

ORIGINAL PAPER

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Posttraumatic stress symptoms and fear of intimacy among treated and non-treated survivors who were children during the Holocaust

Accepted: 30 April 2003

Abstract *Background* This study examines the long-term consequences of the Holocaust on child survivors as implicated in PTSD residues and fears of intimacy. *Method* Participants were 43 Holocaust child survivors who received psychotherapy, 48 participants who also went through the Holocaust as children, but did not receive psychotherapy, and 43 Israeli-born participants who did not directly experience the Holocaust. Data regarding PTSD, fear of intimacy, and exposure-related variables were gathered via standardized self-report questionnaires. *Results* The findings show that both treated and non-treated survivors reported significantly higher levels of post-traumatic residues than the non-Holocaust controls, while the treated survivors reported higher levels than the non-treated ones. Treated survivors also differed from the other two groups in their levels of fear of intimacy. In addition, survivors who had been in concentration camps reported significantly more PTSD symptoms than survivors who had been in hiding. Two alternative interpretations are offered. No differences were found in the fear of intimacy of those who survived in the different settings. *Conclusions* The findings point to the long-lasting impact of the Holocaust experience on child survivors, although they also demonstrate wide variability in survivors' long-term adjustment that should be further explored.

Key words child Holocaust survivors – PTSD – intimacy – psychotherapy

Introduction

Children need a supportive and nourishing environment to ensure their growth and development. When developmental tasks are not achieved in the course of critical periods, due to adverse circumstances, pathological consequences, often irreversible, may ensue (Bowlby 1973). Children who grew up during the Nazi Holocaust (child survivors) were exposed to prolonged and repeated horrors. Those who survived the concentration camps endured continuous threats, starvation, humiliations, dehumanization, and torture. Other children, who survived in hiding, often lived under assumed identities and in perpetual fear that they would be discovered or be reported to the Nazi authorities. Most were isolated, many confined in small dark places, and some were subjected to abuse at the hands of the persons they thought would protect them. Most of these children lost family, friends, home, and belongings.

A large body of both clinical and empirical studies of child Holocaust survivors indicate that many still suffer from severe and debilitating disturbances including depression, guilt, somatization, anxiety, abnormal sleeping pattern, and cognition and memory deficiencies (Dor-Shav 1978; Eitinger 1963, 1973; Niederland 1964, 1968). Studies also reveal that many of these survivors find it difficult to trust others and to form and maintain intimate relationships (Chodoff 1963; Dor-Shav 1978; Eitinger 1963, 1973; Krystal 1968).

Nonetheless, some researchers claim that, in general, survivors are an emotionally healthy group as many of them have demonstrated recuperative power and have accomplished social tasks (Harel 1982; Krell 1985; Leon et al. 1981; Moskowitz 1983; Orenstein 1981). These observations point to considerable variability in survivors' responses and cast doubt on the hypothesized generalized vulnerability of the survivors. Some researchers

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(e. g., Harel 1982; Leon et al. 1981) claim that most pathological findings stem from a methodological artifact, because these studies are based on help-seeking clinical populations and did not include either child Holocaust survivors who had not applied for psychological assistance or adequate control groups. However, Dasberg (1992) claims that even among the non-clinical population, despite successful careers, there is a deep loneliness, difficulties in belonging, and an inability to enjoy success without feeling guilty.

The present study aims to assess two long-term consequences of being Holocaust child survivors: (1) post-traumatic stress symptoms and (2) fears of intimacy. The implications of the unique characteristics of the exposure in these outcomes are examined. These variables will be examined among treated and non-treated Holocaust child survivors, and a control group that did not experience the Holocaust.

■ Posttraumatic stress disorder (PTSD)

The most common and conspicuous sequela of trauma is posttraumatic stress disorder (American Psychiatric Association 1994) marked by a variety of intrusive, avoidance, and hyper-arousal symptoms and often accompanied by heightened anxiety, depression, and hostility (e. g., Shalev 2001). Several empirical studies that examined child Holocaust survivors support the hypothesis that child survivors are at increased risk for developing PTSD. Orwid et al. (1995) found that all the 21 Jewish Holocaust survivors that they interviewed met DSM-IV criteria for PTSD. Kuch and Cox (1992) found that 46 % of the 124 Holocaust child survivors met DSM-III-R criteria for PTSD. Two recent studies reported similar rates of PTSD symptoms (Cohen et al. 2001; Lev-Wiesel and Amir 2000). Yehuda et al. (1997) found that some symptoms, such as intrusive thoughts and irritability, were endorsed by more than 80 % of the sample. While the findings are consistent, none of these studies made a distinction between clinical and non-clinical populations when evaluating PTSD.

■ Fear of intimacy

Among additional functions that trauma is believed to undermine is the ability to create and maintain intimate relationships (Solomon 1993). This is particularly salient in human-made trauma (Herman 1992). As noted, most children who survived the Holocaust experienced premature and traumatic separation from their parents. Thus, they were deprived of emotionally nourishing, stable, and secure parent-child relationships.

Furthermore, very early in life as children they witnessed human cruelty more than love and caring. Such experiences in formative years often undermine the sense of self, the ability to trust others, and the capacity to form and maintain intimate relationships. Accumu-

lated clinical impressions suggest that even socially successful child survivors suffered from deprivation and developmental interference in acquiring basic trust and the capacity for reattachment, as well as affective isolation, suppressed anger, and damaged ability for intimacy (Hogman 1985). Shoshan (1989) claimed that early disruptions cause identity disorder in late life and undermine a full experience of belonging. Empirical findings noted identity problems, feelings of insecurity, difficulties with interpersonal contact, and impaired emotional expression (Krell 1985).

■ Exposure-related variables

Studies conducted on Holocaust survivors (Lev-Wiesel and Amir 2000; Yehuda et al. 1997) suggest that some of this variability may be explained by factors related to each survivor's individual traumatic experiences: the length, type, and severity of exposure, age during the Holocaust, whether or not he/she was with the parents throughout the Holocaust, and if he/she was not with parents, his/her age at separation.

Results regarding type of exposure and PTSD findings are inconsistent. Kuch and Cox (1992) found that persons who had been in a concentration camp were three times more likely to meet diagnostic criteria for PTSD than persons who had not been in concentration camps. However, Yehuda et al. (1997) and Lev-Wiesel and Amir (2000) did not find differences in the level of PTSD between survivors who had been prisoners in concentration camps and others who had been in hiding.

Regarding age at the time of the trauma, two studies conducted on child Holocaust survivors found differential patterns between age at the time of trauma and current symptoms. Yehuda et al. (1997) found that older age at the time of trauma was associated with increased symptoms of intrusive thoughts and nightmares, while participants who were younger at the time of Holocaust were more likely to report current symptoms of amnesia, emotional detachment, and hyper-vigilance. Sigal and Weinfeld (2001) found that prolonged stress was apparent among those who were teenagers or adults at the end of the war, but not among those who were children or preteens.

The current study examines the impact of the Holocaust on both treated and non-treated survivors. Since most of the literature to date is on clinical populations, the study addresses the question of whether non-clinical child survivors of the Holocaust suffer from similar mental distress and impaired intimate relationships. As mentioned before, earlier studies suggested that treated child Holocaust survivors are more vulnerable than a non-professional help-seeking cohort. It is, however, plausible that the latter group's failure to obtain treatment is part of an avoidance process associated with PTSD and that this group is as impaired, if not more so, than those seeking help. In addition, it might be that different exposure in earlier years can explain the variabil-

ity in later outcomes. The study will examine the differences between the groups as well as the implications of exposure-related characteristics in the variability in those outcomes without extrapolating specific hypothesis.

Subjects and methods

Participants and procedure

The sample comprised three groups totaling 134 participants.

The *treated child survivor* group consisted of 43 Holocaust survivors who received psychotherapy from AMCHA (Israeli Association for Psychosocial Support of Holocaust Survivors and the Second Generation). Participants of this group were approached through their therapists. They had either completed treatment a short time before the study or were still in treatment at the time of the study. Treatment was based on the psychodynamic approach and lasted between 1 and 5 years. Participants who expressed willingness to participate in the study received and returned the questionnaires by mail. Their response rate was 80%.

The *untreated child survivor* group consisted of 48 participants who also went through the Holocaust as children, but did not seek professional help. These participants were located via records in the "Yad Vashem" Memorial Institute of the Holocaust and Holocaust Survivors in Israel and via the first conference of child survivors held in Israel in 1992. The response rate in this group was 94%; of the returned questionnaires, 4% were not fully completed and thereby excluded from the study.

The *control group* consisted of 43 Israeli-born participants who did not experience the Holocaust. These participants were recruited with the help of the Holocaust survivors in the other groups who were asked to locate friends willing to participate in the study. Potential participants received questionnaires through the mail, and 85% of them responded.

Table 1 presents socio-demographic data on the three groups. Half or more of the participants in all three groups were women, most of them married. Significant group differences were found in age, education, and employment. Participants of the control group were significantly younger than the two other groups [$F(2,133) = 27.01$; $p < 0.001$] (Controls: $M = 55.88$ years, $SD = 4.29$; treated survivors: $M = 61.70$ years, $SD = 4.88$, non-treated $M = 62.06$ years, $SD = 4.10$). Only 30% of the treated child survivors had a university education, as opposed to 40% of the untreated survivors, and 74% of the control

group. Along similar lines, fewer than half the treated survivors were employed, as opposed to 71% of the untreated survivors, and 93% of the control group.

Measures

PTSD inventory

PTSD was assessed via the PTSD Inventory which is a self-report scale based on DSM-III-R criteria (APA 1987). The questionnaire consists of 17 statements corresponding to the 17 PTSD symptoms listed in the DSM-III-R (APA 1987). Participants were asked to indicate whether or not they had suffered from each symptom in the previous month and whether or not they had suffered from it at some time in the past. While the research group related to the Holocaust, the participants of the control group were asked whether they had experienced an extreme event. If they answered "yes", they were directed to answer whether they had experienced these symptoms. Based on their responses and according to the DSM-III-R, participants were diagnosed whether they had had PTSD some time in the past, and/or at the time of the data collection. In addition, the number of symptoms endorsed gauged the intensity of posttraumatic symptomatology.

The scale was found to have a high convergent validity when compared with diagnoses based on structured clinical interviews (Solomon, et al. 1994).

Internal consistency among the 17 items in the current sample was high (Cronbach alpha = 0.89 for symptoms in the previous month; and 0.83 for symptoms in the past).

Fear of close personal relationships questionnaire (FCPRQ)

This questionnaire was developed by Sheehan (1989) on the basis of Feldman's theory (1979) of marital intimacy. Feldman names five types of fear of intimacy, each stemming from a specific underlying problem: 1. *Fear of merger*, of losing individuality within the dyadic relationship, which is prominent among people with a weak sense of self; 2. *Fear of exposure*, exhibited especially by people with low self-esteem and self acceptance; 3. *Fear of attack*, which occurs when personal relations are associated with fears stemming from early developmental stages; 4. *Fear of abandonment*, typical of people who experienced traumatic separations and formed an unconscious association between intimacy and loss; and 5. *Fear of one's own destructive impulses*, in which unresolved childhood anxieties stand in the way of adult intimate relations.

The questionnaire contains 30 questions, six items for each type of fear (e.g., Are you worried that your partner may leave you? Do you tend to cling to others?). Participants were asked to indicate how fre-

Table 1 Distribution of socio-demographic variables by research groups

	Treated child survivors N (%)	Untreated child survivors N (%)	Control group N (%)	
Gender				
Male	16 (37)	24 (50)	22 (51)	
Female	27 (63)	24 (50)	21 (49)	$\chi^2 = 2.1$; df = 2
Family status				
Married	33 (77)	45 (94)	36 (86)	
Unmarried	10 (23)	3 (6)	6 (14)	$\chi^2 = 5.36$; df = 2
Education completed				
Elementary school	7 (16)	8 (17)	1 (2)	
High school	11 (27)	10 (21)	8 (19)	
Professional	13 (30)	11 (23)	2 (5)	
Academic	12 (28)	19 (40)	32 (74)	$\chi^2 = 32.74^*$; df = 6
Present occupational status				
Work	20 (48)	34 (71)	40 (93)	
Does not work	22 (52)	14 (29)	3 (7)	$\chi^2 = 21.14^*$; df = 2

* $p < 0.001$

quently they showed each behavior in their current or last intimate relationship on a scale ranging from 1 (never) to 5 (always).

Sheehan (1989) reported good psychometric properties and Cronbach alphas ranged from 0.57 to 0.78 for all five types of fear.

Holocaust experience

In the current study, we examined two exposure variables: type of exposure (concentration camp vs. hiding), and age at the beginning of the war.

Results

First, we examined the rate of participants in each of the groups that suffer from PTSD. Table 2 presents the number and percentages of participants in each of the groups and the results of χ^2 .

As shown in Table 2, the groups significantly differed. Further χ^2 analyses between each of the two groups revealed that regarding PTSD in the past, a significant difference was found only between the treated survivors (76.7%) as compared to the two other groups. Regarding current PTSD, the total number of participants who suffer from PTSD is smaller, but the three groups significantly differ: 46.5% of the treated group suffer from PTSD, 22.9% of the untreated group, and 7% among the controls.

Second, we examined group differences in the level of posttraumatic symptoms in the past and in the present. MANOVA analysis revealed a significant main effect beyond the two periods [$F(4,250) = 12.68$; $P < 0.001$]. Scheffe tests for pair's comparison revealed significant differences in the mean number of current PTSD symptoms in all three groups. As can be seen in Table 2, the treated Holocaust survivors reported the highest number of symptoms, the untreated survivors the next high-

est, and the control group the fewest. The tests also reveal a significant difference in the mean number of past PTSD symptoms of the treated survivors and the other two groups.

Third, we examined the group differences in fear of intimacy. MANOVA analysis revealed an overall significant effect for all types of fear of intimacy [$F(10,248) = 7.43$; $p < 0.001$]. Scheffe tests for pair's comparison were carried out on each of the five dimensions of fear of intimacy. These tests revealed significant differences between Holocaust survivors in psychotherapy and the other two groups. As seen in Table 2, the treated survivors reported greater fear of intimacy on all five dimensions than the other two groups. The greatest difference was in their augmented fear of abandonment.

Since the groups differed in age, education, and occupational status, a MANCOVA was carried out to determine whether these differences affected the group differences in posttraumatic symptoms and fear of intimacy. No significant effects were found. Thus, the group differences in PTSD symptoms and fears of intimacy were not associated with either education or employment.

Finally, we examined the association between type of exposure and age at exposure to the variability in outcomes measures. We found that 26 participants (29%) had stayed in concentration camps and 65 participants (71%) had stayed in hiding. No significant association between type of exposure and research groups was found ($\chi^2 = 0.63$, $df = 1$; $p > 0.05$).

Manova analysis of 2×2 (group X type of exposure) revealed only the significant effect of exposure. Survivors who had been in concentration camps reported significantly more past and current PTSD symptoms ($M = 11.73$; $SD = 0.18$ in the past and $M = 7.65$; $SD = 0.26$

Table 2 Rates and means of PTSD, and fear of intimacy by research groups

	Treated child survivors (N = 43)		Untreated child survivors (N = 48)		Controls (N = 43)		
	N	%	N	%	N	%	
Past PTSD	33	76.7%	19	39.6%	13	30.2%	$\chi^2 = 21.01^{***}$
Current PTSD	20	46.5%	11	22.9%	3	7%	$\chi^2 = 17.99^{***}$
	M	SD	M	SD	M	SD	
Mean number of past PTSD symptoms	12.24	0.18	8.67	0.23	7.14	0.23	21.50 ^{***}
Mean number of current PTSD symptoms	8.33	0.25	4.76	0.28	2.55	0.20	20.31 ^{***}
Fear of intimacy							
Fear of merger	2.93	0.73	2.25	0.62	2.12	0.66	20.07 ^{***}
Fear of exposure	2.55	0.74	2.31	0.55	2.224	0.64	3.01*
Fear of attack	2.86	0.68	2.56	0.57	2.39	0.57	6.66 ^{**}
Fear of abandonment	2.46	0.62	1.81	0.50	1.84	0.39	20.48 ^{***}
Fear of own destructive impulses	2.93	0.73	2.25	0.62	2.12	0.66	20.07 ^{***}

*** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$

in the present) than survivors who had been in hiding ($M = 9.86$; $SD = 0.26$ in the past and $M = 5.95$; $SD = 0.29$ in the present). No differences were found in the fear of intimacy of those who had survived in the different settings.

Pearson correlations were carried out on the study groups to determine the association between the age at the start of the war and outcome measures (Table 3).

Age at the start of the war had a significant association only among the non-treated survivors. The untreated survivors who were older during the Holocaust reported higher rates of posttraumatic symptoms. An insignificant similar trend was found also among the treated survivors.

Discussion

The findings show a complex pattern: both treated and non-treated child survivors of the Holocaust reported higher levels of posttraumatic symptoms than the non-Holocaust controls. This finding emphasizes the long-lasting impact of the Holocaust experiences on the survivors. It emphasizes the enduring nature of early traumatic experiences and is consistent with the literature on individuals who were exposed as children to other traumatic experiences (Terr 1991).

At the same time, the findings also demonstrate variability in responses among survivors. There was a clear difference between those who were in therapy and those who were not. The treated group reported a higher level of both posttraumatic distress and fear of intimacy in all five dimensions, and especially in fear of abandonment, than the non-treated survivors. These findings can be interpreted in two ways. One interpretation is that the treated survivors sustained more serious psychological injuries than the non-treated survivors and that their elevated levels of distress motivated them to seek therapeutic help. This explanation is supported by clinical impressions made on child Holocaust survivors which show that this group of survivors is at high risk for psychopathology and adjustment problems (Moskowitz and Krell 1990; Robinson et al. 1994; Tauber 1996). This explanation also receives support from studies of traumatized war veterans which have shown that those who seek treatment reported a higher level of pre-treatment symptoms than traumatized soldiers who did not seek treatment (Solomon et al. 1994).

Table 3 Pearson correlation between age at the start of the war and outcome measures

	Treated Holocaust survivors	Untreated Holocaust survivors
Past PTSD symptoms	-0.17	0.03
Current PTSD symptoms	0.20	0.32*
Fear of intimacy	-0.23	0.04

* = $p < 0.05$

The other possible explanation is that the greater report of distress observed among the treated survivors is not an antecedent of treatment, but rather a result. Treated survivors may have become more aware of and more able to admit and report their distress. This is specifically relevant to psychodynamic treatments. While behavioral and cognitive therapies have been consistently shown to be the most effective in symptom relief, other approaches do not target symptoms so directly (Tantam 2002). It could be hypothesized that psychodynamic therapy that does not attempt to directly address and reduce PTSD symptom, will indeed raise the client's awareness of them without reducing them. This interpretation is supported by findings obtained from a group of traumatized soldiers who underwent a treatment program for posttrauma. At the end of the program, these soldiers reported more symptoms than a group of posttraumatic controls that had not undergone treatment, as well as more symptoms than they had had at the start of the program (Spiro et al. 1989).

This study cannot differentiate between these interpretations. However, yet another finding of this study, namely that there were no significant differences in the fear of intimacy of the untreated survivors and the control group, lends support to the first interpretation. It suggests that the untreated survivors did not have unusual problems of intimacy and probably fared better than the treated survivors in their interpersonal relationships.

This study also points out that almost one-quarter of the untreated child Holocaust survivors suffered from PTSD at a clinical level during the data collection, and 40% reported that they had suffered from PTSD in the past, but had not applied for psychotherapy. This finding is consistent with a recent study that found that supposedly healthy non-clinical child survivors exhibited posttraumatic symptoms to a degree far beyond what is expected of healthy people, but did not ask for help (Cohen et al. 2001).

Dasberg (2001) suggests that this population as children, and later as young adults and adults during the rebuilding phase, wanted nothing better than to be normal, like other children. Therefore, they acquired the ability to induce and maintain a split between their outward tenacity and resilience and the inner hidden, hurt child. The struggle for normal life could not accommodate asking for therapy.

In addition, not asking for therapy might be due to the low accessibility of therapeutic centers especially for Holocaust survivors. The social climate in Israel in the first years after World War II resulted in a conspiracy of silence that caused repression of emotions and feelings. It was only in the 1980s that specific centers for Holocaust survivors were established and asking for treatment was not considered shameful.

Concentration camp survivors, both treated and non-treated, reported significantly higher levels of posttraumatic symptoms than those who had been in hiding. The probable reason is that, on the whole, the concentration

camp survivors had been exposed to more frequent and intense brutality than those who had survived in hiding. These findings are consistent with clinical reports that describe camp survivors as having greater difficulty in processing the trauma, as manifested in their low ability to cope with memories of the Holocaust, than those who survived in hiding (Robinson et al. 1994). These findings are inconsistent with recent studies that did not find differences in the level of PTSD symptoms between concentration camps and hiding (Lev-Wiesel and Amir 2000; Yehuda et al. 1997). Studying the association between the type of experience in the Holocaust and long-term adjustment is a complicated issue. First, some people were exposed to more than one type of experience. Second, while studies statistically controlled some of the variables, other variables were not controlled, so it is difficult to detect the unique contribution of type of exposure. Moreover, most studies, including ours, have small samples that can bias the results. It appears that the type of experience does have an impact on later adjustment, but this impact, due to the extraordinary experiences of the Holocaust, is more complicated and needs more detailed study.

Age at the beginning of the war had a significant effect only among the untreated survivors. The non-treated survivors who were older during the Holocaust reported higher levels of posttraumatic symptoms. This finding is consistent with earlier findings (Sigal and Weinfeld 2001; Yehuda et al. 1997). Sigal and Weinfeld (2001) suggest that this might be due to differences in cognitive development. By adolescence, children become capable of perceiving their own vulnerability and can evaluate the threat of traumatic events (Fletcher 1996). The older participants may have more fully grasped the significance of their experiences and, as a result, have been more traumatized than the younger ones.

This study has several limitations. The three study samples were relatively small, so we cannot assure their representation. This limits the generalizability of the findings. Moreover, the scope of the study made it impossible to include more variables regarding the specific Holocaust experiences of the survivors, as well as other experiences both preceding and following the Holocaust which may have had an impact on their adjustment. In addition, the knowledge about the treatment clients received is rather incomplete and should be elaborated in future studies.

Conclusions

Finally, the study highlights the variability among Holocaust child survivors. Treated survivors suffer from more posttraumatic symptoms and greater fears of intimacy than untreated survivors. While the study samples are quite small, we found different patterns between type of exposure and age and the long-term measures of adjustment. In addition, we identified some people who

suffer from a high level of posttraumatic symptoms who did not apply for treatment.

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