

Clinical Considerations In The Treatment of Anxiety In Third Generation Holocaust

Survivors

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Introduction and Background Information

The motivation for the present paper is based on the hypothesis that the third generation holocaust survivors is a group, although larger and more diverse than the second generation, likely to exhibit similar traits and have similar needs, as well as being characterized by particular attributes specific to the generation. In particular the focus of this work is to shed light on considerations that a clinician should be mindful when working with patients that belong to such group, especially when dealing with anxiety. Anxiety, as described by several authors (Danieli, 1988; Fossion, 2003; Simmons, 2008) is a common manifestation of the inter-generational trauma so it is highly likely to be one of the most encountered maladaptive behaviors in the third generation survivors, as has been in previous generations.

Before discussing the particular group of focus, some basic concepts and a brief history of the etiology of the trauma follow. Starting with the term Holocaust, which is a term generally used to describe the massacre of 6 million Jews and approximately 5.5 million other people such as Gypsies, homosexuals, mentally disabled, Slavs, Jehovah's Witnesses and communists (Landau, 1992). The word holocaust comes from the ancient Greek, *olos* meaning "whole" and *kaustos* or *kautos* meaning "burnt." Appearing as early as the fifth century B.C.E., the term can mean a sacrifice wholly consumed by fire or a great destruction of life, especially by fire.

According to the Holocaust Memorial Museum in Washington DC (2012) by the late 1940s, however, a shift was underway. Holocaust (with either a lowercase or capital H) became a more specific term due to its use in Israeli translations of the word הארוע

(sho'ah). This Hebrew word had been used throughout Jewish history to refer to assaults upon Jews, but by the 1940s it was frequently being applied to the Nazis' murder of the Jews of Europe. (Yiddish-speaking Jews used the term חורבן (churbn), a Yiddish translation of sho'ah.) The equation of holocaust with sho'ah was seen most prominently in the official English translation of the Israeli Declaration of Independence in 1948, in the translated publications of Yad Vashem throughout the 1950s, and in the journalistic coverage of the Adolf Eichmann trial in Israel in 1961.

Currently the generic perspective for the word Holocaust, based on the definition of the Merriam-Webster dictionary (2012) is 1: a sacrifice consumed by fire 2: a thorough destruction involving extensive loss of life especially through fire 3: the mass slaughter of European civilians and especially Jews by the Nazis during World War II.

The phenomenon of a generic word becoming a descriptor of an isolated event in history is certainly due to many factors. One significant reason could be the vastness of the research and publications that have been developed based on such event, not to mention mass media such as television, movies, pop culture magazines, books, etc. that have used the theme immeasurably. A simple search on the ProQuest database throws out over 3,000 articles containing the word Holocaust and a search in Google brings out countless related websites.

A significant amount of the knowledge about the Holocaust has been obtained through the testimonies of some of the survivors, those who decided to talk about their experiences. However, many of the survivors decided never to talk about their experiences as well as never to seek psychological treatment. Golwasser (1986) suggests several reasons for such decision; he thinks that survivors could not be treated unless they

committed to intense, long-term psychotherapy typically restricted to an inpatient setting. Survivors strongly avoided such services, holding on to a collective self-image of resilience and bravery instead of a psychiatric diagnosis. Others were restricted by their financial situation. The Germans did not provide any mental health treatment to the survivors as the impact of trauma on people was yet to be fully recognized and understood by the psychological society.

Sadly enough, those survivors who decided to confront their losses, according to Danieli (1988), many therapists were emotionally incapable of containing and confronting the brutal truths of the Holocaust experience. Huttman (2003) goes further and says that survivors were avoided and isolated, silenced and denied validation. However Jews were no strangers to isolation from others.

Whealey (2011) in his recount of the history of Jews and the Holocaust, which spans from the early Greeks to the establishment of the State of Israel, describes several periods in history in which the Jews were singled out and attacked by different groups. All throughout history, Jews showed a similar attitude, which is characterized by a self-isolation and seeking support exclusively within the group they identify with, even when facing despair.

It is no surprise that survivors of the Holocaust who never received any treatment, utilized their own families as captive audiences in which to grieve. Danieli (1988) described survivors as parents as being fearful, anxious, distrustful and overprotective, they discouraged individuation and emotional expression, while they valued academic achievement and material comforts above all else. The result of such parenting style was that the children developed conflicting sentiments towards their parents, seeking to shield

them from any and all forms of psychological distress, all the while, harboring resentment towards them and yearning for a childhood that never was (Fossion, 2003).

Research related to the effects of the Holocaust on the parenting style of the survivors and the impact on their children has been well documented since the late 1970s. There is vast literature that has emerged from the efforts of people known as the second generation, people who sought validation and community through one another and have worked tremendously in understanding the trans-generational impact caused by the experience of the Holocaust, with the majority of the publications coming from the United States and Israel.

With all the work produced thus far about the effects on the survivors and the second generation, it is somewhat bewildering that only a few studies have addressed the question of the grandchildren of survivors, referred to now as the third generation. The third generation is a specific group that is affected by the trans-generational transmission of trauma, but also has been thought to be the catalyst in unfolding the past (Fossion, 2003), probably because there is enough time distance for the survivors to be ready to revisit their own past.

The third generation is being addressed in the present work with the interest of recognizing better ways of treatment, in particular in regards to anxiety disorders. Anxiety has been selected because several authors (Rosenthal, 1980; Sigal, 1998; Fossion, 2003; Scharf, 2007; Simmons, 2008; Cornejo, 2009) mention anxiety to be one of the main intergenerational manifestations of the trauma. In the next section, anxiety is explained and contextualized for the purposes of this paper.

Understanding Anxiety

Worrying is one of the main factors in anxiety (Carlson, 2010); however, neurologically, the correlations of worry and anxiety are poorly understood. It is believed that pathological worry is somehow connected with some microscopic neural disorder, such as a neurotransmitter dysregulation. The specific neurotransmitter remains to be identified; however, given the usual pharmacotherapy approach for anxiety disorders, the most probable candidate is the serotonergic (5-HT) system.

A study performed by Paulesu et al. (2009) showed that the anterior cingulate and dorsal medial prefrontal cortex were associated with worry (Paulesu, 2009). The study, which according to the authors is the only study on the matter so far, concluded that a deregulation of the mentioned area and its circuitry might explain the inability of GAD patients to stop worrying.

The mentioned study was performed on a group of eight people diagnosed with GAD and 12 healthy controls. Both groups underwent functional magnetic resonance imaging (fMRI) while having their mood induced by spoken phrases or the showing of images of faces designed to generate either neutral mood or cause worrying. The only difference found was in the post test, the people with GAD would continue to be worried for a longer period of time. The results suggested that worrying is a disproportionate prolonged preoccupation and not qualitatively different from anxiety.

Anxiety disorders are among the most prevalent psychiatric conditions throughout the world (Kuzma & Black, 2004). Patients with these disorders make extensive use of medical and mental healthcare resources. To get an idea of how significant an issue

anxiety disorders are, the costs for the care of these disorders represent as much as one third of all psychiatric disorders combined (Kuzma & Black, 2004). One of the reasons for the high costs is the constant and long-term recurrence of patients to hospitals when suffering from a panic attack. It is believed that anxiety disorders are usually chronic disorders that frequently co-occur with a variety of co-morbidities. Therefore anxiety disorders are serious conditions that require long-term treatment (Katzman, 2009).

Anxiety disorders encompass several diagnostic categories within the DSM-IV-TR (APA, 2008), which include panic disorder, agoraphobia, specific phobias, social phobia, obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder, generalized anxiety disorder and substance induced anxiety disorder. However, the focus of the present work is to understand what is anxiety in general terms, why is it relevant when talking about the third generation holocaust survivors and to recommend treatment alternatives and considerations to be mindful when facing such disorders in the third generation survivors.

The essential features of anxiety disorders described by the DSM –IV-TR (2008) are excessive worrying, difficulty controlling the worry, panic attacks, recurrent and persistent thoughts that cause distress, excessive or unreasonable fear sometimes cued by the presence or anticipation of a specific object or situation. Overall, one of the main traits of the anxiety disorders is intense fear or discomfort in the absence of real danger and it is usually accompanied by somatic or cognitive symptoms (2008, pp.429-484).

When several of the symptoms are present in a person it becomes what it is called a panic attack, a characteristic feature of most anxiety disorders. Panic attacks are characterized in three types: unexpected (uncued), situationally bound (cued), and

situationally predisposed. Each type is defined by a different set of relationships between the onset of the attack and the presence or absence of situational triggers that can include cues that are either external or internal (2008, pp.430-431).

Another study that may help to understand anxiety mentions that the serotonin transporter (5-HTT) gene is associated with increased emotionality and susceptibility to depression apparently it is related to differences in the structure and activity of the amygdala and particular regions of the prefrontal cortex (Carlson, 2010). The author also mentions that family studies and twin studies indicate that GAD, as well as panic disorder and social anxiety have a hereditary component. Lastly, the author mentions that GAD is approximately two times greater in women than in men (2010, pp. 587-589).

The fact that anxiety can be inherited makes sense in light of the observations reported by several researchers (Danieli, 1988; Fossion, 2003; Simmons, 2008). Anxiety has been reported to manifest across the generations. Therefore in order to move into the specific group of interest, the second generation should be briefly described first.

The Second Generation

Researchers have noted that the most important mission of the Holocaust survivors was to perpetuate life by creating a family (Fossion, 2003). At the same time, due to the effects of the trauma endured, they faced important difficulties in fulfilling their role as parents and spouses. The effect of the trauma in the survivors has been called a form of “psychological death”, which consists of extinguished areas of emotion (Fossion, 2003). They lost the capacity to cope with their own instinctive needs and those

of people close to them. Survivors did not communicate about their trauma and silence was their only means of expression.

In some of the survivor families studied, the second generation is mentioned to depend emotionally on their children, from whom they demanded compensation for their own damaged childhood (Fossion, 2003). Therefore, the issues faced by the second generation impacted their own children, resulting in a double feeling of failure for the second generation, both as children and as parents

Other researchers think that although the concept of trauma in the second generation is a controversial matter, it is impossible to grow up in a Holocaust survivor family without absorbing some of the emotional scars of the parents (Kellermann, 2001). In that study children of survivors are distinguished into two categories: those with direct and specific transmission, where a mental syndrome in the survivor parent leads directly to the same specific syndrome in the child; and indirect and general transmission, where a disorder in the parent makes the parent unable to function as a parent, which indirectly leads to a general sense of deprivation in the child (Kellermann, 2001).

Some commonalities between the symptoms of the first and the second generation that have been identified are depression, anxiety guilt and separation problems (Cornejo, 2009). Additionally, parental trauma symptoms, which were measured as PTSD symptomology, were passed down from survivors to their children. A study found different modes of transmission, such as over-identification with the parents' anguish, and hyper-arousal reactions as a result of parental vigilance and social mistrust (Cornejo, 2009).

But some authors believe the transmitted trauma's effect also generated positive results in the second generation. Thus the second generation has been described as the unconscious repositories of both negative *and* positive attributes that their parents passed on to them (Simmons, 2008).

Additionally, some strengths that are characteristic of the second generation have been mentioned, they include: increased self-knowledge, pride, self-actualizing tendencies, greater sensitivity to others, ability to form and maintain intimate relationships and marriages, possessing a heightened sensitivity to suffering and a broader sense of social responsibility, and a personal connection to the State of Israel (Liebenau, 1992).

It should be noted that the literature is still divided among authors in the topic. Some believe the Holocaust continue to have an effect on the functionality and psychological health of second generation survivors, while others support that children of survivors do not stand out in any measurable way from control populations.

The Third Generation

Turning now toward the third generation of holocaust survivors, which refers to the grandchildren of the survivors of the holocaust, what follows is a description of the group. Most of the people of such generation were born between the mid-70's and mid-90's. Such generation has only been formally addressed slightly with the intent of understanding the consequences of the trans-generational effects of the holocaust.

The first ever-documented case to address directly the third generation of holocaust survivors is a case presented by Rosenthal (1980). The case portrays the treatment of a seven year-old boy of mixed ethnic background who presented symptoms of extreme anxiety, mixed fears and high preoccupation with health, he also showed self isolation, nightmares, insomnia and eagerness to talk about his fears, which interestingly enough were similar to the symptoms his grandmother was presenting at the time.

His grandmother, a holocaust survivor, provided ethnic stability and clarification of the family's history to the boy. The author attributes part of the reason of the child's disorder to the father's unwillingness to discuss the holocaust background of the family, as well as the grandmother's rejection of him because of his marriage with a protestant woman. Because of the father's attitude, the child sought his grandmother's love, developed a strong identification with her and a literal acting out of his grandmother's character.

The case had a tragic ending with the grandmother committing suicide after watching a documentary showing scenes from the Auschwitz concentration camp. The parents decided not to tell the child what exactly happened to his grandmother, but the child did not believe the parents' stories and concluded "the Germans killed her".

By the end of the treatment, the child summarized his experience of therapy as follows:

"This all started with my grandfather. My fears come from my grandfather to my father, from my father to myself. I am the stop-sign person. When I get a scary feeling I send the stop-sign to daddy, then daddy cannot send nobody, nobody is

scared....Talking is the green light not talking is the red light.” (Rosenthal, 1980, p.578)

After that explanation, the therapist asked whether the child remained scared after he passed the “stop-sign” to his father and the child answered that his father usually passed it back to him and he remained scared.

Fossion (2003) also recognized the impact of holocaust related trauma going down the generations as presented in the clinical observations made during therapy sessions with certain families of holocaust survivors. Such families consulted with Fossion and his colleagues because of the symptoms presented by the grandchildren of holocaust survivors.

The main symptoms encountered were not specific and included various categories, such as problems at school, eating disorders, cannabis abuse, depressive or anxiety disorders and problems with aggression. The families also presented some specific patterns in their relationships, which led Fossion to consider that the symptoms presented by the third generation might be a consequence of the family’s history and the trans-generational transmission of holocaust trauma.

One of Fossion’s findings that relates to the Rosenthal case is that in several of the families, the symptoms presented by the grandchildren were linked to the trauma that had occurred two generations earlier. The symptoms originated in the selection of what was transmitted or not through the two previous generations, the grandchildren did not have enough knowledge of their own family history to put their parents attitudes into perspective.

Through his work with the families, Fossion came to several conclusions, one of which is that “it takes the time span of two generations to stimulate the willingness and motivation to revisit the traumatic past” (Fossion, 2003, p.525). He based his method of treatment on the premise that holocaust survivors were more likely to talk about their past to their grandchildren than they were to their children, therefore grandchildren become catalysts in unfolding the past.

Fossion also described the third generation to have grown with fear and anxiety everywhere and with no room for creativity. He describes the grandchildren of the holocaust survivors to have issues of separation-individuation that appear unsolvable, mainly because they had to sacrifice themselves to protect their parents from their own feelings of helplessness.

Sigal (1998), talked about the intergenerational effects of trauma based on his studies and work mostly with children, but also with grandchildren of holocaust survivors. He thinks it is obvious that grandchildren would be affected by the trauma of growing up with parents who he described as hyperactive overachievers or depressed underachievers, anxious, fearful and unable to separate from their parents, to have problems in controlling their aggression and to suffer from low self esteem and identity problems. On the other hand he mentions a study that addressed the specific description mentioned, which found no difference in psychological distress between a group of children of survivors and the control group. Furthermore he mentions that more children of survivors reported positive effects than reported negative effects on them of their parents’ experiences of WWII, specifically in the areas of mental health, family life and national identity.

Sigal and some colleagues (1998) performed a study in which grandchildren of survivors were overrepresented by 300% in a clinical population of a psychiatric clinic. However in a comparison study also performed by Sigal, grandchildren of survivors were seen to be functioning better than comparison groups. The weakness in this last study is that the comparison groups are not well described.

In the studies referenced thus far it is assumed that grand children of survivors are a group that could potentially show similar traits without considering differences of the survivor being either the paternal or maternal grandparent or both. Cornejo (2009) mentions that researchers have found that effects of the Holocaust on the third generation may be due to which parent is the child of survivors. Cornejo (2009) references a study, which found differences in participants whose fathers only, as opposed to mothers only, or both parents were second generation survivors. These participants reported significantly less family cohesion, less commitment, intimacy and uncritical acceptance of partners in intimate relationships, and described their fathers as emotionally withdrawn, rigid, un-empathic and authoritarian.

On the other hand, Scharf (2007), in a sample of adolescents who had two second generation parents, found that the adolescents perceived their parents as less accepting, less encouraging independence and reported less positive self-perceptions. Also their peers rated them as less well adjusted during military training.

Finally, Simmons (2008), described the third generation, based on his research, as to not exhibit higher levels of psychopathology than normative samples, however, they may possess unique characteristics and a distinctive personality style resulting from the intergenerational transmission of the Holocaust experience. Simmons (2008) thinks that

grandchildren of survivors, when they are children, may be more likely to suffer from separation-anxiety disorder and phobias as a result of Holocaust related intrapsychic conflicts. When they become adults, they may experience greater levels of depression, anxiety fear and nervousness.

Recommendations for clinicians

When treating anxiety disorders pharmacotherapy is the most widely used treatment. Several health organizations (The World Federation of Societies of Biological Psychiatry, the British Association for Psychopharmacology, the National Institute for Health and Clinical Excellence and the Canadian Psychiatric Association) agree that the first line of pharmacotherapy for a patient with anxiety disorders should be an antidepressant, either a Selective Serotonin Reuptake Inhibitor (SSRI) or a Selective Norepinephrine Reuptake Inhibitor (SNRI).

Three short-term studies and a six-month long study in a double blind placebo-controlled group of 1800 people proved the efficacy of SSRI in the treatment of GAD. The Clinical Global Impression Improvement test showed an improvement of 68% after eight weeks for the group on the SSRI Paroxetine, while the placebo group showed 46%. A 34% for placebo versus 73% for Paroxetine was found after six months (Katzman, 2009).

The difficult aspect of the pharmacotherapy is the side effects. Some of the possible side effects SSRIs can have include nausea, dry mouth, headaches, diarrhea,

agitation or restlessness, reduced sexual desire, erectile dysfunction, rash, weight gain, drowsiness and insomnia (Mayo Clinic, 2012).

Another method for treating anxiety disorders is psychotherapy, which is really more the focus of this work. When performing psychotherapy dealing with anxiety disorders, therapists use behavioral techniques broadly. According to Deacon and Abramovitz (2004), psychotherapies involving cognitive and behavioral procedures have been established as empirically supported treatments for anxiety disorders. Although there is not any literature specifically addressing the results of behavioral interventions in third generation survivors, it is highly likely that it would be just as beneficial for them. As far as psychotherapy research with the particular group in focus there is some literature reflecting the experiences and research of mental health professionals.

One of the first researchers to work with survivor families in the interest of approaching the third generation was Sigal (1998). Sigal found the children and grandchildren of survivors to be fairly resilient, he also explains that the fact that a person is resilient in one area does not mean he will be equally resilient in all areas. However, he found the Psychodynamic model to be highly applicable to the treatment of survivors and their families. He believes that talking about the family history, including the traumatic portion, brings perspective to the current reality of each generation.

Sigal (1998) also mentions that in his research he came across a group of survivors whom his colleagues labeled “superrepressors”. It was a group of people who did not talk about their experiences yet were well physically and psychologically. The researchers question whether for this group remembering would have worse

consequences than forgetting, but they think that dismantling defense is not always a constructive therapeutic activity.

Fossion (2003) experimented with a family approach for the treatment of third generation survivors. Since he realized that grandchildren have a privileged position in the family because the survivors were more prone to talk about the past to them than they had been to their children, he assigned the grandchildren to talk to their grandparents and ask them about their memories. However Fossion (2003) was specific in that the grandchildren should ask about the memories of life before the Holocaust. The survivors generally welcomed the opportunity resulting in a reactivation of the process of transmission within the family and created new interactions. The open communication provided much understanding and relief to the entire family.

During the therapy sessions, the information collected was discussed with a focus on the difficulties the grandchildren encountered during the process of exploration with their grandparents, in order to better understand the changes that the gathering of information caused within the family structure. All the questions also allowed new light to be shed on the family history, which in addition to the reinforcement to the grandparent-grandchild relationship the therapy helped the children of the survivors to modify their parental and spousal attitudes. For the grandchildren, the improved knowledge of their family history together with their parents' enhanced autonomy, helped them clarify their own personality and resulted in a progressive improvement of their symptoms. The symptoms exhibited represented several issues, but mostly depression and anxiety disorders.

Other authors have also talked about the benefits third generation survivors can gain from learning about their family's history. Simmons (2008) suggests that third generation members should be cognizant of the ways in which their family's background may have impacted their worldview, behaviors and relationships. Specifically when dealing with anxiety, he thinks that particular attention should be paid to anxieties concerning their well-being which may limit their opportunities or ability to take risks.

Taking a risk would be overly difficult for a person with an anxiety disorder, since one of the main traits of the anxiety disorders is intense fear or discomfort in the absence of real danger. Also because of the constant worrying and unfounded fears, an important point to work on in therapy with third generation survivors, based on Simmons' (2008) recommendations, would be to work on the suspicion of others (especially non-Jews and Germans). This suspicious attitude may serve to impair their relationships and again, limit the individual's opportunities.

Conclusions

The third generation survivors, has only been addressed slightly in the literature, however it has been characterized as a group who may experience greater levels of depression, anxiety, fear and nervousness (Simmons, 2008). The present paper addresses anxiety and offers some recommendations for treatment within the third generation.

The anxiety has an etiology in the trauma generated in the Jews who went through and survived the Holocaust. They were eager to create new families because the most important mission of the Holocaust survivors was to perpetuate life (Fossion, 2003), but

due to the effects of the trauma endured survivors had a hard time performing their role as parents and spouses.

Most survivors decided not to talk about their experiences and never to seek any kind of treatment (Goldwasser, 1986), some told their stories, but whichever way the survivors decided to go, the effects of the trauma went down the generations. One of the most common manifestations of the effects of the trauma across the generations is high anxiety and anxiety disorders (Danieli, 1988; Fossion, 2003; Simmons, 2008).

The third generation has been noted to be well adapted and better functioning than control groups in some cases (Sigal, 1998), however the fact that they are able to function does not mean there is no internal suffering (Sigal, 1998). Therefore, the third generation survivors, represents a specific group that has inherited the effects of trauma, but has been under-addressed by researchers and clinicians alike.

The present work is an attempt to address the treatment of anxiety in the specific group mentioned. With that intention some recommendations are offered: The first suggestion is based on the usual first line of action used by clinicians to address anxiety disorders, which is pharmacotherapy, mainly the use of SSRI's. SSRI's are highly effective, but have several side effects.

Although all the side effects can be difficult to endure for any person, when a third generation survivor is prescribed SSRI's, the reaction could be uncertain. Based on several authors' opinions (Rosenthal, 1980; Simmons, 2008) the particular group in focus is highly preoccupied with their health and well-being, but are also suspicious of others so they could have ambivalent reactions to a physician prescribing medications.

The second set of recommendations directly addresses psychotherapy. When performing psychotherapy Sigal (1998) recommends a psychodynamic model. He believes that delving into the past and learning about the family's history provides perspective.

Fossion (2003) was successful in reducing anxiety symptoms in third generation survivors using a family systems approach based on his understanding that grandchildren have a privileged position in the family because the survivors were more prone to talk about the past to them than they had been to their children. He asked the grandchildren to talk to their grandparents, promoting a shift in the family relationships across all three generations, as well as providing relief to the grandchildren by learning about their family's history.

Lastly, Simmons (2008) recommended that third generation survivors should be mindful as to how has their family's background impacted their own worldview. He believes that anxiety based on family history can limit a survivor's grandchild's possibilities in life.

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