studies that parental Post Traumatic Stress Disorder (PTSD) symptomatology is more than likely related to offspring adverse psychological and social impacts. Results also support that those children whose parents show high levels of PTSD, and who experience certain psychological and social troubles tend to have an anxious attachment style with their parent. Finally, findings show children of Holocaust survivors characteristically feel driven to undo and heal their caregiver's trauma by defending their caregivers from emotional and social injury. Results that were not significant are discussed along with limitations to this investigation, and suggestions for further research are outlined.

**EXPLORATION OF INTERGENERATIONAL TRANSMISSION OF TRAUMA IN
HOLOCAUST SURVIVORS.**

Lisa S. Guthery

Smith College School for Social Work

A project based on an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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CHAPTER I

Introduction

Overall, debate exists as to whether or not the effects of traumatic events such as genocide, war, rape, abuse, or neglect are transmitted intergenerationally. In particular, current research presents conflicting findings regarding the intergenerational transmission of trauma among Holocaust survivors. Intergenerational trauma can be best defined as the transmission of traumatic stress response symptomatology from the initial victims of the trauma to their offspring and subsequent generations. The presence of psychopathology symptoms in the children and grandchildren of survivors indicate the transmission of trauma.

Whereas clinical case studies and therapists unequivocally report evidence of intergenerational trauma among Holocaust families, controlled empirical studies report conflicting results, suggesting empirical studies might not be capturing the actual transmission process (Kellermann, 2001; Sagi-Schwartz et al., 2003; Sagi-Schwartz, van IJzendoorn, & Bakermans-Kranenburg, 2008). A large body of research confirms evidence of the intergenerational transmission of trauma among both Holocaust families and surviving families of other types of mass genocide. This confirming research seeks to clarify discrepancies in the research by identifying the mechanisms of intergenerational transmission of trauma from parent to offspring. These studies look at how risk and protective factors either contribute to or inhibit the intergenerational transmission of trauma (Leen-Feldner et al., 2013).

However, another body of research mostly headed by Sagi-Schwartz et al. fails to find evidence of intergenerational transmission of Holocaust trauma (Sagi-Schwartz et al., 2003; Sagi-Schwartz et al., 2008). Sagi-Schwartz et al.'s 2003 and 2008 studies of attachment and

intergenerational traumatic stress in Holocaust families confound the assumption that certain risk factors contribute to the phenomenon of transmission, and this research suggests that the existence of certain protective factors may explain the absence of intergenerational transmission of trauma among Holocaust families. Resolution of this contradiction as it pertains to Holocaust survivor families necessitates the current study. What is preventing or, conversely, enabling the passage of symptomatology from one generation to the next, thereby accounting for the contradiction in research, and clinicians' observations during their work with Holocaust families?

The present study harbors significant relevance to clinical social work. The findings of this study will inform the focus of intervention for clinicians working with Holocaust families experiencing the effects of trauma in order to interrupt the intergenerational transmission of trauma. The results of the study will assist clinicians in identifying the most salient factors of resilience present within the family on which the clinician can focus interventions. Ultimately, the findings will inform the most effective and efficient care of Holocaust families experiencing trauma to support clinicians practicing in the short-term treatment climate of managed care.

CHAPTER II

Literature Review

What is accounting for the contradiction in research, and clinicians' observations during their work with Holocaust families? This literature review focuses primarily on research that clarifies the presence or absence of intergenerational transmission of trauma in Holocaust families, and factors within families or communities that prevent, or conversely enable the passage of psychopathology symptoms from one generation to the next. This chapter is divided into three sections. Section one describes the current dispute among clinicians and researchers concerning intergenerational transmission of Holocaust trauma. Section two provides the theoretical framework that is the foundation for this research. Section three presents several salient themes throughout the research pertaining to risk and protective factors in the transmission of Holocaust trauma.

Current Debate

Confirming studies

In a meta-analysis conducted by Leen-Feldner et al. (2013), researchers not only reviewed over one hundred studies that documented the existence of intergenerational trauma among diverse populations, they also examined the specific biological and/or psychological variables of the phenomenon that impact the functioning of offspring of parents with PTSD. This meta-analysis reviewed a majority of gold-standard research studies that examined the epigenetic, genetic, and parent behavioral mechanisms of transmission, and it concluded there is

increasing evidence that symptoms of parental PTSD appear to be related to an array of negative offspring outcomes both behaviorally and genetically.

Understanding how PTSD affects offspring genetically, a study by Perroud et al. (2013), tested cortisol levels in offspring of twenty-five women who were pregnant in the Tutsi genocide and compared it to offspring of Rwandan women who were living outside of the country. They determined that children of mothers who had experienced the traumatic event had higher PTSD symptoms and depression severity as well as lower cortisol levels than non-exposed children. Another finding in this study was that PTSD symptoms were passed down to the children of these survivors. On the other hand, other studies have found trauma raises cortisol levels. It could be that initially after trauma exposure, cortisol levels are raised, but repeated over-exposure leads to exhaustion of the limbic system. Either way, cortisol levels are abnormal among offspring of traumatized parents (Davies, 2011).

Furthermore, Song, Tol, and Jong's (2004) qualitative study, which explored how the effects of trauma among Burundian former child soldiers (FCS) transmitted intergenerationally, added to a previous mixed methods study that compared 15 FCS and their children to 15 matched civilians. These researchers confirmed the transmission of trauma to subsequent generations in the presence of specific risk factors (Song et al., 2004). Additionally, Myhra's (2011) ethnographic study, which explored the transmission of historical trauma to descendants and the relationship between drug abuse and historical trauma, indicated that historical trauma transmits to subsequent generations as well. Yet another study by Bezo and Maggi (2015) also looked at intergenerational trauma after interviewing 45 survivors of the Holodomor genocide, their children, and grandchildren, and determined the genocide impacted all three generations in the form of stress and anxiety.

Finally, Giladi and Bell's (2012) individual study of Holocaust survivors and their families quantitatively found a presence of secondary trauma within the second and third generations of Holocaust survivors. Unlike Sagi-Schwartz et al. (2008), even though levels of secondary trauma were within normal ranges for most participants, second generation (2G) and third generation (3G) children of Holocaust survivors had significantly higher levels of secondary trauma than the control group. So, although 2G and 3G functioned well, they appeared to be affected by family trauma.

Disconfirming studies.

Another body of research mostly headed by Sagi-Schwartz et al. failed to find evidence of intergenerational transmission of Holocaust trauma (Sagi-Schwartz et al, 2003; Sagi-Schwartz et al., 2008). In 2003, Sagi-Schwartz et al. sought to confirm the assumption that poor mother-daughter attachment in Israelis contributed to the phenomenon of transmission, but found although survivors suffered from unresolved loss and trauma, their daughters did not. Therefore, Sagi-Schwartz et al. (2003) concluded survivors successfully protected their social lives and family relationships from being influenced by their Holocaust experiences. Sagi-Schwartz et al. (2003) explained survivors' parents or other attachment figures did not create the traumatic events stemming from the Holocaust; rather, these events emerged from an almost anonymous destructive force (the Nazis). Furthermore, survivors had experienced several years of normal family life before the Holocaust. Also, Israeli Holocaust survivors were oriented toward future goals such as building a new nation in Israel, and a large Israeli community with a collective memory of the Holocaust surrounded them. These protective factors therefore allowed Israeli survivors to cope with the challenges of adapting to normal family and social life after the war, and to become attachment figures themselves.

In 2008, Sagi-Schwartz et al. again tried to address the divergence of clinical and non-clinical findings on the intergenerational transmission of Holocaust trauma, this time by conducting a meta-analysis of thirteen studies that examined the effects on diverse (i.e. not only Israeli) grandchildren of survivors. Sagi-Schwartz et al. (2008) again found no evidence of transmission, and they again suggested the existence of certain protective factors might explain the absence of intergenerational transmission of trauma among Holocaust families.

Content vs. process.

What both schools of thought seem to agree on, therefore, is the transmission of trauma cannot be limited to the *content* of the trauma; rather, there seems to be a *process* by which Holocaust survivor parents influence certain types of children in particular circumstances. As previously highlighted, past studies have postulated this process is based on several aggravating and mitigating mechanisms: psychodynamic, relational, sociocultural, socialization, family systems, communication, biological, and genetic factors (Kellermann, 2001). Moreover, in order to measure this process, there needs to be specific tools developed to measure the transmission of trauma among massively traumatized cohorts rather than using unidimensional measures made for the larger population that have been utilized in disconfirming studies such as Sagi-Schwartz et al.'s 2003 and 2008 studies (Danieli et al., 2015).

Theoretical Framework

Structural theory and attachment theory provide two conceptual frameworks that are useful to understand the mechanisms of the transmission of trauma in order to establish hypotheses about the resiliency factors that may inhibit the transmission of trauma. These two perspectives are described below in terms of how they apply to an understanding of intergenerational trauma.

Structural theory.

Wilfred Bion's theory of group dynamics enhances the understanding of intergenerational transmission of trauma, particularly in relation to Holocaust experiences, by conceptualizing the family as a "work group." Three basic assumptions, dependence, fight-or-flight, and pairing, describe the tendencies of group behaviors. Dependence establishes the need for emotional security, fight-or-flight establishes the need to fight or escape from threats to survival, and pairing establishes the need to create a new force that will secure a better future. Bion's theory continues to describe a phenomenon known as valence in which a person experiences a compulsion or tendency to assume particular roles in groups (Berger, 2014).

Therefore, following a trauma of genocidal proportions, the family system experiences a pull toward pairing, in which children are born in attempts to secure a better future. The child, experiencing valence, then assumes a position of sensorial or symbolic replacement to satisfy the parents' dependence on lost familial objects. Families experiencing trauma have difficulty delineating roles and establishing clear authority and boundaries; therefore, transposition occurs in which second generation survivors coexist between their own lives and their survivor parents' wartime experiences. Ultimately, the child experiences low levels of differentiation because the family's dependence inhibits motivation for individuation (Berger, 2014).

Attachment theory.

Attachment theory is based on the concept of a "general transmission model" wherein parent's internal and unconscious working relational models drive caregiving behaviors. These behaviors in turn influence the infant's development of an internal working model, which is subsequently reflected in the overt behaviors of the infant, and serves as a blueprint for further relationship successes and failures throughout the child's life (Kope & Reebye, 2007; Shilkret &

Shilkret, 2011,). John Bowlby and Mary Ainsworth developed the concept of Internal Working Models of attachment (IWMs), which are understood as templates of interactions with the caregiver that define the infant's understanding of relational behavior (Shilkret & Shilkret, 2011). These templates are powerful, for they are quite literally encoded in the child's brain. At birth, an infant's right hemisphere is immediately fully functional, and it is this part of the brain that encodes interpersonal experiences from the infant's environment and interactions with his primary caregivers. Repeated modes of interaction are solidly encoded in the baby's right hemisphere via neural pathways. These neural pathways, therefore, are the very neurological forms of IWMs that then inform and shape future relationships as the infant grows into an adult who goes on to interact with his or her own children, and so on (Moore, 2007).

Concerning Holocaust survivors, the major trauma and genocide they experienced rocked their IWMs, or what Brothers (2014) refers to as Systematically Emergent Certainties (SECs). For example, before the Holocaust, German Jews felt safe and secure in their communities. Oftentimes, German Jews had lived in Germany for centuries, were successful, were prominent figures in their communities, and honorably served in WWI for Germany. However, the Holocaust completely shattered this SEC – neighbors turned on neighbors, loyalties were disregarded, citizenships were stripped, and people were murdered by those they previously considered friends and colleagues. Many survivors emerged from the ashes with an SEC that the world was unpredictable, unreliable, and distrustful, and this SEC was rigid and resistant to change. A rigid SEC is a common response to severe trauma – it is better to be distrustful and rigid in thinking rather than have to navigate and make sense of the painful and dysregulating atrocities one has survived (Brothers, 2014).

What then occurred with children of Holocaust survivors is that despite the fact they did not themselves experience the trauma of the Holocaust, they were born “into” the trauma; in other words, children of Holocaust survivors were born into their parents’ altered, rigid post-trauma SEC that these children themselves internalized via their observations of, and interactions with attachment figures. So, despite the fact children of Holocaust survivors did not actually live the trauma, they adopted the rigid, untrusting worldview of their parents even though that worldview was no longer applicable to the environment into which they were born. These children of Holocaust survivors then passed on the only SEC they have ever known to their children, who then passed it on to their children, and onward, resulting in the intergenerational transmission of trauma via the internalization of caregivers’ SECs.

Furthermore, an attachment theory conceptualization of intergenerational trauma provides a framework to understand how parental, and specifically maternal, PTSD may affect a parent’s relationship with their child, which then also dictates the development of the child’s IWM. Due to an infant’s right brain sensitivity even from birth, he or she can sense what their primary caregiver is feeling. For example, infants born to a depressed parent are very attuned to that parent’s emotions, and the infants learn to adjust their relational patterns accordingly, thereby influencing their right brain development and IWMs (Divino, personal communication, November 10, 2015). In particular, Mary Main’s understanding of a fourth level of attachment - disorganized attachment - describes infants who behave fearfully of the caregiver or adults whose responses “showed episodes of manifest disorganization in their discussion of early trauma or a recent upset” (Shilkret & Shilkret, 2011, p. 154) when interviewed to assess attachment style. In recent decades, a large body of research deals with the question of how trauma experienced by the caregiver herself, including abuse and maltreatment, can result in

disorganized attachment styles in her children that persist throughout a lifetime. Bosquet-Enlow, Egeland, Carlson, Blood, and Wright (2014), who draw from a number of research studies, including Main and Hesse (1990), speculate that this is due to caregiving behaviors that are:

Withdrawing, negative-intrusive, role-confused, and disoriented responses; affective communication errors; dissociation, massive numbing, or affect intolerance; and hostile behaviors, all of which are hypothesized to engender a conflicted state in the infant, leading to disorganized behaviors (Bosquet-Enlow et al., 2014, p. 114).

The child then goes on to encode an IWM that promotes factors of distrust, avoidance, and ambivalence. In turn, this disorganized person's right hemisphere function and IWM is particularly salient when they themselves become parents, resulting in a high risk of insecure attachment with their own children, and intergenerational transmission of trauma (Davies, 2011).

In addition, maternal PTSD may increase offspring vulnerability to traumatic experiences and responses in their own lives separate from the trauma their parent experienced. Bosquet-Enlow et al. (2014) note multiple "theoretical reasons to hypothesize that each type of insecure attachment increases vulnerability to PTSD" (p. 43). Bosquet-Enlow et al. (2014) theorize that impaired caregiving responses not only result in high levels of insecure mother-infant attachment, but also that insecure-avoidant and insecure-disorganized/disoriented attachment styles affect a child's ability to elicit support from others and to employ protective behaviors when threatened or under stress. This conceptualization of the development of IWMs that promote factors of resiliency or vulnerability within an individual provides another theoretical framework that helps to elucidate the possible mechanisms of transmission that are at play in the transmission of intergenerational trauma.

Furthermore, rigid beliefs that emerge after severe trauma, such as the Holocaust, have been found to pre-dispose individuals to developing PTSD if exposed to trauma in their own lives. In other words, the IWMs adopted by offspring of Holocaust survivors might cause the children themselves to have a higher risk of developing PTSD should they be exposed to trauma in their own lives, thereby accounting for the transmission of intergenerational trauma. Such maladaptive views include: over-general and hyper-activated fear activity; distorted, inaccurate beliefs about one's self, the world, and other; and fear of emotional reactions. For example, negative attributional styles - whether or not a person attributes a trauma to internal stable and global causes - has been linked to a higher risk of developing PTSD. In addition, negative appraisals about the self, others, and the world have been associated with a person's reactions during a trauma, the meaning of continued symptoms of PTSD, and the subjective sense of threat in the current environment. In fact, looming, or the tendency of persons to tendency to predict a threat in the environment, and that this threat is quickly increasing has also been associated with the development and maintenance of PTSD symptoms (Bomyea, Risbrough, & Lang, 2012).

While theoretical conceptualizations of phenomena are useful to understand complex interactions and to make meaning of similar or disparate observations in casework, it is important to consider the strengths and limitations that each theory provides. Primary limitations of Berger's (2014) application of Bion's theory to conceptualize the transmission of trauma within a family system includes a reliance on a heteronormative family structure, and a lack of attention given to influential factors outside of the family unit. Furthermore, there are still many questions about the impact of multiple attachment figures throughout the lifespan and the complex ways that different types and levels of trauma may or may not affect attachment styles over the span of an individual's lifetime.

Risk Factors/Protective Factors

There are several salient themes throughout the research pertaining to risk and protective factors, such as parental mental health, community environment, and parent-child attachment styles. These themes are explored further below.

Parent-child attachment styles.

There is also a discrepancy in research concerning attachment's role in the intergenerational transmission of trauma. Sagi-Schwartz et al. (2008) interpreted the lack of intergenerational trauma among descendants of Holocaust survivors to the fact that attachment figures did not inflict the traumatic experiences of the survivors. Rather, an almost anonymous, destructive process with bureaucratic characteristics attacked this community. The Holocaust may not have undermined the basic feelings of trust in survivors' attachment figures, allowing them to fulfill their role as trusted parents. In other words, Sagi-Schwartz et al. would state Holocaust survivors had intact IWMs encoded in their neural pathways prior to World War II, and the severe trauma they experienced did not overwrite these pathways.

Conversely, Song et al.'s (2004) study argues parents' PTSD disrupts their interpersonal experiences with their children, and therefore negatively affects their children's IWMs. These investigators identified children's sensitivity to parental "emotional flooding" (p. 247), which illustrates how the fluidity of boundaries in families experiencing trauma develops into low levels of differentiation of self. Similarly to Song et al. (2004), and in support of Bion's theory, Giladi and Bell (2012) found not only a presence of secondary trauma within the second and third generations of Holocaust survivors, but also low levels of differentiation among these generations. This study also found a significant relationship between all three variables - high differentiation of self and high levels of family communication were found to be associated with

low levels of secondary trauma. Giladi and Bell (2012) hypothesized the relationship they identified to be due to poor anxiety regulation within the family, thereby postulating a connection between attachment and mental health.

Similar to Giladi and Bell (2012), Field, Om, Kim, and Vorn (2011) also studied the parent-child relationship, but in a different cultural context. They explored the adaption of different parenting styles in response to the genocide in Khmer Rouge. Field et al. (2011) found Cambodian mothers surviving the genocide exhibited a significant level of role reversal, a parenting style in which the parents had their emotional needs met by the child. The children then felt responsible for the parent's emotional welfare and had to restrict their own emotional attachment needs, thereby contributing to high levels of anxiety among the daughters. This type of role reversal is often observed in very serious disorganized attachment in children. These results suggest the prolonged trauma and resulting unstable home life experienced by Cambodian mothers made it difficult for them to later develop a parenting style with their own children (Field et al., 2011).

Attachment and priming for PTSD.

Bosquet-Enlow et al. (2014) conducted two quantitative studies that looked at independent prospective longitudinal data sets to test a first hypothesis that maternal PTSD symptoms would result in insecure infant attachment styles, and a second hypothesis that insecure-attachment style in early childhood would affect the likelihood of trauma experience and development of PTSD in adolescence. To test the first hypothesis Bosquet-Enlow et al. (2014) followed a sample of 43 mother-infant dyads in an urban, primarily low-income ethnic/racial minority birth cohort through the first year of life, and assessed attachment twice at six month intervals. The results of study one confirmed the hypothesis that elevated maternal

PTSD symptoms were associated with increased likelihood of an insecure-disorganized/disoriented attachment classification.

In the second data set, Bosquet-Enlow et al. (2014) evaluated the hypothesis that a history of insecure attachment in infancy, specifically insecure-disorganized/disoriented attachment, would translate to an increased likelihood of PTSD development following trauma exposure in childhood or adolescence. Bosquet-Enlow et al. (2014) tested the second hypothesis by following a primarily white and low-income birth cohort sample that they assessed for attachment style and trauma response symptomatology multiple times from birth to adolescence. Results of this study only partially supported the second hypothesis. While the results did suggest that the insecure quality of attachment at infancy was associated with risk for the development of PTSD by adolescence, a history of insecure-disorganized/ disoriented attachment was not necessarily associated with higher risk of developing PTSD. Notably, infants who were rated as secure at multiple points in childhood did have the least risk for developing PTSD. Results also partially supported the hypothesis in that a history of insecure-disorganized/ disoriented attachment did result in more severe PTSD symptoms by 17.5 years of age if the individual was exposed to trauma during childhood. In light of the results of these two studies, Bosquet-Enlow et al. (2014) conclude that:

- (a) maternal PTSD may increase risk of child and adolescent PTSD through its effects on the quality of the mother–infant attachment relationship, and (b) a history of an insecure mother–infant attachment relationship has persistent effects on an individual’s vulnerability to developing PTSD in later life (p. 56).

Following these conclusions, Bosquet-Enlow et al. (2014) also suggest that further research is needed to understand how symptoms of maternal PTSD are likely to result in an insecure

mother–infant attachment relationship and that there is need to better understand the resilience factors that may compensate for an insecure attachment history to inform treatment.

Bosquet et al.'s (2014) findings can be applied to Holocaust families. According to Berger's application of Bion's group dynamics theory, families that endure genocidal trauma are exceptionally vulnerable to incidences of identification with the aggressor because of the need to satisfy fight-or-flight tendencies as well as the drive toward reenactment to master the experience of trauma (Berger, 2014). In a foundational quantitative study to measure both biological and psychological factors among children of Holocaust survivors, Yehuda, Halligan, and Grossman (2001) explore how Parental PTSD may influence the presence of emotional abuse among children, which may link to Berger's conceptualization of identification with the aggressor utilizing Bion's group theory. Building on an extensive body of research that documents the multitude of adverse effects that childhood trauma can have on the later mental and physical health of an individual in adulthood, Yehuda et al. (2001) look at the relationship between childhood trauma as a risk factor for victimization in adulthood and later development of PTSD. In this study, researchers also consider whether, and how, parental exposure to trauma and Parental PTSD may also pose as risk factors for later development of PTSD in their adult offspring.

One of the major contributions Yehuda et al. (2001) made to the existing research on intergenerational trauma is not only evidence that the experience of trauma during early development is a risk factor for development of PTSD, but also that these experiences may influence epigenetic or biological changes within an individual that set up a biological predisposition for the development of PTSD in adulthood. This study finds evidence of higher levels of self-reported childhood trauma among adult offspring of Holocaust survivors, which

also correlates to the existence of Parental PTSD, thereby providing evidence that childhood trauma may be a vehicle of symptom transmission from parent to child (Yehuda et al., 2001). A notable strength of this study is that the researchers analyze multiple and interrelated risk factors of PTSD in order to develop more complex and therefore realistic hypotheses about “vulnerability, exposure, and illness” (Yehuda et al., 2001, p. 750). One limitation of this study is that in order to control for other risks factors of trauma, the study population is limited to middle class Jewish participants and this research offers relatively little discussion of how cultural or socioeconomic factors may have influenced the data reported.

Parental mental health.

The influence of mental health factors has been found in several studies across diverse populations. In a quantitative study of 854 Yugoslavian refugees in five Balkan and three Western European countries, Bogic et al. (2012) found a positive correlation between exposure to trauma and mental health diagnoses - those refugees who were witness to a high number of traumatic events during and after the war were likely to have high rates of mood and anxiety disorders. Likewise, Song et al. (2004) sampled 25 Former Childhood Soldier (FCS) parents, 15 demographically matched civilians, and children of FCSs. The study employed a multi-phasic methodology to collect data, which included individual semi-structured interviews with parents, focus group discussions, and observational data of parent-child interactions. Song et al. (2004) also found that the presence of severe mental distress such as PTSD or depression, parental dissociation, or parental anxiety predicted the transmission of trauma to children of FCS.

Regarding substance abuse diagnoses, Myhra (2011) sampled six women and seven men, representing one northwestern and nine different upper Midwest Native American tribal communities, from the Minneapolis metropolitan area. The study gathered data through loosely

structured interviews and utilized an “intergenerational transmission of historical trauma and loss” (p. 21) map to guide the exploration of familial patterns and experiences of historical trauma (Myhra, 2011). Myhra (2011) found learned behaviors influenced the transmission of historical trauma between generations. A strong correlation existed between substance abuse and “negative impacts of historical trauma, intrafamilial trauma, and personal experiences with microaggressions” (Myhra, 2011, p. 31). Diagnostically, substance abuse can be characteristic of PTSD.

Finally, from a biological perspective, an article on the Tutsi genocide attempted to understand the biological impact of PTSD on children born to Tutsi genocide survivors (Perroud et al., 2014). This study examined how epigenetics may provide insight on how children are affected by parent survivors of prolonged trauma who have been diagnosed with PTSD. The results of this study found that children of mothers who had experienced the traumatic experience had higher PTSD and depression severity than non-exposed children and cortisol levels were much lower in their offspring. Collectively, descendants of trauma survivors experiencing depression, anxiety, PTSD and substance abuse related to PTSD are at an increased risk of experiencing symptoms of traumatic stress.

Community environment.

Community characteristics, both positive and negative, impact the transmission of trauma among multiple generations. In general, individuals and families are less likely to be severely affected by a disaster if they are sustained by positive relationships after the sudden and unexpected event (Marris, 1991). For example, Sagi-Schwartz et al. (2003) attributed the lack of intergenerational psychopathology to the social support survivors received in their respective post-genocide communities, such as the establishment of the State of Israel and the building of

memorials. In addition, Bogic et al. (2012) found Yugoslavian refugees were more likely to suffer from symptoms of mental illness if their new country's policies were not supportive of new immigrants, resulting in: prolonged unstable residential status, living under threat of deportation, and ultimately not feeling accepted by the host country.

Findings from Song et al.'s 2004 study further identify the impact of community on the intergenerational transmission of trauma. In addition to parental emotional distress, Song et al. (2004) found the "political and social stigma" (p. 248) children of FCS encountered within the community correlated with the experience of traumatic distress among the children. Myhra's (2011) study further reifies the community's influence on the transmission of trauma across generations. Participants in the study described facing negative stereotypes beginning in their formative years, feared experiencing additional trauma due to their Native American identities, and reportedly felt as if they "did not belong" (p.32) in society (Myhra, 2011). A hostile community reinforces the experience of trauma among second and third generations. Finally, in another study where the community perpetuated the transmission of trauma, Bezo and Maggi (2015), examined the impact of collective trauma on forty-five survivors of the Holodomor genocide, their children and grandchildren. They determined that ethnic shame was a cross generational theme. Therefore, an unsupportive and threatening community environment presents a stressor that increases the risk of parental mental illness, and the intergenerational transmission of trauma.

Summary

Collectively, several studies herein represent diverse traumatic experiences and systems that support the transmission of trauma within the family unit. Additionally, each study alludes to some sort of relationship between mental well-being, community support, attachment, and the

transmission of intergenerational trauma. However, none of the studies investigate the relationships between these four variables as a whole. Furthermore, it is evident there has been a history of significant disagreement as to the existence or nonexistence of psychopathology in the offspring of Holocaust survivors. Whereas psychotherapists repeatedly note and describe different types of emotional distress in this population, researchers are failing to pick up on these phenomena with objective instruments. This discrepancy could be due to the fact that data collection tools are often excellent at measuring content, but are limited in picking up on process. This limitation is particularly relevant to intergenerational trauma, as it seems it is not the symptoms/content of PTSD per se that are transmitted; rather, there is a particular process involving intricate interactions, culture, socialization, family systems, communication models, and biology that is being passed on from generation to generation.

In particular, studies have found the problem seems to be situated around offspring's inability to effectively cope with stress, and a higher vulnerability to developing PTSD in their own lives. In other words, children of Holocaust survivors do not necessarily display post traumatic symptoms related to their parents' trauma; rather, these children adopt their parents' world views and/or psychopathology that then primes offspring for developing PTSD if and when they are exposed to a separate trauma in their own lives (Kellermann, 2001). Overall, several studies lack the analysis of caregiving systems outside of heterosexual normative family structure. Taking these strengths and limitations into account, the field has a need for a study that investigates the nature of the relationships between mental distress, community support, attachment, and trauma symptomatology in Holocaust families.

CHAPTER III

Methodology

What was preventing or, conversely, enabling the passage of symptomatology from one generation to the next, thereby accounting for the contradiction in research, and clinicians' observations during their work with Holocaust families? The following chapter describes the purpose of this mixed-methods correlational study, and the methodology used to conduct this research.

Research Purpose and Design

The purpose of this mixed-methods correlational study was to resolve the contradiction present in the literature about intergenerational transmission of trauma among Holocaust survivor families. The following research question guided the current study: how did the presence of protective factors in families and communities predict the resolution of intergenerational transmission of trauma in Holocaust survivor families? Disconfirming research grounded its reasoning on the presence of protective factors. Exploring the impact of protective factors on the transmission of trauma through generations would ultimately confirm the presence of the phenomenon. For the purposes of the current study, *Holocaust trauma survivor* referred to persons who survived the Holocaust and their descendants and *mental distress* and *trauma symptomatology* referred to the expression of the DSM criteria of PTSD as well as the Danieli Inventory's measures of Holocaust offspring's: Insecurity about One's Competence, Reparative Protectiveness, Need for Power or Control, Obsession with the Holocaust, Defensive Psychosocial Constriction, and Immature Dependency (Danieli et al., 2015).

For this study, this researcher sampled second-generation Holocaust survivors. A

mixed-method, correlational design measured the relationships between the following variables using a Likert scale questionnaire: parental mental distress, attachment styles, the psychological and social impact of parents' Holocaust experiences on offspring, and positive or negative community presence. This questionnaire was combined with qualitative feedback to gain a holistic picture of the experiences and perceptions of participants' attachment histories, community support, and psychological states. This researcher utilized an online questionnaire. Originally, this researcher planned to use Survey Monkey; however, Qualtrics proved to be more conducive to data analysis, so, with permission from the Smith College School for Social Work's Human Subjects Research Committee, this researcher changed the protocol to Qualtrics (see Appendices D and E). This choice reflected the difficulties of reaching participants in communities who did not know the researcher personally. An online questionnaire had the ability to reach this population without participants feeling unethical pressure to partake in this study. In addition, an online format removed unneeded bias the researcher might have. This researcher was undertaking this study to complete her MSW thesis and it was presented and possibly published.

This researcher hypothesized children of Holocaust survivors who reported higher levels of PTSD symptomology in their parents would in turn report higher levels of negative psychological and social impacts in themselves as well as higher levels of insecure attachment styles. Furthermore, it was expected that high levels of community support, low levels of parental mental distress and high levels of secure attachment would be related to low levels of negative psychological and social impacts among descendants of trauma survivors. Also, this researcher hypothesized attachment style would mediate the relationship between mental distress and offspring psychological/social impact. Finally, it was predicted levels of community support

would moderate the relationship between mental distress and trauma symptomatology, as well as between attachment styles and trauma symptomatology.

Sample

The sample, which was drawn from the larger population, specifically consisted of adults ages 38-75 years old who spoke English, and who had access to a computer. The sample also had a Holocaust familial connection. For the purpose of this study, the Holocaust connection was defined as present if the participant self-identified at least one primary caregiver who is or was a Holocaust survivor (Giladi & Bell, 2012). Therefore, there was a sample of second-generation children of Holocaust survivors. Holocaust survivor meant persons who survived the Holocaust. Those excluded from the study would be any family members such as grandchildren, spouses and extended family members who did not have a direct link to Holocaust survivors as parents.

This study utilized a nonprobability, non-random method of sampling selection known as purposive sampling and snowball sampling. This sampling technique influenced recruitment since the researcher obtained contact information for potential participants through her work in the field of social work, personal contacts, and through public databases. The present study also relied on several biases including: the researcher's personal connection to the material as a descendant of a Holocaust survivor, the assumption of English as the primary language, and access to technology. Furthermore, this study did not represent diverse traumatic experiences and systems, and it sampled only a particular ethnic group. Therefore, it lacked generalizability.

The recruitment process included local and national avenues. The recruitment process originally consisted of two advertising sources to recruit potential participants, and with recommendations from personal contacts, and permission from Smith College School for Social Work's Human Subjects Review Committee, recruitments sources expanded to eight places: (a)

social networking tools (Facebook and LinkedIn) (b) online Holocaust survivor community forums (Facebook groups), (c) national Holocaust museums, (d) speakers' bureaus at national Holocaust museums, (e) national Jewish Community Centers, (f) Brandeis University's Jewish Studies department, (g) synagogues in New England, and (h) B'nai Brith Youth Organization chapters. Once permission was granted, the Facebook advertisement (Appendix A) and the Holocaust community advertisements (Appendix B) for the study provided a link to the Qualtrics site where those recruits learned more about the study. The advertisements consisted of a brief synopsis of the questionnaire, eligibility requirements, and a link to the questionnaire. The E-mail recruitment consisted of a brief synopsis of the questionnaire and the eligibility requirements (Appendix C), as well as a link to the questionnaire. Permissions to all of these recruitment sources are attached, except for those that are this researcher's own sites/sources, in which case permission to post was not necessary since those sources are this researcher's Facebook page and LinkedIn profile (Appendices D and E).

The potential participant was directed to an online questionnaire, where three screening questions were asked (Appendix F). If a possible participant answered “yes” to all questions, then they were tagged as a participant, and were sent to the informed consent page (Appendix G). However, if a potential applicant answered “no” to questions 1 and/or 2, then they were redirected to a screen that explained they were ineligible to participate in the study.

Data Collection Methods

This study asked participants to partake in an online questionnaire. The questionnaire consisted of five parts and took no longer than 30 minutes. Only if a participant agreed to the informed consent, by clicking on a box that says “I agree” at the bottom of the screen, did they continue on to the questionnaire. The first part of the questionnaire collected demographic data

from the participant while the following sections collected qualitative and quantitative data on PTSD symptomatology in the primary caregiver and offspring, parent attachment styles, and the presence or absence of community supports. The demographic data, collected in the first part of the questionnaire, was used to get a better sense of who the participants were. The information collected included: age, gender, race/ethnicity, geographic location, and socio-economic status.

The second part of the study consisted of four sections of both multiple choice questions and qualitative questions. The first section, Part 1, assessed offspring's perception of parental trauma or lack thereof using the Civilian Version of the PTSD Checklist that was modified to apply to the Holocaust survivor population. Although this measure had face validity, participants who piloted the survey stated it was difficult for them to serve as reliable informants as to whether or not certain parental behaviors could be attributed to their parents' Holocaust experiences since some survivors did not openly talk about the Holocaust. Rather than eliminate certain questions, this researcher decided to insert a "do not know" option into the first section – with permission, this researcher changed the question order so the "do not know" option was listed at the end of the measure (see Appendix E).

The next section, Part 2, asked questions about participants' attachment history with their parents using the Experiences in Close Relationships-Revised Adult Attachment Questionnaire, which brought forth information about participants' current working model of attachment via recalling memories of past and current relationships with parents (Fraley, 2012). The third section, Part 3, assessed the psychological adjustment offspring have made to parental trauma and possible psychopathology via The Danieli Inventory of Multigenerational Legacies of Trauma (Danieli et al., 2015). The fourth section, Part 4, inquired about community supports the participant's family experienced (e.g. books, Jewish Community Center, Place of Worship,

Therapist, Community mental health, memorial services, friends, Internet, etc.), and if participants found those supports helpful.

Data Analysis

The quantitative questions were analyzed primarily using descriptive and significance statistics. Significance of association and directionality were used to further explore if trauma was transmitted, and if so, by what means. Directionality and testing for moderating/mediating relationships further delineated if and how protective factors functioned. Moderating/mediating relationships were analyzed using regression equations (Steinberg, 2009). With the permission of Smith College School for Social Work's (SCSSW) Human Subjects Review Committee (HSRC), this researcher used an outside data analyst to run these regression tests since these types of tests were not covered in SCSSW's curriculum (see Appendix E). The qualitative data were analyzed through thematic coding and looking for patterns amongst the responses concerning all variables. A general inductive approach was an appropriate method for meaning making – it allowed this researcher to incorporate both inductive and deductive approaches in content analysis (Thomas, 2003). This researcher hoped these data would determine if trauma was transmitted intergenerationally, how this trauma was transmitted, and what protective factors prevented the transmission of this trauma.

Ethics and Safeguards

This study had some risks of participation. The study's questions may have caused distress for some participants as the questions pertaining to parents' mental health, parent/offspring attachment styles, and participants' coping skills could have brought up experiences and memories of familial trauma. Although they were not be asked to discuss trauma, as that could have been upsetting, the questions may have brought up triggers that

reminded the participants of trauma or distress associated with the Holocaust and its aftermath. All participants received a referral list with the informed consent. Before agreeing to the informed consent, the participants were asked to print a copy of the informed consent and referral list to keep for their records. The referral list consisted of four sources that the participant could have contacted if they would have liked to talk to someone at any point while taking the survey, after taking the survey, or if they chose not to take it.

In addition, to the best of this researcher's knowledge, there were no relationships between participants and her. However, since this researcher was an active member in her local Jewish community, and a descendant of Holocaust survivors, there could have been a chance participants were personally known. It was expected that due to the anonymity and nature of the online questionnaire, it would be highly unlikely this researcher would be able to identify participant responses. Participants who were direct clients with this researcher were not interviewed. None of the participants were thought to be members of vulnerable populations as federally defined.

Furthermore, participation in the study was voluntary and participants could refuse to answer any of the questions. This was explained and included in the informed consent section prior to participant's entry into the survey; therefore, participants were made aware of the ability to stop filling out the questionnaire prior to taking and submitting the questionnaire. Also, the questionnaire was administered through Qualtrics, and this survey software does not supply to researchers any names, e-mail addresses or IP addresses of respondents. A participant could leave the questionnaire at anytime, and although those data were saved through the survey software, this researcher did not use partial survey responses (less than 50% completed) in the findings. A participant could skip any question, but once a survey was submitted, the data could

not be withdrawn from the study. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

Participant anonymity was assured, and it was more than likely this researcher was unaware of the identity of participants; however, there was a chance open-ended responses indicated a person's identity, as this researcher was an active member of the local Jewish community. Participants were advised in the informed consent form, and again within the survey itself to refrain from disclosing any identifying information in the open-ended questions. Qualtrics would designate a code number automatically to all participants' responses. This researcher reviewed all open-ended responses and removed any names or place names that could have potentially compromised the participant's identity before allowing her research advisor to view any data. Two statistical consultants and this researcher had access to the data following the coding done by Qualtrics and the removal of identifying information by the researcher. Published data were primarily presented in a summarized group form to disguise participants' identities. Some illustrative qualitative quotes were presented, but were not attached to any demographic data, thereby precluding recognition except for the author of the quote.

CHAPTER IV

Findings

What was preventing, or, conversely, enabling, the passage of symptomatology from one generation to the next? The purpose of this study was to resolve the contradiction in research as to whether or not the traumatic effects of the Holocaust were transmitted intergenerationally. This was a correlational study that employed a mixed-methods design.

Demographic Characteristics

The sample size of this study consists of 209 participants. The data analyst removed 4 files from those who said no to the informed consent and an additional 112 who left the informed consent form blank. Furthermore, two did not answer the four inclusion criteria questions. In addition, although five participants said yes to the inclusion criteria, they were outside of the specified age range, so their data were deleted as well. Fifty-four participants (25.6%) identified as male, one hundred and fifty-five participants (73.5%) identified as female, one participant (.5%) identified as transgender, and one participant (.5%) preferred not to answer. No respondents chose the "Other" option for gender.

One-hundred thirty-one (62.3%) participants identified as some version of White/Caucasian, forty (19.4%) participants stated they were exclusively racially/ethnically Jewish. Twenty-eight (13.8%) participants stated they were a mixture of Jewish with another race/ethnicity (American Jewish, Ashkenazi Jewish, Eastern European Jews, English/Irish/Jewish, Jewish American, Jewish American of Polish descent, Jewish Israeli, Jewish white, White/Eastern, European/Jewish, White Ashkenazi Jewish, White Jewish,

White/Non-Hispanic/Jewish). Finally, one (.5%) participant identified as European, one participant (.5%) said they were Israeli, one (.5%) stated they were Latina, and one (.5%) reported they were Polish. Five (2.4%) participants did not answer this question.

Ninety (42.7%) participants stated they were from the Northeast, sixty-one (28.9%) stated they were from the West, seventeen (8.1%) said they were from the Midwest, ten (4.7%) were from the South, and thirty-three (15.6%) chose the "Other" option and said they were from: Canada (1), Chicago, IL/Sarasota (1), Colorado (1), East (1), Europe (1), California and now live in Florida (1), United States and now live in Israel (1), Israel (4), Mid-Atlantic (6), military-deployed in Japan (1), Mountain States (1), Northwest (1), West and now Israel (1), Rocky Mountain Region (2), Southwest (7), and West Coast (1). One-hundred and fifty-eight (74.9%) participants described themselves as financially comfortable, thirty seven (17.5%) stated they were making ends meet, and fifteen (7.1%) were having some financial stress.

Parental PTSD Symptomatology as Measured by the PCL

For the online survey, participants were asked to identify one parent/primary caregiver who survived the Holocaust, and to answer the questions in response to that identified parent/primary caregiver. For questions rating their parent's symptoms of PTSD, participants were asked to refer to the Holocaust as the major traumatic event, and to rate how much they believed their parent/primary caregiver was bothered by each symptom. Unfortunately, there was an error in the PTSD Checklist (PCL) data collection for thirty respondents, so their scores were not included in the analysis of the PCL. After these scores were eliminated, the mean for the sample's ratings of their parent's PTSD symptoms was $M = 34.85$, $SD = 14.51$. There was a considerable amount of variability in the sample's scores, so individual scores did not truly

represent the average (Feinberg, 2009). In fact, given an SD of 14.51, most scores ranged from 20.34 all the way up to 49.36.

Participants were given the opportunity to describe in their own words what, if any types of problems and complaints their Holocaust survivor parent had. There were nine overall themes that emerged from these qualitative data, and a single response often contained more than one theme embedded within: struggles with parenting (struggles with independence particularly during adolescence, protectiveness, specific focus on the children, and the absence of emotion), not speaking about the Holocaust, openly speaking about the Holocaust, no complaints, contempt (contempt for God, religion, and the government), struggles with interpersonal relationships (emotional distance, suspicion, antisocial behavior, and anger), mental illness (psychosis, substance abuse/addiction, sleeping problems, depression, anxiety, and somatic symptoms), grief (survivor's guilt, and anger/regret their life was interrupted), and fear (distrust, and fear of losing resources).

The following are examples of struggles with parenting:

My mother was very negative about normal childhood activities, no was her first answer – to a sleepover, to help with the homecoming float, to wear go-go boots, to wear makeup, to go to a dance, etc. She was very controlling, I developed my ways of coping, sneaking, circumventing her. She was jealous of time I spent with friends. I learned from an early age to spend as little time at home as possible. So these are my problems that I had living with her. Her problems included feeling uneducated and uncredentialed despite innate intelligence, which was more cleverness than intellectual, a practical conniving approach to life. She

feared dogs. She was diagnosed schizophrenic paranoid. Later I learned term that I thought applied, toxic parenting.

Very controlling and fearful something would happen to her children.

Emotionally needy and codependent. Until her senior years, tried to keep her Holocaust experience secret from outsiders. This parent doesn't respect boundaries or set boundaries well. Expects fulfillment to come from family members. This parent cares about her children, but is also wounded, manipulative and fearful.

Lack of trust, over-protective, scared it would happen again, didn't want anyone to know we were Jewish.

Found my mother overprotective, but that could have been because I was an only child rather than a result of her being a victim of the Holocaust.

Trusting other people, not having people in the house, over-protective with the children, paranoia, depression.

She was very tied to me and my future. She lived her life through me, as if my successes somehow made up for what she couldn't do in her life.

My parent worked very hard to become an American. I was taught not to trust and to always have a plan with an escape plan. This parent kept secrets of his past from the kids. Eventually they came out but much was left to hearing stories from other family members. The biggest thing I remember was never being allowed to cry because I had nothing to cry over. Emotions were never allowed to be a part in our lives. All decisions needed to be based on facts and situations, not feelings. Today, I struggle with anxiety and fear based on my parents' experiences.

One fear my mother had was being left alone. She lost her parents, and 2 brothers. She stayed in a bad marriage because she did not want to be alone again. She always felt if her parents, and her brothers were alive, my father would not have gotten away with the way he treated my mother [...] My mother never had trouble talking about her experiences and to this day she will be willing to talk to anybody about it. She says her friends always bring up the topic. My mom's emotions seem dull and the strongest emotion she shows is anger. She does not give hugs, or show a great deal of love. She lacks gentleness. She is more of a realist, and resents that I am more gentle and kind. She calls me Mother Theresa, but not as a positive statement.

They could not trust anyone and wanted the family to be all important. However, they were manipulative with the offspring, pitting them against each other, so that my parents' words were the final and ultimate, with no compromising. They were rigid and insisted that the 3 of us become fiercely independent. They gave us little emotional or financial assistance and were quite distant. They were physically abusive, all in the in quest for perfect behavior/allegiance to them. We had no other relatives or friends and for me, as the oldest and the daughter, life was quite unpleasant in their household.

Some responses indicating the parent did not want to talk about the Holocaust included those below:

My parent acted as if it had never happened. For example, as a child I found pictures of my parents' family and showed it to my mom. It was very difficult for

her to see and talk about the pictures. The next day when I went back for the pictures they had disappeared again. We never really talked about the Holocaust and family until she turned 92.

Nightmares also nightmares about dogs although he loved dogs startled to sudden noises difficulty focusing lost in thought [...] he wanted his kids to have a happy childhood and did not speak of the Holocaust until he was a grandpa to middle schoolers [...] my parents did not tell me about the concentration camps until I was a 6th or 7th grader.

Stressed, always worrying, but the biggest weight I carry is their fear of bringing more Jewish children into a hostile world, so I was an only child, also secrets – I still don't know whether I had a sister on my father's side – he never told me, my mother said maybe on her deathbed, rest of family said they knew – how could I have not been told??

On the other hand, some caregivers did speak openly about their experiences:

Openly discussed it with anyone willing to listen to their stories. Obsession with always having and keeping enough food.

My mother shared her experiences openly and wanted us to know her journey. Her parents and she were very open in talking with us about their experiences, and this may be why my Mom did not seem to have any unusual problems or complaints except about we 3 children if we were misbehaving. Even then, her reactions were not excessive or hostile. But there was an underlying protectiveness. As one memorable example in my mind, my parents would not allow me to attend the funeral of my great-grandmother, who survived 5 years in a concentration camp in southern France, reunited with our family in 1946, and

with whom I was very close while she was living in the same city as my parents and me. Yet she also supported me defending myself against bullies and strongly supported the downtrodden and oppressed minorities. I therefore think overall she had a healthy attitude toward life.

The following are examples of no complaints:

My parent was very young during the Holocaust and seemed more interested in learning more than avoiding discussing it.

My dad never really complained about what life had dealt him. He did complain that he was afraid people would forget what had been done to him.

No specific problems or complaints.

Examples of contempt included:

Contempt for American children who "had no idea what suffering was," and for God. Antagonism towards others Holocaust survivors especially if they received reparations. Conflicted emotions about organized religion. Rejection by other immigrants who (ostensibly) said things like, "No one helped us; we don't owe you anything." Exhibited helplessness when it came to participating in my sisters and my care, left much of it to my mother. Was testy and impatient with my sisters' and my acquisition of Hebrew skills (our mother told us he wanted us to be knowledgeable but he was conflicted about girls learning (he had been raised in Europe where his Orthodox upbringing discouraged women from learning). I remember my father as predominantly silent and brooding, very anti-social, very intellectual and politically savvy but argumentative. My American mother's credo was (as spoken to my sisters and me), "You are the proof that Hitler failed." I

know she meant to console my father, but I was an adult before I realized that my father was inconsolable.

Very bitter and cynical about the state and society.

Because of the experience, my father felt that no one had it as bad as he did and he would rub that in people's faces.

Some examples of struggles with interpersonal relationships follow:

His problem was mainly that his mother was murdered in the war and he felt guilty about leaving her and surviving. He was detached and depressed, love was mainly fear that his family would be hurt.

Unable to form personal attachments, suspicious.

No friends, no family, feeling like a "foreigner," unwilling to join groups, thunder sounding like bombs.

He was very angry most of the time, very short fuse. He blew up at things that seemed liked nothing. He was emotionally unavailable. I was generally afraid of him.

Other participants indicated challenges with mental health:

Paranoid. Thought they were being watched. Fear that someone would retaliate if they spoke up against someone who was causing them some harm.

Didn't value "things" and seemed to always be trying to escape – became a compulsive gambler.

Still has nightmares, travels all over the bed as though he is running, sometimes falls out of bed. Wakes up tired.

My mother suffered from severe depression. She underwent psychotherapy, electro-shock therapy and lengthy hospitalizations in a psych ward.

Father was excessively worried and exhibited ICD tendencies regarding his contact and connection to his immediate family (siblings and mother) who also survived. He could not be apart from them and was in contact with them at least daily or even more often. Was disturbed when they were sick or ill and was excessively attentive to their needs at all times.

Mistrust of the outside world, suspicious of my teachers and friends as well as of her peers and work associates; colon cancer; a sense of lost opportunity, lost love, lost family fortune. A reactive digestive tract (stress induced).

Some responses referring to grief follow:

The daily, constant reminders in life of what they had lost and experienced.

Everything had a tinge of sadness.

My mother left her mother behind and would cry often about it.

Health issues were related to anxiety and stress. My parent often felt inadequate.

He regretted that the Holocaust cut his education short.

Finally, other participants shared their caregivers struggled with fear:

Distrustful of all "outsiders." Definition of "outsiders" changed but always included Germans, Austrians, etc., which is interesting because my mom is Austrian. All people were identified as Jew or non-Jew, and all non-Jews were somewhat suspect no matter what.

They both seemed startled when the phone rang. An unexpected knock at the door really freaked them out when they were in their thirties. By the time they

reached 60+ they would hesitate to answer the door but with less in trepidation than in their 30s and 40s.

Although he'd fall asleep quite easily, he'd awaken frequently particularly at night shouting out – my mother explained they were nightmares from the war. And although he'd limit things she could buy, he'd stockpile items for himself – I recall her showing me drawerfuls of unused pajamas, underwear, shorts. In later years, it expanded to food, toothpaste, non-perishables.

Attachment Styles as Measured by the ECR-R

Participants were asked about their attachment patterns with their parent/primary caregiver on the 7-point Experience in Close Relationships-Revised (ECR-R) scale ranging from "Strongly Disagree" to "Strongly Agree." The mean for the sample's Avoidance scores was $M=4.15$, $SD =.89$. Therefore, there was low variability in the sample indicating participants were typically well above the norm ($p < .0001$) for Avoidance as compared to the average population, and scores did not vary widely from this central tendency – Fraley (2012) reported the average of a sample of 17,000 in the early 2000's was $M=2.92$, $SD=1.19$. Put another way, most of the sample indicated they neither disagreed nor agreed they had an avoidant relationship with their primary caregiver, and the most often responded category was 5.00, with 21 participants (10.0%) stating they slightly agreed they had an avoidant attachment with their parent.

Participants were offered the opportunity to describe their relationship with their primary caregiver in their own words. Some of these participants described this relationship in terms reflective of an avoidant attachment. The parent was described as angry in general, specifically

toward the participant's needs and distress as a child; as a defensive strategy, the participant was forced to become self-reliant, oftentimes turning to support outside of the home (Davies, 2011):

She often appeared distant/staring off and plagued by intrusive thoughts. She rarely laughed or smiled. She could have been described as having a chronic agitated depression. She would have angry outbursts around trivial things and would be angry when myself or my brother were ill...As a child I felt she was deeply troubled and upset if she felt I was having troubles and I did not want to burden her. She did not understand my needs developmentally as an older child/adolescent. Her adolescence had been so different from my own and she was not actively participating in society, new technological advances or popular culture and did not understand my world. For this reason it was not helpful to go to her for advice.

My mother was extremely difficult and hard on us. Everything we did was bathed in the light of the Holocaust experience. We always had to be exemplary and we could never really burden her with our needs.

I was so attached to her, and she didn't seem to love me at all.

She had a very difficult life. Couldn't speak about myself. Always said I wish I could have your easy life.

...emotionally distant, not empathic...need to please.

She seemed angry a lot, and I think the anger may have covered up anxiety. I think there were big problems in parenting her two oldest children, as her own parenting was negatively impacted by the Holocaust...We fought a lot. She was the only person in the family who could express emotions. High school and

college were especially bad between us. When I was in High School, she once slapped me across my face, in front of my younger brothers, and told me I was the most selfish person she ever met.

One of these participants also indicated struggles with other interpersonal relationships: Neither parent could understand the trials and tribulations of growing up and competing with others. They never understood peer pressure. You could never enjoy weakness because they expected perfection. Anything less is failure. You can't survive unless you are perfect. If I tried to confide they would tell me that I am lucky to have parents, food and shelter. There was no purpose to confide or ask for guidance.

The mean for the sample's Anxiety scores was $M=2.05$, $SD=1.70$, indicating the majority of participants were well below the norm ($p < .0004$) for anxious attachment – Fraley (2012) reported $M = 3.56$, $SD = 1.12$. Most of the sample strongly disagreed they had an anxious relationship with their parent - the most often responded category was 1.00 ("Strongly Disagree"), with ninety-seven respondents (46%) selecting this point, followed by ten participants (4.7%) selecting the 2.00 point. Reflecting this sentiment, some participants described their caregiver as someone who was responsive, and whom they knew was available:

Was very involved in teaching. Very involved in his synagogue, PTA of children's schools, speakers committees, Israel. Close, many similarities, shared interests.

Always felt great love and caring from my mother and we had a terrific relationship.

I felt loved and cared for.

Close and loving.

Could always turn to parent for advice.

The caregiver was openhearted and provided for feeling of security in the most troubled times, without being overprotective.

Both my parents continuing to be loving, nurturing, supportive and present even to this day.

According to Fraley (2012), those individuals who indicate high Avoidance and low Anxiety can best be described as having a dismissing-avoidant attachment in which they are not worried their parent will abandon them, but they are uncomfortable opening up to or depending on their caregiver (Davies, 2011). Overall, the participants in this study reported a slightly dismissing-avoidant attachment with their parent, as was reflected in some open-ended responses:

My mother was emotionally unavailable to me. I knew my mother loved me, but I couldn't count on her for emotional support.

I was very close to my mother but I needed to do what she wanted or she withdrew her love (I did not realize that until much later).

...and he did have a tendency to be short-tempered and to be intolerant of views other than his own. I have always loved and looked up to my father, but as I reflected above, for the most part I did not share my feelings with him. I did not share them that much with my mother, either (who was also a Holocaust survivor), but in general if I wanted sympathy or support I would have more likely gone to her.

She did the best she could. She was very loving but I couldn't talk to her about my own issues.

The parent announced often that they have no patience and withdrew quickly and frequently. There was shared love but it was distanced and controlled.

Loving relationship but I did not want to add to her burdens so I took care of myself.

I felt deeply loved, and I loved him. He was so proud of me, and thought I was very smart. He made sure I was independent and could take care of myself. I worked alongside him and my mom growing up in business together. Even though he was emotionally closed to others, he would look at me with soft, loving eyes and I knew he loved me. I didn't want to disappoint him or burden him with my problems. At the end of his life, there was nothing that I left unsaid, and I was grateful I had him as my father.

Participants were also asked about their experiences and perceptions of themselves on the 7-point Danieli Inventory ranging from "Strongly Disagree" to "Agree". Means on the thirty-six self-ratings ranged from $M = 1.72$ ($SD = 1.04$), showing highest disagreement with phrase "I often rely on my parent to rescue me financially" to $M = 3.99$ ($SD = 1.08$), and showing highest agreement with the statement "Most days I wake up looking forward to life." In terms of subscales, participants indicated highest disagreement ($M = 1.87$, $SD = .88$) with statements grouped under Immature Dependency ("I often rely on my parent to rescue me financially"; "I have often resorted to alcohol, substance abuse, sex, or food to soothe myself"), and participants indicated highest agreement ($M = 3.39$, $SD = .84$) with statements gathered under Reparative Protectiveness ("I have sometimes felt I need to make up for my family's losses"; "Sometimes I felt I had to fill in for my murdered family members"; "I feel responsible for my parent's happiness"; "I would feel I had betrayed my family and myself if I didn't respond to a negative

remark about my faith/group/race/ethnic/social group"; "When there is illness in the house, I feel it is my responsibility to make sure that every detail is take care of"; "I think of my parent as vulnerable"; "I did my best not to burden my parent with my own problems/issues"). As can be seen in Table 1, the subscale Immature Dependency had low internal reliability (alpha = .14), and the subscale Need for Power and Control had somewhat low internal reliability (alpha = .55).

Table 1

Frequencies for Offspring Negative Psychological and Social Impacts

Danieli Inventory Subscale	N	M	SD	Cronbach's Alpha
Insecurity About One's Competence	159	2.86	.75	.86
Reparative Protectiveness	158	3.39	.84	.75
Need for Power or Control	163	2.76	.91	.56
Obsession With the Holocaust	163	3.02	1.07	.78
Defensive Psychosocial Constriction	153	2.51	.81	.63
Immature Dependency	163	1.87	.88	.15

When openly describing their relationship with their parents, some participants' answers reflected questions grouped under the subscale Reparative Protectiveness:

I was always secure in my mother's love for me, and felt I could depend on her to take care of me. At the same time, I was protective of her and didn't want to burden her with my problems because they seemed inconsequential in light of what she had already endured.

I always felt that my father had enough trauma for a lifetime, and my job was not to give him any more.

I felt protective of him and didn't want to give him any cause to worry about me.

He had suffered enough.I felt very protective of his feelings so I would hide

anything I thought would disturb him and didn't want to get in any trouble or create trouble for him.

Community Support

Participants were then asked whether or not they or their family used community resources regarding the Holocaust, and to rate how helpful they found each community service on a Likert scale ranging from "Not Helpful at All" to "Extremely Helpful." As can be seen in Table 2, means ranged from $M = .26$ ($SD = .89$), in which participants found the least helpful community resource to be Community Mental Health Centers, to $M = 3.04$ ($SD = 1.65$), followed by Holocaust museums ($M = 2.32$, $SD = 1.81$), and Holocaust memorials ($M = 2.29$, $SD = 1.77$).

Table 2

Frequencies for Community Support

Community Resource	Did not use	Did use	M	SD
School	83	74	1.16	1.55
Youth movements	89	66	1.23	1.68
Non-familial role model/mentor	88	67	1.36	1.77
Books	25	131	3.04	1.65
Community Resource Center	127	27	.49	1.19
Community Mental Health Center	138	15	.26	.89
Jewish Community Center	94	60	1.02	1.46
Jewish Family Services (JFS)	110	43	.73	1.37
Place of worship	54	100	1.88	1.71
Individual/Family Therapist	75	81	1.96	2.07
Summer camps or retreats	103	94	1.03	1.66

Online community Community Resource	112 Did not use	42 Did use	.76 M	1.34 SD
Allied Jewish Federation	133	20	.33	.96
Place of worship support group	133	21	.43	1.19
Anti-Defamation League	130	25	.43	1.09
Holocaust museums	48	108	2.32	1.81
Holocaust memorials	45	110	2.29	1.77
Other	54	33	1.78	2.26

Fifty-six participants (16.7%) stated they used other community resources which they specified to be: Second Generation support groups (6), friends (6), Children of Survivors support groups (5), relatives (5), informal support groups (3), Jewish genealogy (2), self-directed research and trips to Europe (2), self-founded non-profits (2), 12-Step Program (1), conferences and Holocaust Studies classes (1), book clubs (1), interviewing parents (1), and the Jewish Defense League (1). One participant stated they did not know where to get support, and still do not know. Some participants stated they used some of the specified community services, but that these community resources did not provide support specifically regarding the Holocaust:

I did not have any issues that needed help. I wanted to learn about my family and other people's experiences and read about them. Youth groups, etc. did not focus on this.

I don't understand this page. I don't see these organizations/programs as supporting me or my family.

I have used many of these resources but not to help support me or my family related to the Holocaust. That did not seem necessary.

Fifty-two participants (24.6%) stated they did not use any community services.

For community services, the data analyst recoded the data for Community Support into used/did not use, and then summed to get the number of supports used. The mean for the sample's ratings of Community Support was $M = 20.50$, $SD = 14.37$. Therefore, this overall score indicating whether or not an individual found their community to be a source of support fell into the "Not Helpful at All" and "A Little Helpful" range. Furthermore, there was a considerable amount of variability in the sample's scores, so individual scores do not truly represent the average (Feinberg, 2009). With an SD of 14.37, most scores ranged from 6.13 all the way up to 34.87.

Correlation Results

Another goal of this study was to examine the interrelations between variables. First of all, this researcher hypothesized there would be a positive correlation between Parental PTSD symptomatology and offspring's negative psychological and social impacts; i.e, the higher the PTSD symptomatology in the parent, the higher the negative psychological and social impacts would be in the child. This hypothesis was confirmed – Table 3 shows the results of Pearson's r correlational tests run for the PCL and the subscales of the Danieli Inventory. All correlations were significant.

Table 3

Correlations Between Parental PTSD and Offspring Impacts

	Parental PTSD Symptomatology
	r
Insecurity About One's Competence	.45****
Reparative Protectiveness	.43****
Need for Power or Control	.27****

Obsession With the Holocaust	.29****
Defensive Psychosocial Constriction	.49****
Parental PTSD Symptomatology	
r	
Immature Dependency	.37****
Note: *** p < .005, **** p < .001	

The next hypothesis was there would be a positive relationship between Parental PTSD symptomatology and Anxious and Avoidant Attachment. In other words, the higher the Parental PTSD, the higher the Anxious and Avoidant Attachment styles would be. These results were interesting, as can be seen in Table 4. Whereas there was a significant positive correlation between Parental PTSD and Anxious Attachment, there was a significant negative correlation between Parental PTSD and Avoidant Attachment.

Table 4

Correlations Between Parental PTSD and Attachment

Parental PTSD Symptomatology	
r	
Anxious Attachment	.39****
Avoidant Attachment	-.31****
Note: **** p < .001	

In addition, this researcher predicted there would be a negative relationship between Community Support and adverse psychological and social impacts; i.e., the higher the

Community Support, the lower the negative psychological and social impacts on the child. As outlined in Table 5, this hypothesis was not confirmed. In fact, the results suggested the opposite – all subscales of the Danieli Inventory, except for Immature Dependency, were significantly positively correlated with Community Support.

Table 5

Correlations Between Community Support and Offspring Impacts

	Community Support
	r
Insecurity About One's Competence	.22**
Reparative Protectiveness	.29****
Need for Power or Control	.22***
Obsession With the Holocaust	.22**
Defensive Psychosocial Constriction	.19*
Immature Dependency	.12

Note: **** p < .001, *** p < .005, ** p < .01, * p < .05

Finally, this researcher examined the role of attachment as the mediator between parental mental distress and offspring psychological/social impacts. Before testing mediation, the data analyst needed to run correlations to test whether or not attachment was significantly related to offspring psychological and social impacts, as a significant relationship between parental PTSD symptomatology and attachment was already established. The results of the correlational analyses between attachment and offspring psychological and social impacts are outlined in Table 6. Avoidance was not a robust predictor of offspring psychological and social impacts,

and when it was, it was a negative predictor; in other words, higher Avoidant Attachment was associated with fewer psychological and social problems in the child. Anxious Attachment, however, was a strong predictor of most impacts in the hypothesized direction.

Table 6

Correlations Between Attachment and Offspring Impacts

	Avoidant Attachment	Anxious Attachment
	r	
Insecurity About One's Competence	-.19*	.51****
Reparative Protectiveness	-.18*	.31****
Need for Power or Control	-.22**	.22**
Obsession With the Holocaust	-.02	.15
Defensive Psychosocial Constriction	-.07	.40****
Immature Dependency	-.13	.32****

Note: **** p < .001, ** p < .01, * p < .05

These relationships between parental PTSD, attachment styles and offspring who exhibited negative social and psychological outcomes are particularly interesting given the overall sample showed a slight tendency toward the opposite attachment style – the general sample had somewhat of a high Avoidant/low Anxiety attachment to their caregivers, whereas those participants whose parents specifically demonstrated high PTSD symptomatology and negative social and psychological impacts had more of a low Avoidant/high Anxiety attachment to their parents. According to Fraley (2012), those individuals who indicate low Avoidance and high Anxiety can best be described as having a preoccupied attachment in which they idealize

the parent, and in which they are worried their parent will abandon them because they themselves are an undeserving and unlovable child (Davies, 2011):

Extremely close and loving, yet difficult at times, which difficulty I attributed to his strict European upbringing.

We idolize him. He was a wonderful optimistic human being and people still come up to me 7 years after his death telling me how much they miss him.

Extremely close.

Extremely close and trusting.

I protected him, constantly, from anything unpleasant or painful. I even protected him from my verbally abusive mother. I would not burden him with anything trivial or my own stupid child stuff. I adored my father and ached for all he had lost and experienced. We got along fabulously. He was a great guy, easy to get along with. I was easygoing too. My other sibling and my mother were **DIFFICULT!!!**

We are extremely close and I have always felt loved and cared for.

Very close loving caring I wanted to make up for her loss.

I adored and loved my parents without an end...we were extremely close.

Lifelong friends and soulmate. Taught me unconditional love, how to develop trust and intimacy.

Intensely loving.

My relationship with my mother was extremely close and loving.

My inspiration, my hero.

Since Avoidant Attachment was only weakly related with negative impacts on the offspring, and because this relationship was not congruent with the hypothesized direction, testing this mediational model was not indicated. However, the data analyst did test the mediational model for Anxious Attachment and the four subscales with which Anxious Attachment was most significantly correlated (Obsession with the Holocaust was excluded). The results are outlined in Table 7. Partial mediation was supported for Insecurity About One's Competence, Defensive Psychological Constriction, and Immature Dependency, but not for Reparative Protectiveness nor Need for Power and Control.

Table 7

Regressions Testing for the Mediating Effect of Anxious Attachment Style

IV: Parental PTSD		
Mediating Variable: Anxious Attachment		
DV: Offspring Negative Psychological and Social Impacts		
	β	Sobel's Test
Model 1: Parental PTSD	.45	
Model 2: Parental PTSD Insecurity About One's Competence	.32	3.11***
Model 1: Parental PTSD	.44	
Model 2: Parental PTSD Reparative Protectiveness	.41	.34
Model 1: Parental PTSD	.27	
Model 2: Parental PTSD Need for Power and Control	.24	.74
Model 1: Parental PTSD	.49	
Model 2: Parental PTSD Defensive Psychosocial Constriction	.40	2.24*
Model 1:	.37	

Parental PTSD	β	Sobel's Test
Model 2: Parental PTSD Immature Dependency	.24	3.00***

Note: *** $p < .005$, * $p < .05$

Furthermore, it was predicted Community Support would moderate the relationship between parental mental distress and offspring negative psychological and social impacts. This hypothesis was not supported. Finally, it was hypothesized Community Support would moderate the relationship between attachment styles and offspring psychological and social impacts. Moderation was only tested for Anxious Attachment, and not Avoidant - moderation was only supported for Immature Dependency ($\beta = -.19$, $p < .05$). The data analyst then split the variable Community Support at the median of the variable to calculate the relationship between Anxious Attachment and Immature Dependency separately for low and high Community Support groups. For the low Community Support group, there was a strong relationship between Anxious Attachment and Immature Dependency ($\beta = .34$). In the high Community Support group, the relationship was somewhat smaller ($\beta = .28$). These analyses suggest Community Support does lower the relationship between Anxious Attachment and Immature Dependency.

CHAPTER V

Discussion

What was averting or, conversely, facilitating the passage of psychopathology from one generation to the next, thereby accounting for the contradiction in research, and clinicians' observations during their work with Holocaust survivor families? When this study began, the intention was to help resolve the current contradiction in research and clinical opinion regarding the intergenerational transmission of trauma in Holocaust survivor families. Was there a relationship between parental PTSD symptomology and offspring negative psychological and social impacts? What processes within families or communities thwarted, or otherwise enabled the passage of psychopathology indicators from one generation to the next?

The results of this research study suggest: 1) intergenerational trauma among Holocaust families is in fact a complex and nuanced process in which the parent's PTSD symptoms are actually related to child psychological outcomes, and in which attachment to the parent is involved in the transmission of trauma, albeit in unexpected ways; 2) children of Holocaust survivors typically feel motivated to undo and repair their caregiver's trauma by protecting them from emotional and social harm; 3) offspring find the most helpful community resources to be those that specifically address the Holocaust, and some offspring are resourceful themselves, developing their own networks of support; 4) those children whose parents show high levels of PTSD, and who experience certain psychological and social difficulties tend to have a particular attachment style with their parent; 5) the community supports outlined in this study do not seem

to improve offspring outcomes, except for offspring's immature dependency on their parents and substances for emotional regulation (Danieli, 2015).

The findings of this study are very compelling. The open-ended responses from participants give a depth of understanding as to *how* the trauma is transmitted to certain children in particular situations. This chapter will discuss key findings, strengths and limitations of the study, literature and theoretical applications, and the implications for social work practice.

Parental PTSD Symptomatology as Measured by the PCL

The overall symptom severity score found in this study is somewhat below a score that would be considered a diagnosis of PTSD in general population samples (National Center for Posttraumatic Stress Disorder, 2012). However, when participants are given the opportunity to describe their parents' symptoms in their own words, a single response often carries several themes specific to Holocaust trauma. Furthermore, although the prompt for this open-ended question does not refer to the parent-child relationship and/or attachment to the parent, twenty-two participants state caregivers struggled with parenting as a result of their Holocaust experiences. Also, while some parents did not speak directly about the Holocaust until they were older, offspring still observed symptoms congruent with PTSD - even when offspring state parents did speak freely about their Holocaust experiences, there is sometimes a hint of overlap with other parental PTSD qualitative themes outlined.

Attachment Styles as Measured by the ECR-R

Overall, the sample indicates an attachment style that is high in Avoidance and low in Anxiety, which can best be described as having a dismissing-avoidant attachment in which participants are not worried their parent will abandon them, but they are uncomfortable opening up to or depending on their caregiver. One of these participants also indicates struggles with

other interpersonal relationships, which is reflective of a dismissive-avoidant relationship working models in which the individual has rigid self-reliance that causes them to consider peers as competitors rather than as those to whom they could turn in times of need.

Community Support

Some participants indicate they feel their parents' open communication regarding their Holocaust experience alleviated their caregivers' symptoms of trauma. Unfortunately, during the 1960s, a "conspiracy of silence" erupted when Holocaust survivors found no one, including clinicians, attempted to listen to or believe survivors when they tried to share their traumas. It is understandable, then, that several participants indicate their parents came to distrust those who were not Jewish, and that they decided not to share their stories (Danieli, 1998). In their closed and open-ended responses, participants indicate the most helpful community resources are those that specifically address the Holocaust. It could be that unlike those networks - including Jewish organizations - that do not fathom the Holocaust atrocities, these Holocaust-specific networks validate the horrors offspring's parents experienced, thereby allowing respondents to fill the gaps and integrate their families' narratives.

Correlation Results

This study confirms parental PTSD symptomatology is adversely related to the next generation's emotional, behavioral, attitudinal, and relational well-being; in other words, parents' symptoms of Holocaust trauma are related to offspring's Internal Working Models (IWM) (Danieli et al, 2015). Therefore, this study counters investigations that disconfirm the presence of intergenerational trauma in Holocaust families.

The relationships between parental PTSD, attachment styles and offspring who exhibit negative social and psychological outcomes are particularly interesting given the overall sample

shows a slight tendency toward the opposite attachment style – the general sample has somewhat of a high Avoidant/low Anxiety attachment to their caregivers, whereas those participants whose parents specifically demonstrated high PTSD symptomatology and negative social and psychological impacts have more of a low Avoidant/high Anxiety attachment to their parents. This complexity of the attachment data paired with that of participants' responses show the investigation of intergenerational trauma in families of Holocaust survivors cannot be limited to simply studying the content of the trauma passed on from generation to generation; rather, certain types of Holocaust survivors in the sample (those whose with higher levels of offspring-reported PTSD symptoms) influence their children in particular ways (through anxious attachment styles that are related to offspring low self-esteem, difficulties expressing and regulating emotion, mistrust, and immature dependency on the caregiver) (Danieli et al., 2015; Kellermann, 2001).

Therefore, the present study elucidates a mechanism by which this trauma could be passed on to the next generation – through attachment style with the parent. In other words, those children whose parents have higher levels of PTSD symptomatology also have higher levels of anxious attachment to their parent, and that anxious attachment is related to particular outcomes: insecurity about one's own competence, limited psychosocial abilities, and immature dependency. Given the purpose of attachment is to establish a sense of security in one's ability to explore, and to help the child communicate his emotions, it is understandable attachment plays a role in Holocaust descendants' psychosocial outcomes. Several participants indicate there was a lack of emotion in their relationship with their parent; that the parent struggled with grief, fear, and mental health challenges; and that the participant did not want to burden the parent with her own emotional struggles. In particular, some participants indicate their caregivers reacted

negatively to offspring's distress signals. Since some offspring lacked a guide when they were emotionally aroused and/or distressed, and because they had to control such distress in order to maintain an attachment to their parent, it is not surprising certain children of Holocaust survivors were more likely to constrict their emotional development, and could presently struggle with emotional and affective regulation themselves (Davies, 2011; Kellermann, 2001).

Furthermore, several participants indicate their caregivers were overprotective, struggled with their child's independence especially during teenage and college years, and were fearful as well as distrustful of the outside world. Therefore, these participants might have introjected their parents' anxieties, and could have struggled to find ways in which they could feel safe to explore and express their independence. Also, a few participants describe situations in which their parent seemed to have dissociated due to intrusive memories and/or grief. These children might have been preoccupied with their caregivers' behavior and moods at the expense of exploration, thereby increasing their likelihood for immature dependency (Davies, 2011; Kellermann, 2001).

In addition, it could be those children with more of an Avoidant attachment style become more dismissive as adults since these children are in positions in which they must learn to develop their own social-emotional abilities. Therefore, it is not surprising these participants report significantly higher confidence in their own competence, as it is characteristic of dismissing-avoidant adults to view themselves as highly self-sufficient. However, dismissing adults also have a tendency to belittle the significance of relationships, which could explain why these participants do not feel drawn to repair their parents' trauma, or to protect their parent in any way. In general, it is often difficult for dismissing-avoidant adults to self-reflect, so it might be challenging for these offspring to contemplate their psychological outcomes (Bennett, 2006; Byers, 2014)

On the other hand, there were some participants who indicate aspects of a secure attachment with their parent in which they were confident of their parent's availability, and they were not engrossed in maintaining the attachment to their caregiver. Further research needs to be conducted in order to explore what makes this subset of participants different from those who indicate an insecure attachment with their parent, but it can be surmised from the present study that those parents who had less severe PTSD symptomology were more likely to have a secure attachment to their child, thereby leading to a higher likelihood of favorable child psychological outcomes.

Strengths and Limitations

One of this study's strengths is that it is a mixed methods design, allowing participants to share their experiences in their own words, and this design adds depth to the quantitative data. Furthermore, regression analyses allow for a more intricate understanding as to how the variables interact (Engel & Schutt, 2013). The survey instruments that are most helpful in gathering reliable and valid data are the ECR-R, and aspects of the Danieli Inventory. It was particularly advantageous to administer the Danieli Inventory, as this instrument was just recently published in September 2015. The least well-designed measurement tool is the Community Support measurement created by this researcher. In open-ended responses, some participants indicate the Community Support measurement tool has poor questioning, too many questions, or does not measure the actual variable. This instrument could be re-designed using the open-ended responses respondents provided, and by further interviewing children of Holocaust survivors to create a standardized, valid, and reliable tool.

Also, the responses to the PCL are highly variable. Offspring have been shown to be reliable informants of caregivers' PTSD symptoms using measures similar to the PCL such as the

Parental PTSD Questionnaire created by Rachel Yehuda, PhD and colleagues. However, Dr. Yehuda herself indicates another measure developed by Yael Danieli, PhD is a better measurement tool (R. Yehuda, personal communication, October 9, 2015). Dr. Danieli's questionnaire is Part I of the Danieli Inventory used in this study, and Part I measures survivors' posttrauma adaptational styles from their children's point of view. Given this part of the Danieli Inventory consists of sixty items, this researcher determined including Part I of the Danieli Inventory would have made the overall survey too long given the limited time and scope of this thesis. However, it is highly suggested future investigations incorporate this standardized scale since this scale acknowledges the need for a specific measure of this particular cohort (Danieli et al., 2015).

In addition, only fifty-four participants identify as male, and the sample overwhelmingly identifies as some version of white and Jewish, signifying the need for a more inclusive sample with a wider range of racial and ethnic identities - one suggestion would be to actively recruit from communities that are not exclusively Jewish, as there were five million Holocaust victims who were not Jewish, including, but not limited to: Polish citizens, those with mental and physical disabilities, those of black heritage, homosexuals, Communists, socialists, and Romani Gypsies. Also, the survey could be translated into Hebrew to recruit those children of Holocaust survivors who live in Israel since Israeli Jewry is more diverse than that of the United States. In addition, there was no control present in this study, so causal conclusions cannot be made. Also, participants' responses could be affected by recall bias, and we do not know what parental factors before the war could have been related to outcomes after the Holocaust. Finally, this researcher acknowledges her bias in researching this topic, as she identifies as a descendent of Holocaust survivors.

Areas for Further Study and Implications for Social Work

Given respondents' reports of fear and mistrust present in family dynamics, and that participants indicate they are protective of their caregivers, the outpouring of responses to this study's survey is truly remarkable, and speaks to participants' courage as well as the importance of anonymity when working with this population. The rich narrative responses participants share highlight offspring's desire to share their caregivers' stories, and to explain their nuanced relationships with their parents in their own words. Children of Holocaust survivors consistently elucidate the effect of the Holocaust has on a massive cohort and its offspring is specific rather than one-dimensional (Danieli, 2015).

The social work field should continue to discuss and investigate the specific characteristics of Holocaust survivors and their descendants so as to gain a better understanding of how to best serve this population as well as other cohorts of mass trauma. Such studies and conversations should focus on how protective and risk factors interact rather than investigating each variable alone, as the intergenerational transmission of trauma is in fact a dynamic, complicated process rather than a one-dimensional phenomenon. In addition, it is highly recommended future investigations use a mixed method research design to provide anecdotal and holistic data for clinicians (Kellermann, 2001). In particular, it is recommended future studies include Part I of the Danieli Inventory, and a more refined measurement of Community Support.

The current study contains substantial application to clinical social work in that it indicates ways in which clinicians can create specific treatment plans for this particular population in order to stop the transmission of trauma from one generation to the next. The findings of this study highlight the importance of the therapeutic relationship in bolstering positive aspects of offspring's relationships with their parents, and this population's ability to

seek Holocaust-specific support within their communities. In addition, clinicians should work to create a secure attachment that allows children of Holocaust survivors to grow in their self-confidence and emotional expression. Powerful interventions clinical social workers could use with this particular population is the analysis of self-narratives and enactments within the therapist/client relationship, as this study indicates the salience of intersubjective and relational factors present within Holocaust families (Ginot, 2007; Ginot, 2011). Therefore, the findings in this study indicate one of the most effective treatment interventions with Holocaust families experiencing trauma is that which focuses on attachment and Holocaust-specific environmental supports. In addition, if the client is willing, it could be healing for offspring to learn more about the Holocaust and their parent's story to fill in gaps in the client's story in order to create a more integrated self-narrative.

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Appendix A

Facebook Recruitment

Facebook Friends! Are you between the ages 38-75 years old? Are you able to read and write in English? Do you have a parent/primary caregiver who identifies or identified as a survivor of the Holocaust? Do you have access to a computer? If you answered "yes" to all of these questions, you could help me out with my Master's Thesis.

It is a brief survey that asks about your parent's response to their Holocaust experience, your attachment to your parent, and how you yourself cope with Holocaust trauma. Speak up and share your valuable knowledge. The survey should take no more than 30 minutes. Your feedback is important!

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix B

Holocaust Community Forum Recruitment

Are you between the ages 38-75 years old? Are you able to read and write in English?

Do you have a parent/primary caregiver who identifies or identified as a survivor of the Holocaust? Do you have access to a computer? If you answered "yes" to all of these questions, I encourage you to consider answering a brief survey about some of your experiences growing up. You will be asked to take a brief survey that asks about your parent's response to their Holocaust experience, your attachment to your parent, and how you yourself cope with Holocaust trauma. The survey should take no more than 30 minutes. Your feedback is important!

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix C

E-mail Recruitment

Dear _____,

Good evening. My name is Lisa Guthery, and I am a second year social work student at Smith College School for Social Work. I was referred to you by _____. My thesis explores the presence of protective factors in Holocaust families and communities, and how those protective factors resolve the transmission of trauma in survivor families. Debate exists as to whether or not the effects of the Holocaust are transmitted intergenerationally. Therefore, my goal is to further clarify this discrepancy in the research by identifying possible risk and protective factors that serve as mechanisms and/or buffers to the transmission of trauma among Holocaust survivors. I will be asking participants about parents/primary caregivers who survived the Holocaust, what participants remember about their parents' response to the Holocaust, participants' attachment to their parents, and how participants themselves cope with Holocaust trauma.

Participation in the study consists of completing four short screening questions online followed by an online survey that should take no more than 30 minutes to complete. I am using Qualtrics, which keeps survey responses secure. Therefore, participants are assured complete anonymity. In order to further protect participant anonymity, I ask participants not to contact me indicating their completion of the survey.

Will you please help me find participants to complete the survey for my thesis? I am looking for participants who between ages 38-75 years old, can read and write in English, have a parent/primary caregiver who survived the Holocaust, and have access to a computer.

Would you please forward this email to anyone who might be interested in completing my survey?

Thanks for your time and help!

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Please click on the link to complete the survey:

Sincerely,

Lisa S. Guthery

Appendix D

Smith College Human Subjects Committee Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 7, 2015

Lisa Guthery

Dear Lisa,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Alexandra Starr, Research Advisor

Appendix E

Smith College Human Subjects Committee Protocol Change Letters



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 16, 2015

Lisa Guthery

Dear Lisa:

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Alexandra Starr, Research Advisor



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 16, 2016

Lisa Guthery

Dear Lisa:

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Alexandra Starr, Research Advisor



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 17, 2016

Lisa Guthery

Dear Lisa:

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Alexandra Starr, Research Advisor



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

April 20, 2016

Lisa Guthery

Dear Lisa:

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Alexandra Starr, Research Advisor

Appendix F

Instrument Guide

Pre-Screening Questions

1. Are you between the ages of 38-75 years old?

Yes

No

2. Are you able to read and write in English?

Yes

No

3. Do/did you have a parent/primary caregiver who identifies or identified as a survivor of the Holocaust?

Yes

No

If you answer Yes to all of the above, and would like to learn more about the study please check 'I meet all criteria and wish to learn more about the study' below.

If you do not say 'yes' to all of the above, you do not meet inclusion criteria and I ask that you exit here. Thank you for your interest!

I meet all criteria and wish to learn more about the study

Part 1: Demographic Questions

1. What is your gender?

- Female
- Male
- Transgender
- Prefer not to answer
- Other:

2. In what year were you born? (enter 4-digit birth year; for example, 1976)

(Comment box)

3. What would you identify as your race/ethnicity?

(Comment box)

4. What answer best describes your United States geographic location?

- Northeast
- Midwest (previously known as North Central Region)
- South
- West
- Other: (Comment box)

5. What answer best describes your financial status?

- Financially comfortable
- Making ends meet
- Having some financial stress

The following questions will ask you about yourself and your parent/primary caregiver who survived the Holocaust. Please identify one parent/primary caregiver who survived the Holocaust, and answer the questions in response to this identified parent/caregiver. If more than one Holocaust survivor parent/caregiver has impacted you, please choose the person who has impacted you the MOST.

Please indicate the extent to which you agree or disagree with each statement by circling a number for each item.

You may skip any question you are uncomfortable answering. Please answer the questions to the best of your ability.

Part 1

For the following questions, please refer to the Holocaust as the major traumatic event that happened to your parent/primary caregiver.

Below is a list of problems and complaints Holocaust survivors sometimes have. Please read each one carefully, and put an "X" in the box indicating how much you believe your parent/primary caregiver was bothered by that problem in your childhood:

1. My parent/ primary caregiver acted as though they were experiencing repeated, disturbing memories, thoughts, or images of the Holocaust.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

2. My parent/primary caregiver had repeated, disturbing dreams of the Holocaust.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

3. My parent/primary caregiver would suddenly act as if the Holocaust were happening again (as if they were reliving it).

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

4. My parent/primary caregiver would get very upset when something reminded them of the Holocaust.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

5. My parent/primary caregiver acted as though they were having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded them of the Holocaust.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

6. My parent/primary caregiver acted as though they were avoiding thinking about, talking about the Holocaust, or having feelings related to it.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

7. My parent/primary caregiver acted as though they avoided activities or situations because they reminded them of the Holocaust.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

8. My parent/primary caregiver acted as though they had trouble remembering important parts of the Holocaust.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

9. My parent/primary caregiver acted as though they had lost interest in things that they used to enjoy.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

10. My parent/primary caregiver acted as though they felt distant or cut off from other people.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

11. My parent/primary caregiver acted emotionally numb or that they were unable to have loving feelings for those close to them.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

12. My parent/primary caregiver acted as if their future would somehow be cut short.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

13. My parent/primary caregiver had trouble falling or staying asleep.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

14. My parent/primary caregiver was irritable or had angry outbursts.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

15. My parent/primary caregiver acted as though they had difficulty concentrating.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

16. My parent/primary caregiver acted as though they were “super alert” or watchful/on guard.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

17. My parent/primary caregiver was *jumpy* or easily startled.

Do not know (0), Not at all (1), a little bit (2), moderately (3), quite a bit (4), extremely (5)

In your own words, please explain what, if any, types of problems and complaints your Holocaust survivor parent had.

Comment box

Part 2

1. It helped to turn to this parent/primary caregiver in times of need.
strongly disagree 1 2 3 4 5 6 7 strongly agree

2. I usually discussed my problems and concerns with this parent/primary caregiver.
strongly disagree 1 2 3 4 5 6 7 strongly agree

3. I talked things over with this parent/primary caregiver.
strongly disagree 1 2 3 4 5 6 7 strongly agree

4. I found it easy to depend on this parent/primary caregiver.
strongly disagree 1 2 3 4 5 6 7 strongly agree

5. I didn't feel comfortable opening up to this parent/primary caregiver.
strongly disagree 1 2 3 4 5 6 7 strongly agree

6. I preferred not to show this parent/primary caregiver how I felt deep down.
strongly disagree 1 2 3 4 5 6 7 strongly agree

7. I often worried that this parent/primary caregiver didn't really care for me.
strongly disagree 1 2 3 4 5 6 7 strongly agree

8. I was afraid that this parent/primary caregiver would abandon me.
strongly disagree 1 2 3 4 5 6 7 strongly agree

9. I worried that this parent/primary caregiver wouldn't care about me as much as I cared about him or her.
strongly disagree 1 2 3 4 5 6 7 strongly agree

In your own words, how would you describe your relationship with this primary caregiver?
Comment box

Part Three

1. It is important for me to feel powerful
strongly disagree, disagree, neither way, agree, strongly agree

2. Even when successful, I feel forlorn
strongly disagree, disagree, neither way, agree, strongly agree

3. I often rely on my parent(s) to rescue me financially
strongly disagree, disagree, neither way, agree, strongly agree

4. Contentment is a foreign concept to me
strongly disagree, disagree, neither way, agree, strongly agree

5. I test my ability to survive by continuously taking risks
strongly disagree, disagree, neither way, agree, strongly agree
6. I did my best not to burden my parent(s) with my own problems/issues
strongly disagree, disagree, neither way, agree, strongly agree
7. I have sometimes felt a need to make up for my family's losses
strongly disagree, disagree, neither way, agree, strongly agree
8. I watch Holocaust/genocide/war-related films and documentaries incessantly
strongly disagree, disagree, neither way, agree, strongly agree
9. I had to seek guidance outside the family about how to live my life
strongly disagree, disagree, neither way, agree, strongly agree
10. I feel drawn to the stories of other children of survivors
strongly disagree, disagree, neither way, agree, strongly agree
11. I find it difficult to say goodbye
strongly disagree, disagree, neither way, agree, strongly agree
12. Sometimes I felt I had to fill in for murdered family members
strongly disagree, disagree, neither way, agree, strongly agree
13. In my fantasies, I would have never survived what my parent(s) had gone through
strongly disagree, disagree, neither way, agree, strongly agree
14. It is important to me to be in total control
strongly disagree, disagree, neither way, agree, strongly agree
15. My first reaction to a new task is, "I can't. . ."
strongly disagree, disagree, neither way, agree, strongly agree
16. I am obsessed with watching and reading everything about my parent's/s' experiences
strongly disagree, disagree, neither way, agree, strongly agree
17. It is very hard for me to just relax
strongly disagree, disagree, neither way, agree, strongly agree
18. I think of my parents as vulnerable
strongly disagree, disagree, neither way, agree, strongly agree
19. I feel responsible for my parent's/s' happiness
strongly disagree, disagree, neither way, agree, strongly agree
20. Most days I wake up looking forward to life REVERSED
strongly disagree, disagree, neither way, agree, strongly agree

21. I would feel I had betrayed my family and myself if I didn't respond to any negative remark about my faith/group/race/ethnic/social group

strongly disagree, disagree, neither way, agree, strongly agree

22. The culture of the society we live in does not encourage expression of emotions

strongly disagree, disagree, neither way, agree, strongly agree

23. When there is illness in the house, I feel it is my responsibility to make sure that every detail is taken care of

strongly disagree, disagree, neither way, agree, strongly agree

24. I find it difficult to delegate responsibility to others

strongly disagree, disagree, neither way, agree, strongly agree

25. My peers' concerns often seemed frivolous to me

strongly disagree, disagree, neither way, agree, strongly agree

26. I am very sensitive to being labeled

strongly disagree, disagree, neither way, agree, strongly agree

27. I find it uncomfortable to be in a position of authority

strongly disagree, disagree, neither way, agree, strongly agree

28. I fear(ed) bringing children into the world

strongly disagree, disagree, neither way, agree, strongly agree

29. I am afraid to imagine what led to my parent's/s' numbness

strongly disagree, disagree, neither way, agree, strongly agree

30. I expect people to take advantage of me

strongly disagree, disagree, neither way, agree, strongly agree

31. I am very sensitive to being criticized

strongly disagree, disagree, neither way, agree, strongly agree

32. I felt cheated when I found out my family's history from others

strongly disagree, disagree, neither way, agree, strongly agree

33. Sometimes I felt overwhelming despair when I didn't live up to my parent's/s' expectations.

strongly disagree, disagree, neither way, agree, strongly agree

34. I worry that others will look down on me I had to seek guidance outside the family about how to live my life

strongly disagree, disagree, neither way, agree, strongly agree

35. I often experience physical pain (headache, backache, etc.) when I feel difficult, stressful emotions
strongly disagree, disagree, neither way, agree, strongly agree

36. I have often resorted to alcohol, substance abuse, sex, or food to soothe myself
strongly disagree, disagree, neither way, agree, strongly agree

Part Four

A. Community Resources

The next few questions ask you about access and use of community services and resources you and/or your family uses or used. If you have not used any community resources for yourself or your family, please answer the questions to the best of your ability.

1. Please rate each community service you used to help support yourself and your family regarding the Holocaust.

- School

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Youth movements

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Non-familial role model/mentor

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Books

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Community Resource Center

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Community Mental Health Center

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Jewish Community Center

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Jewish Family Services (JFS)

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Place of Worship Services

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Family/Individual Therapist

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Summer camps or retreats

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Online community

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Allied Jewish Federation

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Place of Worship Support Group

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Jewish Community Center

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Anti-Defamation League

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Holocaust museums

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Holocaust Memorials

Did not use (0) Not at all helpful (1), a little helpful (2), moderately helpful (3), quite a bit helpful (4), extremely helpful (5)

- Other:

- I did/am not use/using any community services

Thank You!

Thank you for taking the time and consideration to complete the survey! Your time and interest is much appreciated!

Please feel free to share the survey with others who are eligible to participate by forwarding this link: <https://www.surveymonkey.com/s/> via email or through facebook.

If you would like to participate in another study examining the emotional impact of disclosure status among first, second and third generation Holocaust survivors, please click on the following link: <https://www.surveymonkey.com/r/HolocaustNarratives>

Appendix G

Consent Form



2015-2016

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

Title of Study: Exploration of Familial and Community Protective Factors in Resolution of Intergenerational Transmission of Trauma

Investigator(s): Lisa Guthery, MSW Candidate

.....

Introduction

- You are being asked to be in a research study investigating the presence of protective factors in Holocaust families and communities.
- You were selected as a possible participant because you self-identify as having at least one parent/caregiver who survived the Holocaust, and you are between the ages of 38 and 75 years old.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to explore how and if Holocaust trauma is passed from one generation to the next in Holocaust families.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: complete a one-time online survey that will take about 30 minutes. You will be answering questions about childhood experiences, memories concerning interactions with caregivers, how you currently handle life's stressors and reflections on community supports or involvement that you have experienced.

* The questions may bring up triggers that remind you of trauma or distress associated with trauma and/or the Holocaust and its aftermath. A referral list for counseling services is attached.

Risks/Discomforts of Being in this Study

- The proposed study has some risks of participation because it may cause distress for some participants, as the questions may bring up experiences and memories of familial trauma. Although you will not be asked to discuss trauma, the questions may bring up triggers that remind you of trauma or distress associated with the your family and/or the Holocaust and its aftermath. Again, a counseling resources referral list is attached. Before agreeing to the informed consent, you are asked to print a copy of the informed consent and referral list to keep for your records. The referral list consists of three sources that you may contact if you would like to talk to someone at any point while taking the survey, after taking the survey, or if you choose not to take it.

Benefits of Being in the Study

- By participating in the research, you have an opportunity to share what your experiences have been in regards to how the familial trauma/the Holocaust affects mental health and family systems, as well as what can be done to mitigate or eliminate negative outcomes. Your experiences will contribute to the knowledge of the effects of trauma/the Holocaust on attachment and mental health. You may also be contributing to improving services provided to this population. Lastly, by participating in this research and contributing more knowledge on the needs of this population, you are generating more understanding about this population, and are helping other members of this population.
- The present study harbors significant relevance to clinical social work. The findings of this study will inform the focus of intervention for clinicians working with Holocaust families experiencing the effects of trauma in order to interrupt the intergenerational transmission of trauma. The results of the study will assist clinicians in identifying the most salient factors of resilience present within the family on which the clinician can focus interventions. Ultimately, the findings may inform the most effective and efficient care of Holocaust families experiencing trauma to support clinicians practicing in the short-term treatment climate of managed care.

Confidentiality

- Your participation will be kept confidential. I will more than likely be unaware of the identity of participants; however, there is a chance your open-ended responses may indicate aspects of your identity that I might recognize, if we are both active members of my local Jewish community. You are advised to refrain from disclosing any identifying information in the open-ended questions. SurveyMonkey will designate a code number automatically to all participants' responses. I will review all open-ended responses and remove any names or place names that could potentially reveal your identity before allowing my research advisor to view any data. My research advisor and a statistical consultant will have access to the data following the coding done by SurveyMonkey and myself, and only after I have removed any identifying information. Published data will primarily be presented in a summarized group form to disguise all participants' identities. Some illustrative qualitative quotes will be presented, but will not be attached to any demographic data, thereby precluding recognition except for the author of the quote.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. Again, I will not include any information in any report I may publish that would make it possible to identify you.

Payments/gift

- I am unable to offer any financial payment for your participation.

Right to Refuse or Withdraw

You may withdraw at any point if you choose not to continue for any reason. Due to the anonymous nature of the data collection, incomplete information may be included or excluded from the data analysis, and there is no way to know the identities of any of those taking or withdrawing from the survey.

- **Right to Ask Questions and Report Concerns**

- You have the right to ask questions about this research study *and to have* those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee.

Consent

By checking the box below, you will agree to participate in this study, and you will be taken directly to the survey.

Thank you for your interest in the study.

Sincerely,

Lisa S. Guthery

Referral Sources

1). Jewish Family Services of Colorado – Mental Health Services – An organization providing community resources, including mental health support for depression, posttraumatic stress, loss, and family relationship issues.

Contact an intake therapist: 303.597.7777

Or Email: counseling@jewishfamilyservice.org

2). Mental Health Center of Denver – Focuses on recovery and resilience.

Mobile Crisis: 303-602-7220.

Phone: 303-504-6500

www.mhcd.org

3) Mental Health America – An advocacy organization that provides access to behavioral health services for all Americans addressing the full spectrum of mental and substance use conditions

Phone (in crisis): 1-800-273-TALK

Phone: 1-800- 969-6642

Website: <http://www.mentalhealthamerica.net/finding-help>

4). National Alliance of Mental Illness (NAMI) – A national grassroots mental health organization that are in association with local affiliates, state organizations, and volunteers who work in local communities to provide mental health support.

Phone: 1-800-950-6264 (M-F, 10:00 AM-6:00 PM ET)

www.nami.org

BY CHECKING “I AGREE” BELOW, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION. AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please print a copy and save it for your records

