

A psychotherapeutic exploration of the narrative of trauma transmission from vulnerability to resilience in grandchildren of Holocaust Survivors

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Dedication

This dissertation is dedicated to the memory of the author's grandfather Philippe Glanzberg (1920-2010), who with his two brothers, not only survived WWII and concentration camps but were also awarded the Legion of Honour for their heroic, active participation in the French Resistance movement. As well, I dedicate this paper to Philippe's parents and sister who were assassinated in Auschwitz in 1944.

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ABSTRACT

Next year will mark 70 years since the liberation of the concentration camps from the Nazis. Extensive research has covered the effects of the trauma on the survivors and their children. Clinical research on survivors, especially directly after the war and in recent years when many are facing their own death and that of loved ones, describe people still haunted by their past. The literature on the transmission of trauma to Offspring of Holocaust Survivors (OHS) remains divided about what, how and if Holocaust trauma is transmitted. Lately, researchers have started concentrating on the grandchildren of Holocaust Survivors (GHS). Some research depicts stories of transmission of post traumatic disorder or vulnerability. Others concentrate on transmission of post traumatic growth or resilience. This paper aims to explore this controversy within the research of trauma transmission. The non-clinical literature has not found any psychopathology in the general population of GHS. However, some GHS appear to display maladaptive behaviour possibly linked to having a survivor grandparent. These are sometimes presented as a vulnerability and other times as a resilience. The various methodologies, modes, definitions of pathology and variables used in the studies can be partially attributed to the differences in findings. As the time from the original trauma passes, the difficulties in assessing the effects increase. Some clinical research have indicated a possible link between communication and parenting styles and trauma transmission. The GHS have been described as helping to bridge the gap in communication between the generations. Many unknowns still exist about trauma transmission to GHS therefore more research in this area is still required in assessing the possible role interfamily communication plays.

INTRODUCTION

Research Aims & Problem Statement

This paper aims to explore the transmission of trauma focusing on contemporary research on grandchildren of Holocaust survivors (GHS). It will examine narratives from studies and individuals, and try to determine whether they show characteristics of either post traumatic disorder or post traumatic growth. This will be done within a family systems frame of reference with an emphasis on communication and parenting styles. This essay will first explore research depicting vulnerability in GHS or post traumatic disorder. Subsequently, it will continue by inquiring into studies suggesting resilience in GHS or post traumatic growth. Finally, there will be a discussion of the findings and possible implications for psychotherapy.

Trauma is a Greek word which can be translated as to 'wound' or 'pierce'. Its origin can be traced to soldiers getting wounded through their thick armor (Spiers, 2001). This provides a nice analogy to what is known as trauma currently; an overwhelming of psychological defences or a person's ability to manage (Giller, 2013). Over the previous hundred years, trauma studies have had themes of contrasting ideas. One current of thought holds that trauma can be that trauma is caused by weakness in character or that it is a natural reaction to a system being overwhelmed by an experience. The other theme to appear over the years is that of symptoms as either physical or psychological. Although a number of studies were conducted after the war, for the most part, there was silence surrounding Holocaust-related material (Kellerman, 2009). During the eighties, a new profound interest in Holocaust trauma emerged and with it a curiosity about the transmission of trauma to future generations. The literature on survivors, offspring of Holocaust survivors and GHS remains divided. Recently, more and more research projects are focusing on the GHS because they have reached an age of adulthood. Another motivating factor behind increasing studies is the threat of losing Holocaust survivors to old age. This research continues to highlight dualities: that of vulnerability and resilience.

Purpose of the Study

A large amount of trauma literature concentrates on the Holocaust due to its magnitude. Also, it has become more approachable since a minimum of three generations have

passed. The shock of the Holocaust having occurred in Western society might have also added to the increased interest. Kellerman (2009) suggests that research into holocaust trauma is being used as a model and tool for genocide and trauma research. Unfortunately, as human beings, we seem unable to learn from our history, and mass destruction, including genocide, continues to be a part of our present. When the American Psychological Association first published in the Diagnostic and Statistical Manual III the diagnosis of Post-Traumatic Stress Disorder (PTSD) it stated that PTSD was a reaction to extraordinary events. As further studies continue, one wonders if sexual abuse, war, and genocide are such extraordinary events in human history. Therefore, research into the possibility of intergenerational transmission of trauma and how and when it occurs could have a much wider utility. Understanding how future generations might or might not be affected by earlier trauma could be an important tool for health professions that work with trauma survivors and their families.

Models of Trauma Transmission and Key Terms

The different models of transmission of trauma include psychodynamic, sociocultural, family systems and biological (Kellerman, 2009). The modes in which trauma is thought to be transmitted is through the unconscious, parenting, communication and genes. Currently, multi-dimensional and integrative view of trauma transmission encompassing “unconsciously displaced parental emotions, inadequate parenting behaviour, family enmeshment, and/or a hereditary predisposition in combination with specific aggravating and mitigating circumstances” needs to be adopted (Kellerman, 2009, p. 88). Although new research in each model (psychodynamic, sociocultural and biological) provides new insights into the transmission of trauma, these are beyond the scope of this paper. This paper will concentrate on the family systems model of trauma transmission through attachment styles and communication patterns.

For the purpose of this investigation, a very brief explanation of parenting/attachment styles and communication patterns within families is explained below. Attachment styles are based on Bowlby’s theories and the importance of the relationship between an infant and their primary caregiver. This relationship is thought to provide the basis for the infant’s future representation of others (Solomon & Siegel, 2003). How they react around others and expect others to react around them arises from this first founding experience.

Ainsworth (1979 as cited in Friend, 2012) observed infants and their caregivers. Based on her observations, three different attachment styles were identified: secure, avoidant, and ambivalent. A new category was assigned to a small amount of infants who displayed disorganised/disoriented attachment styles (Solomon & Siegel, 2003). These infants were not fitting into the three original categories and a link to unresolved trauma will be further explained in the chapter on vulnerability.

The ways in which the primary caregiver communicates with the infant is believed to have an effect on the transmission of trauma. Additionally, how a family communicates between the different members and through the generations is also theorised to be influential (Fossin et al., 2003). This communication pattern can sometimes have powerful and unconscious effects on family members. Communication patterns will also be examined in more detail in the vulnerability chapter.

Brief Summary of Generational Research

Directly after WWII few studies were conducted on Holocaust survivors. Perhaps the survivors were not ready to share and explore their wounds so close to the trauma. Also, possibly the world was not ready to bear witness to the atrocities. In the sixties and seventies some exploration of narratives on life and death experiences during WWII and research based on clinical material began to surface (Perlstein & Motta, 2013). It was not until the survivors were facing old age and death that many started seeking professional help. Finally in 1987 Amcha (the Israeli Center for Psychological Support of Survivors of the Holocaust and the Second Generation) was established (Kellerman, 2009). The silence surrounding Holocaust-related issues was broken and the amount of research into the area exploded. Although many survivors were able to establish successful lives, many were still haunted by their earlier trauma (Kellerman, 2009). A real paradigm transformation took place shifting from perceived weakness in individual character to recognition and acknowledgement of the resilient and strength inherent in many cases who were able to accomplish so much despite their earlier trauma.

The research on offspring of Holocaust survivors (OHS) is also extensive and divided. Often clinical studies found evidence of psychopathology in many subjects. However, more controlled empirical analysis, including a meta-analysis performed by Van Ijzendoorn et al.

(2003), found no difference between OHS and controls. The complexity and multivariable aspect of trauma transmission has been acknowledged over the last five decades of OHS research (Kellerman, 2009).

This complexity is even more accentuated in the literature on GHS and many of the earlier debates still exist. There is even more difficulty in attributing causation of psychopathology directly to having a Holocaust survivor grandparent. Some have suggested the possibility of a presence of a milder personality, relational, and emotional problems even more challenging to associate (Scarf, 2011). With time elapsing from the original trauma even more variables exist. A division, perhaps even bigger than with the previous generations, exists between the methodologies. Qualitative research empathises more vulnerabilities while quantitative studies often conclude that there was very little or no difference compared to control groups (Bar-On et al., 1998). Though, themes of both vulnerability and resilience exist in the findings of the two different modes of research. As much of the research is qualitative or done with a select population, it is not possible to generalise the findings. Some research indicate certain GHS appear to be more vulnerable in particular situations of stress while other highlight traits of resilience thought to be passed on from earlier generations. It has been suggested that GHS play an important link in opening potentially healing narratives and aiding in ending the silence surrounding the Holocaust (possibly be bridging the gap between narratives of vulnerability and resilience).

CHAPTER ONE: Vulnerability and transmission of post traumatic disorder

It is not surprising that many of the clinical reports on grandchildren of GHS tend to emphasise the victim aspect of descending from Holocaust survivors. According to Sigal & Weifeld (1989), GHS were 300% more likely to present for child psychiatry than other children. Barocas & Barocas (1980) claimed that clinical work displayed the emotional problems survivors faced and the transmission of these to their descendants. Doucet & Rovers (2009) identified four different ways that transmission of trauma occurs. The first is through strong identification with the parents suffering when reaching similar developmental stage. The second is through the intuition children have and changes they make to balance their parents suffering. The third is through the parenting styles passed on though the generations and the final way is through different types of communication styles. The majority of

the research in the area concentrates on the last two modes transmissions of trauma as they are easier to identify and measure than the first two.

A variety of studies investigated parenting/attachment styles and the possibility of transferring trauma to GHS. A study by Wardi (1990) as cited in Bar-On et al. (1998) concluded that the survivor's unresolved loss and their difficulty to show anger left them unable to assess and respond appropriately to their children's needs. Lev-Wiesel (2007) found that the GHS tended to encompass the same parenting style as their parents. These children then might be uncertain how to manage with their own children's emotions. Similarly Rubin & Rhodes (2005) as cited in Kidron (2012) described GHS's experience of their parents fragmented narratives and disorganised behaviour. As a result, GHS have their own experience of traumatic parenting caused by their parents unresolved trauma and loss. Kidron (2012) found that one set of the interviewee parents were emotionally absent and that a dissociating narrative was evident in the majority of respondents. Type D attachment style has been added to describe disorganised and disoriented parenting styles often experienced with unresolved loss or trauma which can be experienced by the child as frightening and unpredictable (Friend, 2012). Adelman (1995) interviewed GHS and they described their parents as bizarre and unpredictable, full of vagueness and contradictions. These opposing and confusing behaviours then become the representations of others and self that could continue well into adulthood. Clinical studies suggest that the effects of traumatic experience on personality organisation results from parenting and attachment styles and the disorganised narratives and behaviours associated with unresolved trauma (Adelman, 1995).

Goldberg & Wiseman (2006 as cited in Sagi-Scwartz et al., 2008) identified higher levels of attachment anxiety in grandchildren of Holocaust survivors compared to their control group. It is important to consider that this research was taking place during a time of conflict and bombing in Israel. It is possible that the attachment anxiety was caused by increased vulnerability to PTSD. In that case what is being observed would be more related to biological transmission of trauma. Themes that have resurfaced in various studies are the difficulties children and grandchildren face with respect to individualisation and separation from their family of origins. Chaitin (2002) observed closeness in families with strong eruptions of conflict. The other theme to emerge is that of children taking on the parental role (Bar-On et al., 1998). Both of these characteristics have been associated with attach-

ment D styles (Solomon & Siegel, 2003). These themes were also present in Fossin et al.'s (2003) summary of clinical family patterns observed when treating families consisting of GHS in Belgium. These families presented with non-specific symptoms. The GHS were characterised by their inability to access their family history and place their parents actions into context, children taking on parental roles and conflicts arising during separation/individuation stages were once again present.

Another possible method identified for the transmission of trauma is through different familial communication styles. Many studies have discussed or focused on how families communicate and what is said or represented with objects about the Holocaust. A few clinical studies have emphasised the silence around the Holocaust issue. This silence prevented the GHS from completing their family history or to comprehend their parents and/or grandparents life experience. Over time, these gaps would fill with more and more catastrophic ideas and notions (Bar-On et al. 1998; Keeler et al., 1998 as cited in Doucet & Rovers, 2009). It is hard to imagine a more horrific story than that of the Holocaust, but perhaps what occurs over the years is a dismissal of some of the 'normality' surrounding the story of experiences before and after the war. Bar-On et al. (1998) continues to refer to the children and grandchildren as second and third generation survivors, as though, they themselves have experienced the Holocaust directly.

It has also been found that not only silence, but also excessive discussion and presence of the Holocaust could also lead to the transmission of trauma (Keeler et al., 1998 as cited in Doucet & Rovers, 2010; Braga et al., 2005). Kidron (2012) describes GHS recalling grandparents recounting near death experiences. Their narratives often lacked clear indications of time and could have been recounting something that had occurred recently or once or many times. The distinction between phantasy and real world can become skewed. A study by Lev-Wiesel (2007) described GHS as hyper-aware of the Holocaust and their grandparents' role. They were also found to over-identify with their grandparents' experience and tended not to trust others. These possible outcomes have been associated with too much or too little communication within a family. Various studies have indicated that GHS carry the burden of the Holocaust. This burden is transmitted in various ways: emotional unresolved loss of parents or grandparents, feeling the need to take care of the parents or pass on the story of the Holocaust to future generations (Doucet & Rovers, 2010).

This burden is accentuated for the third generation as they will be the last generation to have direct access to the Holocaust survivors (Shmotkin et al., 2011).

Some studies encompassed both parenting and communication styles or looked more specifically at outcomes and not the process of transmission. An American/Canadian select sample study conducted by Giladi & Bell (2012) found GHS with higher levels of secondary traumatic stress and lower levels of individualisation. They also displayed a less proficient family communication style compared to the control group. Another similar study by Kellermann (2009) found themes of overprotection and fusion. Although Scharf (2007) found very little difference between control groups and grandchildren of Holocaust survivors, he discovered that grandchildren who had both parents who were offspring of Holocaust survivors had lower self-esteem, presented symptoms of distress and were perceived as having lower military performance. In a more recent study, Scharf (2011) describes a measurable behaviour difference in GHS and the possibility for increased psychological distress in certain situations though notably milder than PTSD. A recent Italian study with the title of *Hopelessness, Temperament, Anger and Interpersonal Relationships in Holocaust Survivors' Grandchildren* concluded that GHS had a more negative view of the other and tended to be angrier than the control group (Illicetto et al., 2011). An American select sample study found that GHS had more difficulties relating to their parents and were more prone to anxiety and depression (Huttman, 2003 as cited in Sagi-Schwartz et al., 2008).

CHAPTER TWO: Resilience and transmission of post traumatic growth

In 2008 Sagi-Schwartz publicised their findings of their meta-analytic research on GHS. They concluded that in 13 non-clinical select and non-select experiments there was no indication of psychopathology. Recently, the story portrayed by Holocaust survivors and GHS tends to be that of a normalising character. One respondent in Kidron's (2012) study described what had been transmitted as "scars as a mode of being". These scars did not signify psychopathological disorders. Even the interpretation of silence was explained as a strength in their parents and grandparents. The stories recounted through the generations often encompassed morals and values important for the survivors to pass to future generations. According to Kidron (2012), this 'scratch' was a transmitted emotional reminder that

differentiated GHS and others. What appears to be transmitted for the majority is not a disorder or vulnerability, but different coping methods and a resilient family narrative.

GHS now tell stories with themes of survival of the fittest and that if their grandparents survived the atrocities of the Holocaust then they could survive anything (Kidron, 2012). This could also be echoed in the GHS' own narrative described by Giladi & Bell (2012) as wanting to be successful in what they do, having greater amounts of empathy, the tendency to be associated with helping professions and their desire to pass on the story of the Holocaust to future generations. Other studies, such as that performed by Chaitin (2002), also found that for GHS the need to pass on the Holocaust legacy and to educate future generations was important. Even the use of the word legacy seems to apply a positive connotation to this transmitted behaviour.

Other studies described what has been transmitted as a positive protecting mechanisms. Bradfield (2011) describes what is transferred through the generations as dissociative defences against self-injury. This defence is used to protect the individuals from future potentially hurtful relationships. Two separate qualitative studies by Chaitin (2000, 2002) found that GHS valued teamwork, family relations as well as non-confirming behaviour. These are all traits that could help to avoid future injury to the self caused by relations with others. Another study by Hogman (1998 as cited in Sagi-Schwartz et al., 2008) also emphasised GHS' value in life and sensitivities to social and political inequalities.

Various studies presented by Sagi-Schwartz et al. (2008) found no difference between control groups and GHS with respect to attachment, communication and self esteem and normative functioning. In 1989 Sigan & Weinfeld requested Canadian parents to rate their children on a 50 item questionnaire. The GHS actually performed better in six of the criteria. Another study conducted by Perlstein & Wotta (2013) found no difference between highly orthodox Jews that had grandparents who survived the Holocaust and those who did not. Interestingly, the Orthodox Jews who had no direct survival grandparent and those who had, both displayed longer reactions to Holocaust related words than the non-jewish population. This might indicate a shared traumatic narrative of the Jewish people.

The amount of verbal communication within a family also seems to have an influence on the resilient narrative. Wiseman (2002 as cited in Giladi & Bell, 2012) discovered that low-

er psychological distress was found in families that were better at communicating. Similarly, Braga et al. (2012) found more stories of resilience in families with better and more affectionate verbal communication. These studies parallel the negative effects excessive or absent Holocaust related communication can have, discussed in the previous chapter. The difference is in the last examples, the GHS and their families are presented as resilient.

If transmission is measured by quality of life, Illiceto et al. (2011) describes GHS as having important positions, good socio-economic status and a positive self perception. This could indicate a successful integration of the trauma. Many studies have indicated no difference between control groups and GHS. This adds to the narratives of resilience in which future generations do not appear to be affected by the transmission of the aftermath of Holocaust related trauma.

CHAPTER THREE: Discussion

Some research indicate negative traits, others concentrate on the positive aspects transmitted or none at all. Until the nineties most studies focused on pathology and PTSD (Doucet & Rovers, 2010). Still, some studies are searching and/or concluding a more vulnerable population (Goldberg & Wiseman as cited in Sagi-Scwartz et al., 2008, 2006; Scharf, 2007; Scharf, 2011). It is only recently that narratives about resistance are surfacing. Kidron (2012) talks about a shift in paradigm; one from victim pathologising to victims as resilient. This can be heard echoed in GHS narratives as they recount their experiences and even within academia. Some of the issues with the literature being divided arise from the different methodologies, modes of studies and definition of psychopathology.

Research into the transmission of trauma has only recently been conducted with GHS who are now of age to express themselves. Some earlier studies relied on the parents own perspective of GHS population. These could have been heavily biased since parents were answering questions about transmitting trauma to their own children (Sigal & Weinfeld, 1989). Also, many of the studies rely on self-disclosure and surveys in which the respondent might be more inclined to relate to themselves as normal.

In the meta-analytic study performed by Sagi-Schwartz et al. (2008) thirteen non-clinical studies were incorporated. The conclusion from this work is that in general, no psychopathological disorder exist among GHS. Giladi & Bell (2012) suggests that although no psychopathology is displayed, the GHS are affected in more subtle ways. These subtleties might be the vulnerabilities reported in clinical studies. Clinical studies tend to provide a more detailed account of individual narratives and experiences than the surveys. Unfortunately these studies are more likely to be subjective and influenced by social and cultural agendas. Clinical or quantitative research tend to focus on the population that are in the most need for psychological assistance (Bar-On et al., 1998). Likely, early results from clinical research of Holocaust survivors and their children were generalised to the entire population. This theory of trauma where psychopathology is passed down through the generations also appears more often in the earliest research on GHS (Adelman, 1995; Bar-On et al, 1998). When Sagi-Schwartz et al. (2008) started publishing their findings that no measurable psychopathological transmission of trauma existed, some future research started focussing on why the population might be resilient to the transmission of trauma (Giladi & Bell, 2013; Kidron, 2012; Shmotkin et al., 2012).

Many of the traits discovered in GHS are difficult to categorise as either a vulnerability or a resilient quality. Illiceto et al. (2011) described the hostility and anger in GHS as a possible defence against trauma related disorders and psychopathology. Even the desire of GHS to pass down the history of the Holocaust has been labelled as a burden or a legacy (Doucet & Rovers, 2009 and Chaitin, 2002 respectively). In our ability to verbalise trauma and understand our experience we are restricted and limited to cultural-specific idioms and terminology (Kirmayer, 2003 as cited in Kidron, 2012). Many papers still use the term second and third generation survivors which in itself would suggest that those generations also survived the Holocaust. There does seem to be a shift in the literature, although it is not always clear, from that of disorder to that of resilience (possibly due the fact that many of the researchers are themselves OHS or GHS perhaps deconstructing their own identity). Another potential reason for this shift is the amount of time that has elapsed since the trauma but also because with any story of vulnerability there is always one of resistance. White (2007) argues that even describing somebody's experience, themselves or through research, as either vulnerable or resilient is culturally determined and can change over time. He continues to describe how lives have multiple different stories. What is chosen as the individual's story is highly selective and only a part of the whole narrative. The re-

search into the transmission of trauma started by telling the story of vulnerability and has only fairly recently included that of resilience. We cannot categorise or diagnose a descendant's experience as completely vulnerable or resilient. Their trauma story will eventually contain both in a paradoxical integrative narrative.

For those individuals that present for therapy and associate some of their neurosis to being descendants of survivors, the question of trauma transmission remains. Rothschild (2010) proposes that only ten percent of people who face trauma require help recovering from the event. Most individuals have the capacity within themselves and through relationship with others to recuperate. Perhaps, the ten percent are those seeking therapy and requesting assistance. These might be bypassed in larger generalising experiments. Those who have not recuperated with the help of their community or therapist would be more at risk of transmitting part of their unresolved trauma to future generations. Shmotkin et al. (2011) discusses the link between GHS who display vulnerability and unresolved trauma being passed on through family dynamics, communication and problematic attachment styles. Who is affected by transmission of trauma and by how much appears to be a continuum, with some more resilient or vulnerable than others. Different researchers are interested in different aspects. Letzter-Pouw et al. (2013) states that research should perhaps concentrate now on those who do display PTSD and look into why this is the case. Some others are more interested in why some families seem to be more resilient.

Interfamily communication appears to be one of the possible important variables. Many of the observed symptoms could be linked to family dynamics, both those of vulnerability and resilience. Sagi-Schwartz et al. (2008) hypothesised that GHS are more inclined to intensive learning and communication with survivors than their parents were. Until the eighties the silence surrounding the Holocaust was evident. GHS were exposed to Holocaust related stories more than the previous generation (Shmotkin et al., 2011). There has also been an increase in interest in Holocaust related studies, films, and books especially in Israel but arguably throughout the Western world in the last thirty years (Letzter-Prouw et al., 2013). Furthermore, GHS are most likely the last generation to have direct contact with the survivor and they could feel the need to continue sharing the story and warning future generations about the Holocaust perils. This heightened interest could also complicate connecting transmission of Holocaust trauma directly to family ties. Perlstein & Motta (2013) suggest the possibility of communal trauma, especially amongst highly orthodox

Jews. Shmotkin et al. (2012) hypothesised that when family dynamics are favourable and parents assist in smoothly establishing communication, the third generation could be used to break the silence between the generations.

Different techniques are being used within families and the community to facilitate communication and help counteract the possible transmission of trauma. Bar-On et al. (1998) argues that the therapeutic task is to facilitate communication between the third generation and that of the grandparents. This assists the generations to fill the gaps and silences. For many, this option might no longer exist as the surviving population is now into their eighties and nineties and most have already died. Adelman (1995) also advocated for the restorative power of an intergenerational shared narrative. A similar form of intergenerational healing is taking place in Israel where youth are listening to survivors' narratives about their experiences. After their experience the youth provide a non-verbal interpretation of what they have just witnessed back to the survivor (Kellerman, 2009). This allows the survivor to release some of the possible held trauma and in turn educate future generations, bridging the intergenerational communication. Trauma survivors and their descendants face the duality of keeping silent (the experience too painful to put into words) and the desire to verbally acknowledge the atrocities, bearing witness to others (Connolly, 2011). Another important healing aspect is when faced with the realisation that there is evil in this world, to find hope. Part of this is what Kellerman (2009) describes as conflicting learning, in which the realisation that the victim is not all good and the perpetrator not all bad. It is important to incorporate both narratives for the complete integration of the trauma (Connolly, 2011). Although these techniques have been mostly used with the survivor generation, they could easily be of benefit for GHS.

There are many challenges to scientifically proving the subtlety of the possibility of trauma transmission. Even when research has indicated a possible connection between poorer family communication and differentiation, it has not been plausible to identify whether this is caused by or the cause of trauma transmission (Giladi & Bell, 2012). A Holocaust psychiatrist, Emmanuel Tonay, talked about a hidden psychopathology difficult to detect but noticeable in the way individuals relate to others and the world (Herman, 2001). The numerous different variables, such as the number of family members, how much time is spent with the person (or persons) who experienced the original trauma, the number and type of traumas experienced since by different members, communication and parenting

styles, country of origin and immigration, etc., provides an enormous challenge for the study of trauma transmission.

As the author is a grandchild of a Holocaust Survivor, a particular effort to remain unbiased was made, although one still doubts the ability to be absolutely objective. This paper was also limited to looking at the transmission of trauma from a family systems perspective. The unconscious, biological and cultural aspects are also important to consider and are difficult to separate from each other. Research into the transmission of trauma from a multidisciplinary team would be beneficial. Most studies concentrate on one country: a large scale study encompassing various countries could provide new insights. More research investigating the link between unresolved dissociative trauma and attachment style is required (Bradfield, 2011). Investigations also need to explore the general role of communication plays in the possibility of trauma transmission, including: attachment styles to future generations and excessive and the effects of different communication styles. It would be interesting to research other genocides, such as the Khmer Rouge, and see that if with time, silence would be replaced by more open communication and if this parallels the vulnerable and resilient narratives.

CONCLUSION

The research into the transmission of trauma remains divided for GHS. The silence and stigma surrounding the Holocaust subsided and a fascination with Holocaust narratives emerged. Recently, many pathologising and vulnerable Holocaust survivor narratives have been replaced with that of resilience. This might be echoed in the literature of GHS as well. There is no evidence for general psychopathology in the GHS population. Some studies have indicated various different possible behavioural changes transmitted due to the original trauma. They include greater amounts of anger, mistrust of others, the desire to pass on the story of the Holocaust, reversed parental roles and difficulties in individualisation and separation. These behaviours have been presented at times as either a vulnerability or a resilience. The importance of integrating the two narratives as normative is perhaps one of the biggest tasks in healing trauma. GHS have potentially been able, in some cases, to assist the earlier generations in communicating more freely (possibly limiting the effects of trauma transmission).

Many studies have focused on family systems theories including communication and parenting styles. Although these appear to be an important mechanism for trauma transmission, findings remain mixed with respect to GHS. Some of the discrepancies between the results can be attributed to different methodologies, modes and definitions of psychopathology. Moreover, when so many different variables exist the complexity in tracing different behaviour patterns directly to having a grandparent who survived the Holocaust, is almost impossible. One cannot ignore the biological, social and psychological aspects involved within trauma transmission. The field would benefit greatly from a more holistic and interdisciplinary perspective.

Further research into the phenomenological, GHS own experience of having had grandparents survive the Holocaust could be valuable in a field with so many different variables. Another important area to investigate would be other genocides, such as those affected by the Khmer Rouge regime. Will some descendants eventually find words to describe their present experience with the previous trauma? Will their narratives include vulnerability and resilience? Finally, more inquiry into the question of whether silence and time can heal such wounds would be beneficial. The conclusion of this paper is that research results warrant more focus on these questions about trauma as well as the possible means and consequences of it being communicated and transmitted to future generations.

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