A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation entitled 'exploring the experience of women who were born to Holocaust survivor mothers: an Interpretative Phenomenological Analysis study'.

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Dedication

This manuscript is dedicated to my father, his brother and his sister who survived the Holocaust, and who without knowing it were an inspiration to me due to their strength, resilience, and determination to create a life that is worth living. This manuscript is also dedicated to the memory of all the members of their large family that lost their lives in the camps.
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Statement of Anonymity

The confidentiality of clients, participants, supervisors and placements has been protected throughout this Portfolio. Pseudonyms have been used in every instance, and any identifying information has been changed or omitted to ensure the anonymity of all people or institutions involved.
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Contents

Introduction to the Portfolio p. 7-13

Academic Dossier p. 14-55

Introduction to Academic Dossier p. 15-16

Essay 1: Erikson & Erikson (1981) saw the major developmental issue in mid-life in terms of ‘generativity versus stagnation’ challenge. How might a Counselling Psychologist work with women who are experiencing this challenge? p. 17-27

Essay 2: Psychoanalytic exploration of non-verbal communication in the consulting room p. 28-41

Essay 3: How does Cognitive Behavioural Therapy understands and treats destructive anger? Illustrate the challenges to the therapeutic relationship with examples from your own practice p. 42-55

Therapeutic Practice Dossier p. 56-86

Introduction to Therapeutic Practice Dossier p. 57

Description of Clinical Placements p. 58-62

Final Clinical Paper: in search of a professional identity p. 63-86

Research Dossier p. 87-241

Introduction to Research Dossier p. 88-89

Year One: Literature Review: trauma transmission between mothers who are Holocaust survivors and their daughters p. 90-131

Year Two: Qualitative Report: exploring the experience of women who were born to Holocaust survivor mothers: an Interpretative Phenomenological Analysis study p. 132-192

Year Three: Quantitative Report: an investigation into the conceptualization of Holocaust trauma transmission between generations by Psychologists and Therapists p. 193-241
Introduction to the Portfolio

This Portfolio consists of a selection of the work that has been carried by me in partial fulfilment of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology course at the University of Surrey. The Portfolio consists of three dossiers: academic, therapeutic practice, and research. These three dossiers convey to the reader some of the learning that was taken place by me during the three years of the course in terms of theories and issues engaged with, clinical experience reflected upon, and the research conducted.

The introduction is intended to provide the reader with some clarification about who I am in terms of background and interests, and how I see the link between this and the issues and arguments presented in the components of this Portfolio.

As will become clear from my name I am not English. In fact I was born in Israel to parents who immigrated to Israel from Eastern Europe. I also spent seven years in Italy in my twenties. An important part of my background stems from the fact that my father was a Holocaust survivor and that I was the first born and my name is the translation into Hebrew of the name of his mother who lost her life in Auschwitz.

I was surprised, and in a way relieved to discover, that being Jewish or an offspring of a Holocaust survivor was not mentioned as an example of being an 'other', while studying this module in University (in the same way that race, sexual orientation, or handicap was). Maybe this is a welcome development, confirming that anti-Semitism is no longer an issue. I however always felt that my Holocaust background was significant in the making of who I am, and I was hoping to be able to conduct some research on this topic. The course provided me with an opportunity to research this topic, and this is the topic of the research
presented in the Research dossier of this Portfolio. I chose to focus on the transmission of trauma within the mother-daughter dyad, which is different to my own (father-daughter dyad), because I wanted to explore the specificity of trauma transmission compounded by the possible effects of a period of physical symbiosis (pregnancy and nursing,) and gender identification. I also thought that I would be better equipped to process material that was not entirely recalling my own situation.

The other effect of my background is that due to the multiple influences of different cultures I was exposed to, I can not identify completely with any specific nationality or religion or race. I see the strengths and limitations in social groups and find it relatively easy to relate to people as individuals.

As I am writing these lines, the news flows in about the War between Israel and the Hezbollah. I feel worried about my parents who are being bombed in Haifa, but I am also mortified to hear that innocent people are killed in Lebanon.

While this is not directly discussed in the Therapeutic Practice dossier, I feel that this quality is essential to the way I see myself as a person and as therapist. Part of what I try to bring to the consulting room is the legacy of survival and the belief in consciously trying to repair and increase ‘wellbeing’ in the world. I feel that the way I internalised my family’s history of loss, re-location, suffering but also endurance, made me hopefully more determined and able to be literally a ‘helping professional’, empathise with people as human beings, and be relatively free from the tyranny of stereotypes and prejudice. I would like to believe that this attitude will make me able to work with
members of the rich human tapestry of a cosmopolitan city like London.

I decided to apply for the training in my forties. Despite working as an honorary psychotherapist in a Psychotherapy clinic for a number of years and reading a lot, I have been mostly a mother and a housewife for the 15 years prior to this moment. Furthermore, my University degree, completed in Italy, required mostly passing exams, and I was not aware of my ignorance in the skills needed in order to produce coursework. In short, I was not familiar with the demands of academic writing. I was not familiar with the latest technology (computers) either. Embarking on this training despite all these challenges was my statement towards the challenge that I was faced with by my own middle age. Some further exploration into this lifespan challenge is covered by my first essay that looks into Erikson’s construct of ‘generativity versus stagnation’ challenge in mid life.

Psychology and psychotherapy are verbal disciplines, and I fully appreciate the contribution of words to the clarification and structuring of feelings and thoughts in both spoken and written forms. Together with this however, I am aware of the limitations of words and of the incredible richness and subtleties that are conveyed in nonverbal communication. This is particularly salient in psychodynamic practice where more emphasis is placed on silences and rarefied slow interactions. My second essay explores the nonverbal aspect of communication that takes place in the consulting room, from a psychoanalytic perspective.

The third and final essay is looking at the conceptualization and treatment of destructive anger as seen through the prism of Cognitive Behavioural Therapy model. The opportunity to co-run a group for the
treatment of 'anger management' provided me with the stimulus to search the literature on this topic, and also to apply clinical techniques to help members of the group to deal with their anger problems. My personal take on this is that like many children of Holocaust survivors, I was quite estranged to my own anger and definitely to the expression of it. The reason for this was that there was an unconscious communication from my father that anger was not allowed, because to be angry made us similar to the Nazis. So in a way, my link to the problem of anger was that I had 'no anger' and found being assertive difficult. I became aware of this repression and more able to experience conscious anger while in analysis.

I will now describe the purpose and content of the three dossiers that this Portfolio contains:

**Academic Dossier**

The academic dossier contains three essays. While these three essays do not intend to cover all the learning accomplished during the three years of my training, I think that they represent three domains of learning that were useful and informative to my growing psychological knowledge.

Essay 1 deal with theories related to 'lifespan issues' (in this particular case Erikson's ideas on the challenges faced by women in mid life), and how they compare with the knowledge obtained by research on this topic. This search for theoretical information scrutinised by testing (theories), provided me I believe with an important dimension of useful learning.

The second essay represents a different kind of learning: in fact it focuses on the non-verbal communication in the consulting room,
explored from a Psychoanalytic perspective. This is a kind of more holistic learning that relies on developing sensitivities, attention to nuances and the capability to notice subtle cues. I found this kind of learning an important channel of perception and analysis, despite being less obvious than the more explicitly cognitive one.

The third and last essay is dealing with more specific, practical, and theory driven learning. More specifically it focused on the conceptualization of anger and application of treatment for destructive anger from a CBT perspective. This kind of learning represents ‘evidence based’ knowledge, and contains specific theories that were developed in order to understand and treat specific presenting problems. While this kind of knowledge is not universally applicable or useful, I found it to be an important reservoir of informative ideas and techniques.

**Therapeutic Practice Dossier**

This dossier is meant to provide the reader with an idea of my activities as a practitioner during the last three years. While the real flavour of a session can not be recreated once it’s over, describing the Placements, the kind of clients seen, supervision and some idea about my activities and responsibilities, might help the reader to get some idea of the settings which were ‘the stage’ on which therapy took place.

The main focus of this dossier is provided by my ‘Final Clinical Paper’. In this paper I have tried to describe the background to my decision to train as a Counselling Psychologist. I also reflected on my experience in each Placement, how I negotiated new models and what I have been able to assimilate from the different models, settings and supervision styles that I was exposed to. This paper also provide the reader with
some idea of my sense of identity as a practitioner at present, and how I see myself developing in the future.

In order to help the reader get some sense of my practice, The 'Final Clinical paper' discusses examples of clients that I found particularly typical or interesting or challenging in each of the three years and invites the reader to contemplate my strengths and weaknesses in my therapeutic engagement with them. I would like to specify here that as already mentioned in the 'Statement of Anonymity' all clients were given pseudonyms and all information that could disclose the identity of a person or an institution was changed.

Research Dossier

The Research Dossier contains three independent reports on Holocaust trauma transmission. While they were written as three separate journal articles, there is a logical evolution in the way they developed, and in a way they could be seen as three stages of the same enterprise.

I was surprised to discover how extensive the published literature on this topic was and that much was written by people like me in the sense that they were ‘second generation’ (children of Holocaust survivors). Is this some sort of collective sublimation of the effect of trauma transmission? I know that researching this topic was emotionally difficult for me, but was also one further step on the road to recovery across generations.

I often asked myself whether the experience of conducting research on this topic would have been any different had I studied in Israel. There is no way to know of course, but I assume that being away and out of ‘cultural immersion’, was protective and made engaging with
such a painful topic possible. I also think that because I was 'AWAY' I could think about this topic from a more objective perspective.

The research dossier consists of both Qualitative and Quantitative research methods and I enjoyed applying both and found both useful in different ways.

The three dossiers are presented next, all prefaced by an introduction in order to outline the content of the elements that are included for the benefit of the reader.
ACADEMIC DOSSIER
Introduction to Academic Dossier

The academic dossier contains three essays that I have selected from the ones written during the time of my training.

The first essay is entitled: ‘Erikson & Erikson (1981) saw the major developmental issue in mid-life in terms of generativity versus stagnation. Consider the ways in which women in mid-life might respond to this ‘generativity versus stagnation’ challenge. How might a Counselling Psychologist work with women who are experiencing this challenge?’

This essay looks into Erikson’s understanding of the psychological dynamics common to women in mid life. I then compared his idea of the challenges women face during this time in their life, to the picture that emerges from some modern studies carried on women who are facing this period in their life. I am arguing in this essay that Erikson’s theory was not always able to provide a useful understanding of the situations and conflicts faced by these women. I also propose a potential alternative way of understanding the processes that women might experience in mid-life.

The second essay is entitled: ‘Psychoanalytic exploration of non-verbal communication in the consulting room’.

In this essay I try to check whether there is evidence for the effectiveness and importance of what can be communicated through non verbal means within the consulting room. This essay was written from a psychoanalytic perspective and tries to differentiate between various levels of nonverbal communication, looks at non verbal communication of both therapist and patient and also argues that some psychosomatic illnesses can be understood as unconscious non
verbal communication. Vignettes to illustrate the points made are provided.

The third and last essay is entitled: ‘How does CBT understand and treat destructive anger? Illustrate the challenges to the therapeutic relationship with examples from your own practice’

This essay was written from a Cognitive Behavioural perspective. In it I look into the clinical phenomena of destructive anger which is when anger (a normal emotional response) happens too often, lasts too long, spoils relationships, leads to violence or is interfering with good health. In this essay I discuss the anger profile as it emerges from the cognitive behavioural literature. I also explore some of the models that were offered in order to theoretically explain how destructive anger operates, and then I describe strategies that were suggested by some cognitive authors in order to alleviate this problem. Vignettes to illustrate the unique challenges presented by clients who are destructively angry, are provided, taken from my case load of individual work and the ‘anger management group’ I co-run as part of my third Placement.
ESSAY 1

ERIKSON & ERIKSON (1981) SAW THE MAJOR DEVELOPMENTAL ISSUE IN MID-LIFE IN TERMS OF 'GENERATIVITY VERSUS STAGNATION'. CONSIDER THE WAYS IN WHICH WOMEN IN MID-LIFE MIGHT RESPOND TO THIS 'GENERATIVITY VERSUS STAGNATION' CHALLENGE. HOW MIGHT A COUNSELLING PSYCHOLOGIST WORK WITH WOMEN WHO ARE EXPERIENCING THIS CHALLENGE?

INTRODUCTION
Erikson is closely associated with the view that development is a lifelong process (Gross, 1996, p.598). He also had a clear idea about the tasks people face during their middle age years. This essay looks into Erikson's understanding of the psychological dynamics common to women in mid life. These are then compared with the picture that emerges from some modern studies carried out on women during this time. Following a short review of Erikson's theory, some of the potential conflicts women in mid life might find themselves struggling with are illustrated. These conflicts start from the relatively benign ones to the more serious difficulties: the response of women to their children leaving home; the need to consolidate an identity while struggling with other competing tasks; the choice of avoiding challenges and opting for a 'happy stagnation' and its potential risk; the shadow side of being a carer; and a failure to deal with emotions in a healthy way as well as what constitutes 'recovery'. I am arguing that Erikson's theory was not always able to provide a useful understanding of these situations and conflicts. A criticism of Erikson using the findings of Carol Gillian is mentioned and a proposition for a potential alternative (no stage theory) way of understanding the processes that women might experience in mid-life is offered. A section on recommendations for
practice with women of this age is also included.

**ERIKSON’S VIEW ABOUT MID LIFE**

Erikson’s theory of psychosocial development is epigenist in the way that it is based on an embryological principle and maintains a fixed pattern of development dictated by a genetic structure and common to all humans (Gross, 1996). He believed that the interaction between the individual and the social environment produces eight psychosocial stages, each of which centers around a developmental crisis. Each stage is thus negotiated through a complex interaction of biological, psychological and social factors that accompany an individual’s progression through life. A crisis point according to Erikson is where development must move either in the direction of strength and vitality or alternatively in the direction of weakness and dysfunction (Hoare, 2002).

The challenge people have in mid life was named by Erikson generativity versus stagnation. The term generativity was originally used in the context of the establishment of the next generation. In a later softening of his position however he no longer maintained that one must have children in order to be generative (Hoare, 2002). Erikson (1963) suggested that generativity has relevance to everything that is created from generation to generation. He subsequently developed his theory of adulthood as the critical antithesis of generativity (which encompasses procreativity, productivity and creativity) versus self-absorption and stagnation (Erikson, 1982). It is this wider definition that I have adopted for the purposes of this essay within which generation can be applied to new beings as well as to new products, new ideas, and a kind of self-generation concerned with further identity development. Erikson suggested that where such enrichment (i.e. generation) fails altogether, stagnation and interpersonal
impoverishment sets in. This idea is reported by Gross (1987) who talks about the stagnant person as someone who is self centered, and over-concerned with their own self and health. In this way Erikson came to conceptualize generativity as a sublimation of genital sexuality and its pathological absence as narcissism which reflects a needy self love (Hoare, 2002). Failing to develop the capacity to determine who to care for, 'no generative' adults turn on others as a form of outward rejection and against themselves in inner self rejection (Erikson, 1980, cited in Hoare, 2002). Erikson thought of the virtue of 'care' as emerging from a healthy resolution of this conflict. Thus it manifests as a growing commitment to take care of persons, products or ideas that one cares for. He further suggests that care is an instinctual and natural response evoked by helplessness (Erikson, 1982).

WAYS IN WHICH WOMEN IN MID-LIFE MIGHT RESPOND TO THIS 'GENERATIVITY VERSUS STAGNATION' CHALLENGE

Various studies focused on the response of women to their children leaving home. Early studies (Bart, 1971, cited in Prozan, 1993) talk about the frequency of depression in middle aged women on first hospitalization. Bart concluded that most of them were affected by their children leaving home. This study pointed out the potential dangers to women in focusing on motherhood as the only meaning in life. Subsequent examination of these women however, emphasized the pathological symbiosis between them and their children as the cause for their feelings of emptiness when their children left (Prozan, 1993, p.443). More recent research on the subject by Rubin (1979, cited in Prozan, 1993) revealed a different attitude towards the 'empty nest' among American women who were actually relieved to have more time for them when their children left home. Thus the women in mid-life who suffered from the 'empty nest' syndrome were those who lost themselves in the process of child rearing and experienced an identity
crisis when the children left. Most women in Rubin's study were sad when their children left but not depressed. These findings are supported by Durkin's research. (Durkin, 1995, cited in Gross, 1996, p.611). He found that most women did not find their children leaving home very distressing. On the contrary, many found the end of childrearing responsibilities liberating and welcomed the new opportunities for a closer relationship with their partner, personal fulfillment through work, education etc.

Arnston (1978, cited in Prozan, 1993, p.445) argues that some women experience a crisis in mid life because unlike men, they must defer identity consolidation until middle age. This was particularly true for the group of 'home makers' (one of four groups Arnston devised and studied), that in her view found it particularly difficult to grow as autonomous human beings during the years of raising a family and attending to the demands of others. The domestic role did not provide these women with a positive self image due to the message of the feminist movement that depreciated their previously respected role. They expressed the need to assert themselves and find self-fulfillment and personal enrichment through work. The other groups of women in her research (early professionals, late professionals and super volunteers) all had their relative difficulties: the early professionals felt guilty for not bringing up their children or choosing not to have them, the late professionals were not able to develop their careers properly and the super volunteers felt frustrated about not doing 'something real'. Arnston concluded that "there is no free lunch when it comes to women's choices"(Arnston, 1978, cited in Prozan, 1993, p. 449). There were however gains and losses in each of the four choices.

It is interesting to notice that some models (see lifespan model of developmental challenge as proposed by Hendry & Kloep, 2002)
suggest a state of a 'happy stagnation' where women in mid-life might be happy with the quality of life they are having. They operate within a well known well mastered set of circumstances and are trying to avoid challenges or changes that are too demanding. While this way of operating does not help these women to develop or increase their 'pool' of resources they are able to conduct an effective and contented life. These women are however at risk of potential future challenges which might demand better resources than what they have available.

Many women in mid-life find themselves taking on caring roles for disabled or elderly relatives. This decision might not be conscious but may follow a sense of duty. Barnes and Maple (1992) talk about the perception of women as carers, by society and by themselves. They talk about women who manage everything and everyone at considerable cost to their own needs and how unable they are to ask for help for themselves. The authors object to seeing women as informal carers, and think of their needs in relation to being a caregiver only. They talk about the stresses associated with this role. The women in their study were often depressed and were often put on tranquillizers rather than helped to understand the loss they were experiencing when the person they cared for died. The authors refer to Bowlby’s conviction that much psychiatric illness has to do with pathological mourning (Bowlby, 1980, cited in Barnes & Maple, 1992, p.81). They argue that women who see themselves as mostly carers risk becoming ill as a result of the pressure. Furthermore, the death of the person they were caring for often did not seem to liberate them but instead left a gaping hole in their lives from which they found it difficult to recover.

Paris and Bradley (2001) published a qualitative research study of three
middle aged women suffering from alcoholism. In trying to understand why women turn to addictive drinking, they refer to Covington and Surrey (1997, cited in Paris & Bradley, 2001, p.649) who suggest that many women begin to abuse alcohol in order to make or maintain connections through which they can feel loved or loving. The women in the study were not capable of generative caring before their recovery from alcoholism. In the same paper Brown's model (Brown, 1985, cited in Paris & Bradley, 2001 p.650) provides a theoretical bridge for understanding the process of psychological renewal for alcoholics. He talks about recovering alcoholics becoming more generatively caring toward others as a result of their recovery. This generative self-extension to others could involve repairing relationships that were dysfunctional during their alcohol dependence (as was the case with one of the participants who was keen on repairing the relationship with her daughter) or the mentoring of others struggling to achieve sobriety. The other important lesson of this study is however that recovery meant different things for each woman: work and independence for one, a family-like context for another and a stable relationship for a third.

HOW MIGHT A COUNSELLING PSYCHOLOGIST WORK WITH WOMEN EXPERIENCING THIS CHALLENGE?

Some women find their children leaving home very distressing. In Erikson's language they cannot find an alternative way of being generative once the most obvious way of caring comes to an end. Prozan (1993) makes use of a feminist analysis of women's lives and advocates the promotion of the woman's capacity to take active charge of her life, make decisions about her future and achieve goals. She sees life-affirming decisions as particularly important in times of transition in preventing feelings of helplessness and depression. Some CBT strategies might be particularly important here.
Women struggling to consolidate an identity while coping with other competing tasks highlight the fact that Erikson’s view of the role and nature of relational themes was narrow and androcentric (Enns, 1997). Erikson noticed that women were often gifted with intimacy but was troubled by the fact that many women did not establish a strong independent self during early adulthood. Nortman and Nadelson (1982, cited in Prozan, 1993, p.465) believe that the life stages of Erikson do not work in the same sequence for women. In the case of women, an integration of autonomy and care persists through the stages of autonomy, identity, intimacy and generativity. Thus women may be in different role patterns and phases at different times because of the particular circumstances of their lives (realities such as parenting work and marriage). Women’s identity and autonomy issues may be resolved only partially in early adulthood and then returned to later on for example when their children are grown. In terms of practice I think that these women will benefit from a Humanistic or Narrative approach that will explore with them the particularities of their unique circumstances.

Women who opt for a happy stagnation might find themselves in trouble when circumstances change unexpectedly and the resources required exceed the ones in their pool. In that case they might benefit from acquiring some new CBT strategies that will provide them with a richer pool of resources to cope with the new challenge.

Barnes and Maple (1992) insist on the need for women who have been carers to learn to claim their share of care from others. These women are in the paradoxical situation of stagnating because they have been in a way over generative and, in some cases they need to learn how to find their way into the outside world again, in other words, become ‘visible’ again (Barnes and Maple, 1992). In many cases these women
need to go through proper grief counseling before they can move on.

Brown’s (1985, cited in Paris & Bradley, 2001, p.649) developmental model of alcohol recovery is similar to Erikson’s (1963) notions of adult development as it involves progressive life tasks. In both theories, each stage is built on the completion of prior tasks. Both involve the movement toward greater interaction with the community as well as individual integrity. The recovery from alcohol dependence at the end of a successful substance misuse therapy helps the patient in completing missed developmental milestones. The picture however of a recovered ex-alcoholic is not unanimous and not for all of them generativity feature as an important outcome.

CONCLUSION
This essay explored the relationship between the way Erikson conceptualized the development of women in mid life and the way they experience their struggles during this stage. While Erikson’s concepts are generally helpful in thinking about adults, this essay argues that they miss the subtleties of women’s experience during this period in their life. As shown before, not all women find their children leaving home distressing (the end of generativity is well tolerated if they have other interests); lots of women are busy consolidating their identity well after the allocated time in Erikson’s theory and their generativity might interfere with the development of an independent identity. Some women actually manage to be generative only if their lives happily stagnate; and for others a caring attitude gone too far ends in becoming the reason for their stagnation. Finally some people lack generativity when having an alcohol problem and while some of them become generative on recovery, others do not. The reason for these discrepancies stems in my view from Erikson’s lack of understanding of the female experience. Of particular relevance is
Gilligan's suggestion (1982), namely that unlike men, women consider issues in terms of relationship, attachment and the moral voice of care. Because intimacy is so important to women, their identity might develop at a later stage. This might account for the fact that a stage theory of development like that of Erikson is not perfectly suited to account for the development and conflicts of women in mid-life and an approach that explains adult development in terms of the impact of critical life events (Gross, 1996, p.598) might be more appropriate.
REFERENCES


INTRODUCTION

The old Cartesian split between mind and body has permeated the attitude of psychotherapy as well as medicine. Psychoanalysis has privileged the role of language when thinking about the structure of the mind and in treating patients. By privileging the mind over the body, the creativity of body language failed to be recognized (Meyers, 2004).

What can we as therapists learn from observing our patients' gestures, posture, facial expressions, silences, voice, and manner of entering and leaving the room? How important is it at all? McCay et al. (1973) compared deaf and non deaf subjects and found that they did not have a significant difference in terms of psychopathology. The importance of these findings is that despite being denied verbal interaction with others, deaf children develop into relatively normal adults. This is overwhelming evidence to the important role that non-verbal language has in affective development. Another study that supports the importance of nonverbal communication is provided by Walsh (1968). He found that people in his study responded to the tone of voice and facial expressions more than to the meaning of words, when these two were incompatible. This convinced Walsh that we are more affected by non-verbal messages than by verbal ones. Body communication is often perceived only in a subliminal way. For this reason, the message conveyed by non-verbal communication is so powerful. It can rarely be controlled in the same way that verbal
communication can. This makes non-verbal communication such a rich source of unconscious and affective material (McCay et al. 1973).

While a lot was said about the use of verbal communication in the consulting room, less was written about the non-verbal communication, which as shown above is immensely important. I would like to make this the focus of interest in this paper. While acknowledging the difficulties in agreeing on the language to use when describing various models, I am going to use the terms 'therapist' and 'patient' throughout the text for the purpose of simplicity. Also the term 'psychoanalytic' will be used in its broadest general sense, meaning everything that comes under the broad umbrella of psychodynamic theory and practice. In trying to explore this topic of non-verbal communication and highlighting its richness and importance, I will make a distinction between 'body talk' and 'body language', explore non-verbal language from the point of view of patients and then of therapists, and look at the area of psychosomatic phenomena. I will end with a brief note about alternative models of therapy that focus on the body more directly. Some vignettes are provided, in order to illustrate the creativity hidden in non-verbal communication.

THE DIFFERENCE BETWEEN 'BODY TALK' AND 'BODY LANGUAGE'
Wiener (1994) describes 'body talk' as a primitive mode of communication that predates actual talking, thinking, and reflecting. It is hypothesized that body talk in adulthood, is a consequence of bad fit in the preverbal communication between mother and baby. If this early mode of communication persists, it can become a substitute for talking, thinking and reflecting and it suggests the kind of early fundamental split between body and mind, which brings to mind the term psychosomatic. 'Body language' on the other hand, is an
essential and unique component in every patient's communication about him/herself. It may be seen as complementary to, rather than a substitute for talking, thinking and reflecting.

If early relating is good enough, body language should develop out of body talk. With body language there is in Weiner's experience, less evidence in the counter transference of the kind of discomfort or dissonance between what the patient is saying and what they are conveying with their body, than there is in the presence of body talk. Weiner finds it helpful to think about three different though overlapping forms of bodily communication from patients which can be viewed as a continuum. Firstly, there are a patient's gestures, movements, way of speaking, and ways of wearing clothes which are to do with his/her characteristic way of being. Secondly, there is body language which is about the here and now of the session, and of the transference (a sudden blush, a stomach rumble). These are 'live happenings' in the room, and betray areas of feeling or anxiety which reflect the nuances of the therapeutic relationship. Finally, there are patients who bring actual somatic illness into the consulting room (psoriasis, bouts of respiratory tract infections). For these latter patients, the illness or somatic explosion might, according to Weiner, protect them from emotional experiences which feel life-threatening. The subjective experience of their body at that time might be that of dissociation and the use of body in sessions might be unconsciously intended to keep the therapist at bay).

**Vignette**

Mohamed is of Indian origin. He suffers from many psychosomatic problems and one of them is a bad back. He needs a special chair to sit on and complains a lot about not being able to sit straight or work. I understand it as 'body talk' and think his unconscious message is about
how broken he feels and how impossible he finds standing erect in front of life and its demands. He is also often discharges some pungent smell that I find offensive, but think that it is probably acceptable in his culture to eat certain foods and have certain smells and that it will be inappropriate to find unconscious meaning in his smell. I think of it as part of his 'body language'.

PATIENT'S COMMUNICATION

Psychodynamic treatment provides unique opportunities for observing transference expressed in body language and body talk. There are endless aspects to the potential non-verbal communication of patients that can be considered. Among these a difference between what the patient conveys verbally and by his body language or body talk is of an obvious interest:

Sidoli, (2000) describes one of her patients whose body sat stiffly in his chair, while his words flowed endlessly, as if intent on leaving no empty spaces during which he might catch a glimpse of his own distress. She was struck by the difference between the animation in his voice, and the lifeless rigidity of his limbs. This led Sidoli to her first glimpse of the split in him that she was otherwise in danger of missing.

Anthi, (1986) talks about the importance of observing the posture and movements of the patient on the couch. Body-based symptoms could be seen as information about the patient's unconscious fantasies that have shaped his/her body image. The patient she presents was lying on the couch on his left side only. This was because he felt compelled to present his right, better body half only, to other people, as he associated his left body half with something bad. Reconstructive work disclosed that he experienced a certain asymmetry of his testicles as an alarming sign of the left testicle being defective. His compulsive need to present his right body side, proved to be a defensive maneuver unconsciously intended to conceal his 'castrated and
effeminate left body half'.

Wrye, (1996) comments on patients who enact the transference by bringing ‘things’ or ‘voicing particular demands’ in the session: he highlights the fact that such communications often occur at a moment of stalemate in the treatment. In his view this should be seen as an evidence of something primitive, preverbal, and maybe even terrible, that was going on and could not be talked about, or perhaps even be named, by either patient or therapist. In those circumstances, the only way to bring it into the room was by enactment. Such actions (like asking to lie on the floor, or put something in the fridge, or bring a cassette for the therapist to listen to later on his own), tend to strain therapeutic neutrality. Wrye warns us about reacting rather than reflecting in such situations, which will not be in the best interest of the therapeutic process.

Gedo, (2000) talks about the appearance of long silences in the session. He thinks of it as profoundly significant events. Gedo thinks that it sometimes need to be thought of as the indication of something from the past being relived by the patient in the present. Another kind of silence is typical according to Gedo to the terminal phase of successful therapy, and has a comfortable sweet and meditative counter transference feeling attached to it.

Coltart, (1991) referred to ‘the silent patient’, who speaks for less than ten percent of the therapeutic time available to him/her in the session. Coltart sees this therapeutic situation as potentially offering special gratifications for both therapist and patient. She thinks that because of the rarefied climate, there might be an opportunity to better take-in information through every sense: hear, smell, see and savor everything that is being felt or perceived.
Vignette

Oliver always put his coat on the back of the chair that faces the computer on the desk. When he comes for his last session with me he puts his coat along a surgical bed behind his chair. He keeps stroking his cheek and looks very lost and sad. While being able to carry a sensible verbal exploration of what he feels he gained from therapy, I am struck by his non-verbal messages and point to him that he does look lost and would maybe like to be comforted and supported. He readily endorsed this, allowing us to share all the difficult feelings of saying good-bye.

THERAPIST’S COMMUNICATION

Several therapists talk about what can be non-verbally communicated by therapists to their patients, and also what can be perceived and communicated within the inner world of the therapist and enrich the therapeutic process.

Blechner, (2001) talks about Szalita’s contribution in relation to how the therapist can lower the anxiety level of the patient, by his/her general attitude and body language. Taking further Sullivan’s (1973) idea about anxiety that can be contagious from one person to another, Szalita observed that lack of anxiety can also be contagious. She felt that the therapist’s calm but alert and interested presence sets the stage for the psychotic patient to come out of his paralyzing anxiety (Szalita, 1958). In an article on the intuitive process in work with schizophrenics (Szalita et al., 1955) she talks about her visual images and affects and how she lets them emerge while listening to a patient. She talked of ‘presence’, the therapist fully there as aware as possible of inner experience and choosing how and when to intervene. She called these different reactions and sentiments that may appear in the body of the therapist.
as a result of a sympathetic understanding of the patient, 'body-empathy' and said they could also be understood as a sort of bodily experienced counter transference.

Sidoli, (2000), observes that with certain patients presence and facial expression are more important than any actual words. Also things like the tone of voice, the degree of light in the room, the temperature, and other minute details. Like Szalita, Sidoli used her intuition and body sensation, to reach the most profound levels of disturbance in her patients. She believed in her own unconscious processes in relation to her patient, and on many occasions describes the fantasy that she allows to arise within her, in response to the patient.

Body language covers occasional physical gestures and token touch between therapist and patient. While normally seen as a definite breech of the therapeutic contract and an ethical violation, Nelson, (2001) has some reservations about this taboo. He remembers as very helpful, an incident in which his therapist offered him one finger to hold. This was in the context of his claim that only by holding his therapist’s hand he would manage to perceive him as real. In his recollections this was a most important turning point in his therapy, in which valuable unconscious material, previously locked away was unleashed. Nelson claims that despite our preference for verbal communication, we must acknowledge that “certain unconscious structures simply play possum unless they are flushed out by a pinch of paradox or a bit of body language” (Nelson, 2001, p. 86).

Gedo (1977, 2000) talks about the need of therapists to express emotions in non-verbal ways. He suggests raising one’s voice, when dealing with patients who go through regressive phases. At such times, some patients become unable to process the meaning of even clear
messages, unless the meaning is amplified by non-verbal indications of affect.

Vignette
I see John for an assessment session and feel overwhelmed by his physically displayed anxiety. His presenting problem has to do with not being able to tolerate being apart from his girlfriend. He also tells me that his mother died two years ago from cancer, and that he was very attached to her. The next session, I spontaneously arrange our chairs further apart than I would normally do in this particular room. I feel apologetic on disclosing this to my supervisor. She however, praises me for creating space between me and John, in which to try and look at his anxiety. John seems to be much calmer in the second session. The reason for him calming down is partly due, I think, to the fact that he unconsciously picked up my message, that there could be some distance between us/ him and his girlfriend/ him and his mother.

PSYCHOSOMATIC ILLNESSES
McDougall (1989) sees psychosomatic illness, as language failure. According to her when a patient is unable to translate emotion into language, he/she regresses and becomes physically ill. She felt that certain patients produce a somatic explosion instead of a thought, a fantasy or a dream when confronted with difficult experiences. In psychosomatic states the body appears to be behaving in a 'delusional' fashion according to her, to a degree that appears physiologically senseless. McDougall does not restrict psychosomatic phenomena to illnesses alone; she includes phenomena like accident-proneness, the lowering of the immunological shield when under stress, and addiction. When thinking about her somatizing patients, McDougall was struck by the fact that they were not able to make connection between their illness and
emotionally disturbing experiences in their lives. She felt that the difficult experiences were not repressed or denied but actually completely ejected from their psyche.

When trying to understand how a physical illness might in fact have a psychological root, Sidoli (2000), thinks of infancy, in which, due to the lack of differentiation between psyche and soma, experiences are psychosomatic. In her view, psychosomatic symptoms point to early trauma related to difficult and unmastered emotions in infancy. In order to survive, the baby needs to split off the fear and pain into his body, which becomes the container of difficult feelings. The reason for this according to Sidoli, is that the mother was not able to help the baby make sense of his distress.

Mothers, in Sidoli’s view, should be able to decode the non-verbal communications of their babies. In order for the mother to experience this ‘reverie’, she has to be able to make space inside herself for the baby’s emotional evacuations. When the maternal ‘reverie’ failed to perform the transformation for the baby, the raw and primitive feelings that are not verbalized manifest themselves in somatic, among other forms. Sidoli, (2000) believes that the fundamental function of the therapist, when working with psychosomatic patients, consists of helping them to name and make sense of these primitive unnamed elements. She encouraged therapists to listen to silences, and perceive all the changes taking place in the patient’s body, vitality levels, breathing patterns, tension, and voice changes. The therapist needs to let him/her be attuned in their own body to the split off emotional states of the patient, to which the patient himself is not conscious. By doing this the therapist performs the reverie that the mothers of these patients had not been able to provide for him/her. Sidoli’s proposition is that the psychosomatic patient is forced to use, for lack of maternal
reverie, his or her body or bodily organs (instead of the mother’s mind) as a container and a kind of stage upon which the unfelt psychic pain can be dramatized and eventually relieved.

Sidoli, (2000) recommends paying a great deal of attention to subliminal messages conveyed by the body, and much less attention to the verbal report. Thus, one must listen with a ‘third ear’ and observe with the ‘third eye’ to detect minute nuances that are extremely important communications but that the patient present as irrelevant.

Vignette

Elizabeth suffers from a number of psychosomatic illnesses, like Irritable Bowl Syndrome and Anorexia. She also went on very early spontaneous menopause age 31, which meant she would not be able to have her own children. Elizabeth could not think of anything that was less than perfect in her childhood. She knew nothing about her father’s life before he married her mother when he was 47 years old and the mother 25 years his junior. In their family, everything had to be about love and she and her brother were kept in the dark about the father being diagnosed with cancer until shortly before his death. It was possible to formulate that growing up in a family that was so strongly ruled by a myth of perfection, the ‘bad feelings’ like anger, confusion etc might have needed to be deposited in the body, rather than be processed in a mental space.

ALTERNATIVE MODELS THAT FOCUS ON NON-VERBAL COMMUNICATION:

I would like to end by mentioning some interesting departures to classical psychodynamic techniques that made the focus on the body their prime instrument of therapeutic work, and offer in my view, some valuable additional tools to help us access feelings and conflicts within our patients. I refer to Ferenczi’s attempt to introduce an emphasis on
nonverbal techniques (Jones, 1957) which involved touch between therapist and patient. This developed then into Moreno's psychodrama technique that proposed an alternative to direct physical contact between therapist and patient by making use of a third person in the room, (Moreno, 1953) in order to avoid accusations of giving or receiving erotic gratification by the therapist.

Continuing in the therapeutic tradition of Moreno, Perls, who has labeled his approach 'Gestalt Therapy', has been particularly concerned with non-verbal communication (Perls et al. 1951). His dictum to 'lose your mind and come to your senses' demonstrate how important to our awareness he found bodily sensations to be. In the work of Ferenczi Moreno and Perls we see some organized efforts to use nonverbal material in diagnosis and treatment.

CONCLUSION

Psychotherapy has been preoccupied with verbal communication and less so with non-verbal one. In this essay I was trying to explore some of the endless components of non-verbal communication within the consulting room, displayed by both patient and therapist. I described some of the various manifestations of body language and body talk and briefly mentioned psychosomatic illness. I conclude by making reference to an interesting line of departure from classical psychodynamic theory and practice, which makes more use of non-verbal means of communication in the therapeutic process.
REFERENCES


ESSAY 3

HOW DOES COGNITIVE BEHAVIORAL THERAPY UNDERSTAND AND TREAT DESTRUCTIVE ANGER? ILLUSTRATE THE CHALLENGES TO THE THERAPEUTIC RELATIONSHIP WITH EXAMPLES FROM YOUR OWN PRACTICE

INTRODUCTION

Anger is a universal, natural, and often justified emotional response. Anger becomes destructive when it happens too often, lasts too long, spoils relationships, leads to violence, or is interfering with good health (Cameron et al. 2005). Anger affects the way people feel, think and behave (Davis, 2000). It is often experienced by the client as part of other difficulties. Clients may seek help because of other problems in which anger is embedded, or specifically for their anger (Trower et al. 1988). There is a huge variety in the patients who present with destructive anger (Berthenya, 2004) and yet, there is no group of disorders for which anger is the primary defining characteristic (Deffenbacher, 1996), but it presents a social & clinical problem in children, adolescents, and young adults (Sukhodolsky, 1998), features as an important variable in the clinical picture of Post Traumatic Stress Disorder (PTSD) and various personality disorders (Novaco & Chemtob, 1998), and is considered a risk factor for hypertension and cardiovascular disease. Some people are born with tendencies to be more emotional (angry in this case) than others. The way people react to their anger however, is learned and can be modified. With violent crime among adolescents, extensive abuse within families, racial tension and acts of terrorism, anger has come to be identified as a significant social problem worthy of clinical attention and systematic research (Beck & Fernandez, 1998).
In the last 25 years Cognitive Behavioral Therapy (CBT) has emerged as the most common approach to anger management. Both narrative (Deffenbacher, 1999) and meta-analytic reviews (Beck et Fernandez, 1998) have concluded that anger management interventions (consisting of a combination of some form of cognitive restructuring and some techniques that promote relaxation) are effective in producing changes on a wide range of variables. In fact, the average CBT recipient would be better off than 76% of untreated subjects in terms of anger reduction. CBT separates cognition from emotion and encourages the individual to distance themselves from their anger (Laughlin, 2005). It draws upon the traditions of behaviour modifications and cognitive therapy (Meichenbaum, 1976) and may combine a variety of techniques such as relaxation, cognitive restructuring, problem-solving, and stress inoculation. It is theoretically guided by principles of learning theory & information processing.

In this essay I will discuss the anger profile as it emerges from the cognitive behavioral literature. I will then explore some of the models that were offered in order to theoretically explain how destructive anger operates and then go on to describe strategies that were suggested by some cognitive authors. The essay will end with a discussion of the unique challenges presented by clients who are destructively angry and I will illustrate these challenges with examples of clients I have worked with in the anger management group as well as in individual work.

ANGER PROFILE
Howells & Day (2002) see anger as a normal emotion, which may become problematic to the individual and others. As with all moods, anger is accompanied by changes in our thoughts, body responses and behavior. Davis (2000) names three categories of
events that make people angry: irritants (like neighbours making a noise), costs (losing money because of someone’s recklessness), and transgressions (trespassing on rules). Davis reminds us that anger has distinctive qualities: it is addictive, and can be recreational to people who use it regularly. Furthermore, it is accumulative and can be displaced. He uses the metaphor of a leaky bucket to describe the way anger can overflow but also that anger becomes less with time if no more irritation occurs. Davis also dispels a myth about anger, namely, that letting anger out might bring relief.

Beck (1976) views anger as a primitive reaction of an organism in order to defend itself against an attack. When a person feels attacked (physically or verbally) he may become angry and counterattack. Beck argues that the common factor for arousal of anger is the individual’s appraisal of an event as an assault on his domain. Beck outlines the sequence of psychological reactions that in his view lead to anger: First the individual makes a primary appraisal in recognizing and labeling a person or a situation as offensive. S/he then assesses her/his ability to sustain, neutralize or repel the impact of the nasty stimulus. The more the offense is perceived as intentional, malicious, and unjustified, the angrier the individual will get. If on the other hand the individual perceives the situation as dangerous or hopeless s/he might feel more anxious or sad. Beck explains that excessive emotional reaction (anger in this case) is fueled by disturbance in thinking. For example in his view, people who characteristically react to a toxic stimulus with anger may suffer from intrusion of unrealistic thinking regarding key issues in their life (anticipation of extreme adverse outcomes (catastrophizing), they may overestimate the degree to which events are related to them (personalization), think in extremes or in absolute terms (black and white thinking) or select a detail out of context (over generalizing), etc. All these ‘cognitive errors’ committed
by the individual sustain and fuel an excessive degree of emotional response. Beck also talks about the 'rules' that shape the individual's interpretation of events, hence predispose him to be particularly vulnerable to find situations as particularly offensive. In Beck's experience however most individuals will generally not be aware of their rules or will not volunteer them and the therapist is advised to derive the rule that guide this individual's life by asking questions. Beck finds that destructively angry people often have dysfunctional beliefs to rule their life, and they produce thinking aberrations that fuel inappropriate emotional responses.

Certain thoughts can make individuals feel angry. In particular thoughts (called hot thoughts) that are particularly fuelling the anger are important to identify and challenge, before anger control can be achieved.

Trower and her colleagues (1988), see frustration as an important component of anger. In their view frustration turns to anger when the individual thinks that the frustrating situation should not have happened. They see anger as problematic when the individual demands that what has happened should not have happened. This is the difference between destructive anger and adaptive anger in their eyes, as adaptive anger results from a preference that frustrations did not occur, as opposed to a demand. In line with this idea, Trower sees dysfunctional anger arising when a person is blocked from achieving a valued goal. When a person is angry there is a tendency towards attacking or retaliating against the perceived cause of the frustration. Trower sees a demanding/blaming way of thinking at the source of destructive anger.
MODELS PROPOSED FOR UNDERSTANDING ANGER

Greenberger & Padesky suggested a diagram to illustrate what they see as the vicious circle of anger (Greenberger et al. 1995). Anger is thus portrayed as a mood that is triggered by a certain event, fueled by certain thoughts (like being treated unfairly), and accompanied by concomitant physiological changes (muscular tension, and some behavior (verbal attack). All these components sustain each other and maintain the cycle of anger going.

Davis (2000) suggests a very simple model to the understanding of anger. He identifies a trigger (unique to a specific person), which is an event that sets the whole sequence running. In his model then the individual will appraise the situation and according to his/her particular beliefs will tell themselves whether or not the incident was offensive. Anger might then be evoked if the response is positive. The anger response is then tempered or not by inhibitions that the individual possess. These inhibitions might be internal (moral) or external (practical). Response is then the outcome of this process of assessment. Throughout this process, a role is played by the beliefs of the individual (in relation to anger, himself and the others). The mood of the individual and his general well being will also impact on how the individual interprets and reacts to a given situation.

A more complex model of anger was proposed by Deffenbacher (1996). Anger in this model seems to be elicited by four types of stimuli called ‘precipitants’. The first stimuli consist in specific external situation which are specific to the individual. Anger can further be triggered through memory components (linked by some trauma). In other cases, anger appears to be elicited by internal stimuli, like worry or other painful emotions. A further factor considered to elicit anger in this model, is the individual's immediate preanger state (being already angry). This variable is composed of two parts: enduring personal characteristics and the momentary state. Individuals with destructive
anger are often more rigid in their beliefs than those who are more adapted. The next area to assess according to this model is the way in which the individual appraise the situation. Primary appraisal involves an evaluation of the precipitating source, which will normally involve some encroachment on the personal domain. Secondary appraisal process involves an evaluation of the person's capacity to cope. The model then introduces the 'anger response'. Physiologically anger is marked by heightened sympathetic arousal. Emotionally, anger is experienced along a continuum from mild annoyance to rage. Cognitively, anger results from the appraisal of trespass which in dysfunctional anger is often biased. The last unit in this model is 'anger-related behaviour'. The individual may behave in adaptive (assertive) or maladaptive (verbal/physical assault, passive-aggressive behaviour, defensiveness) ways when angry. Anger-related behaviour and its consequences should according to this model, be carefully mapped and targeted for intervention as needed.

**ANGER MANAGEMENT STRATEGIES**

Greenberger & Padesky (1995) suggest cognitive restructuring methods to help reduce anger. These methods include identifying the negative automatic thoughts that sustain the anger and challenge them. They also advocate the use of imagery to anticipate situations in which anger might arise and prepare for them, so as to minimize the possibility of destructive anger. Recognition of the early signs of anger is also seen as an opportunity to short circuit any destructive anger by for example choosing to take time out in order to avoid an eruptive incident.

Novaco (1975) adapted Meichenbaum's stress inoculation training (1975) and created a program for anger management. The client is exposed to cognitive reframing, relaxation training, imagery, modeling,
and role-playing to enhance ability to cope with problem situations. In
the first stage, clients identify situational triggers which precipitate the
onset of the anger response. Once these environmental cues are
identified, the clients rehearse self-statements intended to reframe the
situation and facilitate a more balanced response. During the second
stage clients acquire relaxation skills. Combination of cognitive self
statements with relaxation is encouraged, as clients experiment with
exposure to anger provoking triggers. The third phase of the training
consists in rehearsal. Clients practice the cognitive and relaxation
techniques until the mental & physical responses can be achieved
automatically and on cue (Beck & Fernandez, 1998). This basic outline
can also be supplemented with alternative techniques such as
problem solving, conflict management, and social skills training.
Davies (2000) advocates helping the angry individual to replace
dysfunctional beliefs that fuel the anger with more balanced ones. He
suggests using ‘traffic lights procedure’ to help the individual pause (on
red) until s/he reaches a calmer state (with the help of self talk and
relaxation exercises) and then when they are less aroused, (on yellow),
bring to mind a person they regard as a role model, and only once
they are clear of what that other person would have done in the
specific situation, give themselves permission to act (green light). He
also advocates keeping diaries and reviewing results as ways to
consolidate progress.

Cameron et al. (2005) advise to make a list of alternative behaviors to
the angry ones and advocate practicing the new behaviors in angry
provoking situations. In other words, they advocate a meticulous
familiarity with one’s specific anger cycle, choice of alternative
behaviors to replace the angry ones and testing of new behaviors.
With others they recommend relaxation exercises to control the
physical symptoms of anger. On the cognitive front they suggest
challenging of unhelpful beliefs that prevent the person from letting go of their anger.

Trower et al. (1988) propose a three stage strategy for managing destructive anger: firstly it is necessary to challenge the client’s (grandiose) belief that bad things must not happen by asking him/her for the evidence for this belief (Wessler & Wessler, 1980).

The second step is to tackle any ‘awfulizing’ about the frustration, where the client is exaggerating the negative consequences of what has happened. It is important to find the meaning of an event for the angry person. Final part consists in tackling the client’s blaming of the perceived cause of the frustration. A key to overcoming this blaming attitude is to help the client develop compassion and realize that other people are fallible, but this does not make them bad people.

CHALLENGES TO THE THERAPEUTIC RELATIONSHIP

The therapeutic alliance has been shown to be a moderate but significant predictor of treatment outcome across therapeutic models and patient groups (Bambling & King, 2001). Theoretically, most definitions of a therapeutic alliance emphasize the following related themes (Bordin, 1994): the collaborative nature of the relationship, the affective bond between client & therapist and the client & therapists’ ability to agree on treatment goals. Some common characteristics of clients who suffer from destructive anger might challenge these themes considerably.

Howells & Day (2002) suggested the construct of ‘treatment readiness’, (‘blocks’ in Rational-emotive therapy as presented by Wessler & Wessler, 1980). The lack of readiness according to them might create difficulties in establishing a therapeutic alliance. These authors list what in their eyes might interfere with readiness. First of all, anger problems
often appear as part of a complex clinical picture (for example psychopathic tendencies or personality disorders). This complicates the picture considerably and the therapy in these cases needs to be individually tailored. (Eckhardt & Defenbacher, 1995).
In some cases there is a need to focus on the beliefs that the client has about anger, before any bond with the therapist can be expected (DiGiuseppe, 1995). The therapist then should spend time to identify these beliefs, before trying to collaborate on treatment goals with the client. Angry people might not see their anger as a problem or they might see the expression of anger as socially useful. Tiedens (2001) suggested that expressions of anger might portray the aggressor as powerful and achieve compliance from others. These characteristics make angry patients uniquely difficult to engage and create a therapeutic bond with.

Vignette
David (*) took part in the ‘anger management group’ that I co-facilitated as part of my third year placement. He was helped to identify one of his dysfunctional beliefs, namely: ‘If people hurt me, I have to hurt them back, or I will come across as weak’. This belief made it very difficult for him to see hitting people at work as inappropriate. In David’s eyes ‘they deserve it’, and he did not want to come across as ‘weak’.

Another impediment for the creation of a good therapeutic alliance is that often clients with anger are directed to therapy by others who are concerned about their aggressive behaviour. It often is the case that clients with anger problems are forced to attend treatment against their wishes. As the motivation to access treatment is often not genuine it might be more difficult to develop any real involvement in the treatment.
Vignette
Kevin seemed keen to join the anger management group when first assessed, but dropped out after the first session. He criticized us for taking too long to set and start the group and said it was no longer useful for him, as he lost custody of his son in the meantime. In his eyes, taking part in the group could have presented him in a better light in court had it been available sooner. He had no remaining incentive to attend.

Another impediment to readiness for anger treatment was illustrated by Howells & Day (2002) and is to do with cultural differences. Cultures vary in their definitions of when anger is legitimate or not and in their expectations as to appropriate expressions of anger. Cultural differences might interfere with people’s conviction that their grievance is problematic.

Vignette
Rosanne was a lawyer from a big American town. She moved to live in London following her marriage, but was unable to adapt to life in England. She was constantly confronted with what she interpreted as lack of efficiency that was robbing her of time. Her anger was fuelled by a firm belief that if she let go of her constant irritation, her life will disintegrate into total chaos.

Last but not least, clients with destructive anger might become hostile towards the therapist. They might become aroused in the session and dropout. These factors create particular challenges for the therapist in establishing a therapeutic alliance.

Vignette
Peter was referred for individual anger management therapy with me. He was a long term alcoholic and lost his job as a result of assaulting his boss when he was frustrated. He was not drinking when assessed by a
colleague, but was drinking heavily again two months later, when he came to see me. Peter was homeless and demanded to be provided with a house. I tried to explain to him that this was out of my domain, but that I might be able to help him with his anger. He got increasingly hostile, leading me to feel increasingly unsafe. Shortly afterwards he stormed out of the room, slamming the door on his way out, never to come back.

CONCLUSION
As discussed above, CBT offers working models and strategies for the understanding and treatment of destructive anger. The apparent popularity of CBT in the treatment of anger is found by researchers to be effective in achieving treatment goals. Clinicians treating clients with anger control problems using CBT informed anger management programs can expect at least moderate improvements in their clients. There also seem to be specific evidence to the effectiveness of anger management in specific populations like children with Attention Deficit Hyperactivity Disorder (ADHD) (Miranda, 2000), and people who have developmental disabilities (Taylor & Novaco, 2005). Future research may help us to identify the most active ingredients of CBT and integrate them to produce even more effective programs for managing anger. This is particularly helpful currently as ‘evidence based time limited interventions’ are particularly popular. This essay however, highlighted also the particular challenges presented by clients with destructive anger, and consequently informed us that creating a sound therapeutic alliance may be all but smooth in some cases.

NOTES
(*) All clients have been given pseudonyms in order to guarantee confidentiality.
REFERENCES


THERAPEUTIC PRACTICE DOSSIER
This dossier is concentrating on my development as a practitioner during the three years of my training. During each of these three years I was placed in an NHS Placement and expected to assess and provide therapy to clients. On all occasions my practice was supervised by a qualified experienced practitioner and regular reports, case studies, process reports were written and log books were kept.

During all three years I have worked in a GP practice, but in my third year my Placement included a day in Secondary care service, which provided early assessment to clients with more complex presentations than are normally seen in Primary care, referrals to various clinical organizations and therapy to some of the clients assessed.

I assessed and provided therapy in all Placements and during my third year co run an ‘anger management group’. While during the first year I was expected to practice in an Integrative/Person centered way, in my second year I was expected to use a psychodynamic model and during my third year the practice was Cognitive Behavioural therapy.

While I enjoyed seeing all clients and learned a great deal from all my Placements, I particularly enjoyed working in the Psychology department during my third year and found mixing with a group of other psychologists stimulating and containing.

I will now describe each of my Placements and the reader is also invited to find my ‘Final clinical paper’ in this dossier where I talk about myself as a practitioner.
Description of Clinical Placements

Year 1: NHS Primary Care Mental Health Team

My first Placement consisted in a Primary Care Service provided by a Surrey NHS Trust. The service provided Counselling and Support Services to adults with mild to moderate impairment of functions. Examples of the kind of suitable referrals to this service were: life cycle problems, developmental issues, distress following diagnosis of illness, sexual or gender difficulties, pain management and stress related symptoms. The service provides counselling also for clients who struggled with bereavement, depression, and problems of self esteem.

Clients were offered an assessment session, and then, if appropriate, they were normally provided with up to six therapy sessions, in which they were seen on a weekly basis within the practice. The ethos of the service was that an assessment plus six sessions were sufficient to generate an effective outcome with clients who did not demonstrate complex problems.

The service described itself as providing counselling in familiar setting with reasonable waiting time to people with psychological and emotional problems. Occasionally people were referred to Secondary Mental Health Teams, if at the end of their therapy, it was felt that their problems were more complex than initially thought.

In all cases, confidential reports were sent to the referrer GP following the assessment session and at the end of therapy.

The service was based in a green and relatively wealthy neighbourhood and I was encouraged to apply Integrative/Humanistic therapy model with clients which was the
dominant model applied by all members of the team including my supervisor.

In addition to the clinical hours spent seeing clients and in supervision, I was also invited to departmental meetings and practice meetings and found the team particularly friendly and welcoming.
Year 2: Primary Care Mental Health Team in London

My second year Placement took place in a big Primary Care Counselling/ Psychology Service that provide Counselling and Support Services to mixed multi racial group of adults with mild to moderate impairment of functions.

Clients were usually offered up to 12 sessions, in which they were seen on a weekly basis within the practice. These sessions were so structured that the first one to three sessions were conducted mostly as assessment sessions and then developed into therapy sessions. In certain cases the client was referred elsewhere following assessment. In cases deemed appropriate, people were referred as out patients for further long term psychotherapy at the end of their counselling sessions. Confidential notes were kept in electronic form and a report was written at the end of therapy and sent to the referrer GP.

Supervision was Psychoanalytic and of high quality, but there was little contact with other professionals which was disappointing.

I found the diversity of social background and racial origin of the clients interesting and stimulating to work with. While the service was similar to my first year Placement (Primary Care), my subjective experience was actually very different, due to the different model applied, and more importantly, due to the impact of the social fabric of a 'London inner city' population. The incredible variety of presenting problems, social backgrounds and cultural differences made new demands on my skills and challenged me in new ways.
Year 3: Split Placement: Primary Care Mental Health Team
Secondary Care Psychology Service

My third year Placement was in Central London. The model applied was CBT and I have managed to assess and provide therapy to a wide range of clients, presenting a variety of clinical problems, which I was encouraged to treat by a number of techniques. Among the clients seen during this year were patients suffering from eating disorders, panic attacks, depression, sexual dysfunctions, social anxiety, anger problems and clients presenting with borderline personality disorder.

There was a difference between the level of disturbance presented by the clients of the two services with those seen in the Secondary care presenting a more complex and long standing difficulties.

I have become familiar with a wide range of techniques. For example, I have applied and witnessed the benefit of 'Relaxation exercises' and 'Mindfulness exercises'. With the guidance of my Supervisor, I matched suitable treatments to use with different clients. I have experimented with a variety of treatments, ranging from 'protocol therapy' (patients diagnosed with eating disorders), to 'Schema therapy' (clients presenting with depression), as well as a range of Behavioural and Cognitive techniques (Behavioural experiments, work with imagery, completion of diaries to identify and challenge irrational thoughts) to use with other clients.

As part of my Placement I had the opportunity to co run a group of 'Anger management' which was a steep learning curve for me. I also produced a cassette with relaxation and mindfulness exercises for the members of the group to use.
In addition to the clients seen and Supervision, regular meetings were attended on a weekly basis in the Psychology Department with other Psychologists, to discuss referrals and clinical issues. I particularly enjoyed the opportunity to listen and share thoughts with other psychologists and have learned a great deal from the discussions held and more generally from my presence in the department.
INTRODUCTION
It is not an easy task to think about myself in relation to my identity as a counselling psychologist. In a way, I think that being a psychologist or a therapist is a process of constant becoming, and maybe a journey to pursue, rather than a place or a title to reach. Reality however, is so organised that certain moments are seen as milestones or moments of arrival and they demand a clear declaration of identity and capabilities. This paper is an example of such a moment where a focus is demanded into where trainees are in their journey of budding professionals.

In order to describe myself as a professional at present, I will make an attempt to illustrate the background to the decision I have taken to apply for the Surrey course of psychotherapeutic and counselling psychology, describe the flavour and content of each of my clinical Placements over the three years of my training (including clinical examples from each year) and will conclude with some thoughts in relation to how I understand practicing at present and where I think I would like to see myself in the future.

BACKGROUND TO TRAINING AS A COUNSELLING PSYCHOLOGIST
I was born in Israel, and Erich Fromm (1973) was one of the best remembered books I read and was shaped by during adolescence. As an Israeli citizen however, A levels were followed by the compulsory military service, where I also met the man who would then become my husband. His plan was to study Veterinary medicine which was not available in Israel at the time. That was the background to us getting married and moving to Italy. The person I was back then was
motivated to study and succeed but was also loyal to her Jewish values. Those values stated that finding a husband and having a family came first and that my career was secondary to that of my husband. This bizarre combination resulted in me not taking up an offer to study Psychology in Jerusalem, moving to Italy with my husband and study Psychology in Padua instead.

I finished the five year course in Italy and moved with my husband to England for his postgraduate studies and had my first child roughly at the same time. Part of the program I followed in Italy contained the study of Jungian thinking. My supervisor for my thesis was a Jungian analyst and the thesis looked at what children made of the symbolism conveyed in fairytales. I was quite fascinated by Jungian psychology at this point. The way Jung thought about archetypes, dreams and symbols (see Jung, 1978), attracted me and I thought that the logical next step might be to train as a Jungian analyst in Hampstead. I found out however that several years of 'training analysis' as well as some clinical psychodynamic therapeutic experience were needed in order to become eligible to apply for this training. It took several years and the birth of two more children, before any of that will become possible. Eventually however, I started 'didactic analysis' several times a week and obtained an honorary contract with a psychotherapy clinic. I started to see patients for psychoanalytic psychotherapy under supervision and was also attending the in-house training the clinic offered which included seminars, case presentations and discussion of theoretical papers. The setting was strictly psychodynamic and no other model was mentioned. In a way it felt like a seductive but insulated religious bubble. There was an implicit understanding that psychoanalytic theory was the only valid way to think about patients and therapy.
By the time I have assembled together enough clinical experience and therapy hours to consider application, however, I started to become a bit uneasy about the fact that formal training would imply compulsive three or four times a week 'on the couch' analysis for years to come. I also started to doubt the legitimacy of what I felt was too orthodox an attitude to therapy and I started to develop an interest in exploring more recent and different approaches to therapy as well as the classical psychodynamic approach. For example I came across a book written by Yalom (2001) and loved the more open approach he was using with his patients and the fact that he sometimes 'self disclosed'. I felt increasingly awkward about the lack of any symmetry in the therapeutic relationship and increasingly aware that I was 'unable' to deliver the infantilised position which was expected and which I did not naturally inhabit. I could not produce a 'dependent and regressive' transference despite my best wishes. My dreams conveyed 'role reversal' with my therapist.

In reality this dynamic was not reflected upon nor was it understood by the time the therapy ended. It was only via the reading I have done while working on my research (the psychological profile of the offspring of Holocaust survivors) that the dynamic re-enacted between me and the therapist started to make sense to me.

With hindsight, I understand some of the transference and maybe counter transference that were going on in the therapy and were never interpreted while it was going on. My current understanding of my feelings of frustration back then (a sense that the therapy 'was not working') is the following: I was born to a father who was a Holocaust survivor. He was an occupational psychologist in the army and looked strong and functioning to all intents and purposes, but I always felt in my unconscious, that I had to protect him. This dynamic (which as I found in my research is very common between Holocaust survivors and...
their children) was then enacted in the transference-countertransference between me and my therapist, but was never talked about.

There is a possibility that the match between me and this specific therapist was not ideal, or that she was too rigid to accommodate what I needed within the analytic model. Also not being Jewish, she might have not been aware or sensitised to the challenge that my particular cultural background was setting. The end result was however that something very central to the understanding of what was enacted in the analysis was never interpreted.

Analysis was not all disappointing either, however. There were also gains that I could recognise: I learned to remember dreams and to explore them. I felt more aware of emotions (actually realised I had them), and I started to explore parts of myself that were somewhat buried (like becoming more assertive, experience angry feelings, etc.) But despite these gains and a strong (though problematic) attachment to my analyst, I felt that there was a limit to what could be explored with her in the very rigid format of analysis. Also, I felt that analysis was creating a 'parallel world', important in its own right, but that it was taking me somehow away from reality. Still, those years helped me to develop an attitude of respect for the therapeutic process, to become aware of the existence of an internal world, and to practice working with images. The years of working with patients in the Psychotherapy clinic, familiarised me with the satisfying but also messy, confused sometimes frustrating processes that are part of the consulting room scene. Despite the erosion in my resolve to become a Jungian therapist, I still saw myself as a therapist.
It was at this moment in my life that I came across a flier of the Surrey course and felt that it could become the right next step for me to embark on. I liked the fact that it was academic and integrative training and that it will allow me to spread my wings and develop as a professional in a way that will not preclude analytic training in the future but will not focus exclusively on one approach. My children were older by then, and it felt like this course was offering me an opportunity to finally pull together all the important strings of my previous studies and aspirations and consolidate a professional identity. Needless to say, this plan was not supported by my analyst, despite a clear dream in which my plan was depicted as a most creative birth full of vision. I felt that she could not respect a most healthy development, and decided to apply without her blessing. This ‘rebellious’ move was not easy to carry but it felt right, and I still remember the distinct feeling of happiness (triumph?) on hearing that I was offered a place.

YEAR ONE
Primary Care Counselling Service in a small town in Surrey was the setting of my first placement. The clients were mostly White and mostly from a Middle Class background. Many of them were professionals and had families. My Supervisor was working from an Integrative/Humanistic perspective and as clients were seen for brief therapy (six sessions) there had to be a clear focus to the work and more emphasis on present-day difficulties. While I remember that year with affection, it was a challenge to move from a focus on uncovering of and working through of childhood traumas, to therapeutic work based on present-day difficulties using Rogerian core conditions. The other challenge was to learn to conduct assessments which I have not done before. In terms of practice, I had to get used to seeing clients for six sessions where most of my experience hence consisted of years. Psychodynamic thinking could inform my understanding of the client but I had to
practice following Person centre principles. There were similarities between what I was supposed to do now and my previous training: in both models the therapist was expected to 'welcome' the entire client, there were no parts I was supposed to prefer or reject. In the model I was practicing now (Person-centre) it was called 'Unconditional positive regard'. In both models accessing emotions was encouraged, but there were also differences: I had to be less reserved, not a 'blank screen', warmth was important and I still remember how strange it was to 'self disclose' occasionally or talk about my take on what was happening rather than use it in order to produce interpretations. 'Congruence' (see Mearns & Thorne, 1999) was encouraged, not reserve and stillness, interpretation was not welcomed; I had to 'be there for the client and accompany him/her to uncover what their true feelings about a certain problem were. The therapeutic relationship was real (Person-to-person relationship, based on mutuality and reciprocity, empathy and respect (Clarkson, 1995), rather than transferential. Humanistic Psychology assumes that people have within themselves, the resources needed for personal change. These resources can become available in a climate of facilitative psychological attitudes, (i.e. 'core conditions'). Learning can then occur that can be generalised to other aspects of the client's life. I could start a session by asking the client 'How are you?' There were less awkward silences...it felt more like an intimate social interaction and a lot of the 'heaviness' of an analytic session was lifted. In practice I found it to be more difficult than first assumed. It was not easy to move away from working within my self on what things meant in the transference to access what it might feel like to 'that person' in 'that situation' (empathy). The fact that the core conditions correlate with effective counselling is well established in research (Orlinsky et al. 1994) but what does it really mean to be 'empathic'? My supervisor used Yalom's image when she was trying to explain this to me: using the metaphor of
a train journey, it means seeing exactly the same landscape that someone else would see had s/he been sitting in the same chair in the train, facing the same direction. This was empathy: see things exactly from someone else's perspective, 'be in their shoes'. According to this theory (see Rogers, 1951, 2003), people's distress emanated from the fact that while growing up they were criticized and expected to adhere to other people's developmental agenda, and so their self-concept of who they were was not informed by their intrinsic (organism) tendencies, but replaced with other people's prejudices. The task of the therapist according to this approach was to provide for the client the conditions for growth, assuming that all clients have within themselves vast resources for development (growing towards the fulfilment of their unique identities).

As far as I was concerned, this Placement helped me to relax some of the rigid rules that analytic practicing demanded and experiment with a different style of therapy. I was expected to become less 'removed' from my clients and make more use of human warmth. I was positively surprised by the response of some the clients who were able to 'pick up and start walking' (metaphorically) after six sessions of Person-Centre counselling. Also I found that my stance was on the whole different to that of psychodynamic therapist: there was more transparency, and while I was offering empathy, unconditional positive regard, warmth and thinking, the client was the ultimate authority and 'knew best' where they needed to go in order to grow.

The following vignettes are taken from the case load of clients I have worked with during my first year, where I found that applying the core conditions moved therapy forward. In the following vignette, being able to be empathic with the client, helped the client to go deeper and own her feelings.
Vignette 1*

Mrs. DH was a White woman in her early forties. In her therapy with me she was able to talk for the first time about a rape that she endured age 17. The rape started as a consensual sexual encounter with a man, but deteriorated soon into being raped by a whole group. An unwanted pregnancy and termination of pregnancy were the outcome of this unfortunate episode. Mrs. DH was drunk when this was going on and because of this blamed herself for everything that happened to her. I could have analyze her alcohol abuse during adolescence in the light of her traumatic childhood, or worse still try and 'rescue' her from her distress by 'normalising' alcohol abuse during adolescence. I decided however to not analyze or 'take away' her feelings of guilt and instead provide empathy. I commented on how difficult she found forgiving herself for what happened. This conveyed to her that I was aware of her guilt and that I could stay with her feelings. I found that this attitude encouraged her to further explore her painful feelings connected to this episode, and to eventually feel more compassionate towards herself about what took place.

The next vignette is about a moment of spontaneous congruence that was helpful. (Congruence here is understood as a response which is reflective of what the therapist is feeling).

Vignette 2

Mrs. Nina is a young married woman with two young children. In the session under consideration she was telling me about a disturbing phone call she received from her father who was very drunk and asked her whether 'she was coming for sex'. I felt shocked to hear it and in commenting about how difficult it must be for her to be faced with her father confusing her with a prostitute, my voice broke down when I said 'prostitute' (this was clearly caught on tape). My emotions came
through and conveyed to Mrs. Nina that I was shocked by what she was telling me and how much I cared. Later in the session she was able to talk about distancing herself from her parents (with whom she was in 'enmeshed' relationship) and become 'her own person'.

The last vignette is presenting my challenge in providing unconditional positive regard to a client. This I understand as treating the client as valuable in his own right regardless of whether they meet the 'conditions of worth' which make part of my value system.

Vignette 3
Miss Joanna is a 26 year old woman who felt confused and depressed as a result of a parallel relationship that she was having with two men, neither of which knew about the other. Mr. A was the father of her son and a good friend but somewhat depressing in her view, unlike the attractive Mr. B who would not commit to her but had a 'sunny personality' that cheered her up. Miss Joanna came from a 'Hippie like' background with people in her family swapping partners, and living in harmony in a 'commune' with past and present partners. Miss Joanna was starting to realise that this lifestyle worked for her parents but might not work for her at present. In working with her I had to 'step away' from what I felt was a desired process (becoming more emotionally independent and able to take responsibility for her choices). On exploring Joanna's feelings with her, she realised that she was not ready to give any of the two men up, and while calling herself 'greedy' was determined to carry on with both relationships. I felt judgmental about Joanna's 'opportunistic' style and had to remind myself that I was to continue to provide her 'unconditional positive regard', and not become less available to her because her values were different to mine. I told her that we can look together at how her decision could be carried in a way that will be as respectful as possible of all people.
involved. This facilitated an exploration of how to put some healthy boundaries between her and the two men (becoming more realistic about what could be expected from Mr. B, as well as starting to be more open with Mr. A about not offering him an exclusive relationship at present). Joanna was able to be clearer and more open about her needs at present and take some more responsibility for her decisions. She was also becoming increasingly aware of the risk that this involved.

YEAR TWO
My year two Placement was in a large GP practice in the South West of London. The client group was more ethnically and socially diverse than the client group of the first year and allowed me to get exposure to a large mosaic of social and clinical presentations. My supervisor was a Psychoanalytic psychotherapist and clients were assessed, and in suitable cases offered up to twelve sessions of psychoanalytic psychotherapy. There was some sense of 'deja vu' in this experience, and an echo of my years in the Psychotherapy clinic. On the other hand, I was allowed to conduct my own assessments now, and had to apply brief psychodynamic therapy within Primary care context, and so was challenged to integrate previous experiences in a new format. The relationship with my supervisor was different to the one in the more integrative Placement. There was more exclusivity to the relationship, and the use of transference-counter transference based comments was weaved into the supervisory discourse.

Permission to use Psychodynamic model was liberating in a way, but I found the universal criteria of 'up to 12 sessions to all patients', rigid and at times incompatible with the model. A dilemma frequently discussed in supervision, was how much regression and dependency it was safe to encourage, and how the ending had to be managed, so that patients felt contained at the end of 12 sessions?
In following the Psychodynamic model, I was to encourage free association, allow silences, make interpretations, help the client to think about their dreams and the meaning of their responses and use my counter transference to understand some of the experience of the client (see Bateman & Holmes, 1995; Lemma-wright, 1995).

I have chosen to present an extract from a taped session of a client to provide the reader with an example of the work that was carried out in the above Placement (**).

Miss. Margaret(***), was a woman in her early forties who was referred by her GP due to becoming anxious and distressed recently, in conjunction with making arrangements for her wedding and possible pregnancy. She was brought up in a poor and deprived social climate and remembered women being abused by drunken men, and unwanted babies resented on arrival. Miss. Margaret lost her father as a baby and was physically abused by her violent mother. An oasis in this sombre picture however, was school, where devoted female teachers helped Margaret to develop aspirations for a better life.

Margaret managed to leave her country of origin and mix with people from more privileged backgrounds. She went to University and had a successful career. Recently however, while contemplating to marry her boyfriend of six years and maybe start a family, she became anxious and had disturbing thoughts about the abusive background she was a victim of. Margaret became plagued with fears of becoming like the women of her background, a victim, an abuser, and that her life will 'end up in the gutter'. In the session under consideration Margaret is telling me about meeting homeless people in the street and how very vulnerable that made her feel because 'it could have been me'.
My formulation of Margaret was that she created a 'split' between the deprived and abusive elements of her past and her more successful life in London. Her painful childhood experiences were mostly repressed and this defensive situation allowed her to conduct a relatively successful and anxiety free life. The approaching wedding however, and the possibility of becoming a mother, started a process of unconscious searching for internalised identifications with the mothers and wives that she met as child. This process facilitated the re-emergence of some of the repressed memories of her painful childhood and made the artificial defensive division between herself as an abused child and the successful adult part of herself less effective. In the following dialogue I am trying to encourage Margaret to work towards integrating both parts of her experience.

T (**). So it's about how to integrate these painful messy bits within a life that is on the whole good

P (**). It's just that when it comes and it's very strong...umm...just about knowing how to live with it...that's exactly it

T. Umm aha

P. Without it controlling you to a certain degree when you are out of control emotionally, like an emotional cripple, which is rare but it's there definitely. Umm you know I can feel starting, you know, when suddenly I'd walk in the street and I'd see something...other days I'll walk past that and it wouldn't affect me but then something will just affect me and I'd think: 'that could have been me', and then that triggers me into another thing and then I feel you know, really low, and...then I feel you know, worthless and...it's the pain...enormous pain...umm...I don't
suppose that it will ever go...will it? Just need to know to live with it

T. Well, that's part of your life, why would you want it to go...yes it was a painful childhood, but it's still your childhood

P. Didn't think about it that way

T. Umm

P. To a certain degree it gives you some strength as well, doesn't it...

While I was initially critical of my somewhat forceful manner, in suggesting to her that integrating the abused part of herself into a more conscious experience of herself could be beneficial for her, Margaret's response shows that following some initial hesitation, she was able to use my comment to enhance further insight. What was also helpful I think, was that I allowed her time to digest what I have just said (sigh only), rather than jump in with further comments.

I liked working in this model and was lucky to meet some wonderful patients who entrusted me with deep, personal and precious glimpses into who they were. I liked the wide variety of presentations, social backgrounds and ethnic diversity. Among the patients I saw were a prostitute, a woman who was involved in murder, a man with an exceptionally high I.Q who was a member of 'mensa', Blacks and Whites, artists and managers, university graduates and people who had no qualifications at all. I found this very challenging and interesting situation, where I had to be flexible enough and adjust sometimes within a very short time to very different clients and fully respect who they were. What I missed during this year however, was more team work and opportunities to mix with other professionals.
YEAR THREE

My third Placement was split between a GP practice and a Secondary Care Psychology Service, in central London. In both settings I had to assess and also provide CBT therapy for clients. As part of the Placement, I also had the opportunity to co-run an 'anger management group' with my Supervisor and another Psychologist. Part of my contribution to the group was to prepare a tape with relaxation and mindfulness exercises that was provided to interested members of the group. My weekly schedule included also the attendance in meetings with other psychologists, to discuss appropriate referrals and other clinical issues. I particularly enjoyed these meetings and found mixing with other psychologists very stimulating. Worth mentioning was also close contact with Clinical Psychology trainees and the learning and tension that was involved in inevitable comparisons with them. Another characteristic of this year was the integration of psychometric tests as part of the assessment and therapy process and for the purpose of evaluating the outcome of therapy, and lots of report and letter writing.

As for the model itself, the transition from psychodynamic practicing to CBT was not easy. I had very little working knowledge of this model and initially struggled to relate to it. I still remember my shock on watching a video of a CBT master class presented by Padesky, and discovering that a CBT session is often conducted with the help of pen, paper and writing during the session. There were also worksheets and 'homework' for the client to complete between sessions. The therapeutic relationship was mostly collaborative and explicitly stated (working alliance more than transference - see Clarkson, 1995) and the contract between client and therapist could include the specification of therapeutic goals for the therapy.
Reading Beck (1976, 1991) helped me to make a link between the models I have used already and this new model. Beck was a psychoanalyst but he noticed that despite the fact that his patients were following the rule of 'free association', there was a type of ideation that had gone unnoticed unless patients were instructed to identify these thoughts via introspection. These were his first glimpses to what was then coined 'negative automatic thoughts'. The stream of thoughts that was emerging automatically and rapidly was not reported by his analytic patients and was nevertheless important in understanding the disturbing emotions these patients had.

With the help of this 'bridge' provided by the historical link between psychoanalysis and Cognitive Behavioural Therapy (CBT), I was in a better position to learn more about this method. I actually started to become intrigued by the premises of this approach. The main premise was that it was not events themselves that generate the feelings/behaviour, but rather a person's thoughts, beliefs and assumptions about these events. The other premise was that individual's problems stem from certain distortions of reality that originated in defective learning during the person's cognitive development and as people were 'problem-solvers' the therapist could help them to unravel the distortions in their thinking and learn alternative, more realistic ways to formulate their experiences. I quite liked the idea that the 'architecture' of one's irrational core beliefs, assumptions and automatic thoughts could be teased out and challenged, and so a more balanced rational 'cognitive apparatus' could gradually replace it.

Once I started to understand more, my initial trepidation of this mostly unknown model was gradually replaced with interest and curiosity. In fact modern CBT is a very versatile model and I found it surprisingly stimulating. I was delighted to find out that relaxation exercises and
'mindfulness' exercises (see Evans, 2006) were used in certain cases as part of CBT. I had some beneficial contacts with Eastern practices and traditions in the past, and was pleased to discover that Western mental health was incorporating some techniques taught in the East. There was apparently even an evidence based support to the use of these techniques (see Baer, 2003). I quite liked the combined use of CBT and Mindfulness, as it promised an integration of the intellect of the West and the 'being' of the East, in creative marriage. In general, I found that CBT could be a varied and creative method with plenty of skills to draw upon. Practitioners could use behavioural techniques ('behavioural experiments', interviews, graded exposures and role plays), as well as work on the cognitive apparatus (efforts to access maladaptive cognitions and challenge them, work with imagery, test beliefs, etc.)

A very interesting aspect of modern CBT consists in 'schema work' (see Young et al. 2003). This new development of CBT helps the client to identify his/her 'negative core beliefs' (the deepest template that skew the way clients perceive and analyze the world), challenge them and develop alternative more balanced core beliefs. I have attempted schema work with some clients that I saw for the entire year and found that it facilitated more depth in the work, and helped both of them to modify some of their perceptions of themselves, others, and the world.

A common criticism of CBT is that insufficient emphasis is placed on the therapeutic relationship, while tools and techniques are more focused on. This is particularly relevant in cases that involve challenges to personal beliefs and habits, which could make clients feel exposed and intruded upon if not in the context of a good working alliance.
The following account is an example of a client dropping out prematurely from therapy, which I think was at least partly due to the fact that as I was still grappling with learning and applying new techniques, I did not allow enough time for the therapeutic relationship to develop prior to asking my client to disclose some of her daily routines. I think this was perceived by her as intrusive despite superficial compliance.

Miss Diana was a young single woman. She was obese in a way that put her health at risk. She was diagnosed as having an eating disorder but was reluctant to join a group that dealt with this disorder. It was then felt that treatment for ‘binge eating disorder’ in the context of Individual therapy was more indicated. I was instructed to follow a specific program meant to treat 'binge eating disorder' with her in the context of a time limited CBT.

Miss Diana presented as very pretty, compliant sweet woman. She described her worries of becoming like her mother who was also very obese, and died in her early fifties from a weight related heart failure. As I had a set number of sessions available and a program to follow, I asked her quite early on to fill a diary of her typical weekly diet. She agreed to complete the above diary and brought it back the next session. Her diary reflected an excellent regime for healthy living. When I pointed out that there was nothing in her diet which could be remotely excessive, she started to cry and said that nobody believes her that the reason for her weight is entirely medical. I suggested that we stop focusing on her diet for a while, and think about how being obese make her feel and help her to cope with what she felt were the implications for her self esteem, relationships and career (Miss Diana is a photographer which she described as an 'image conscious' world). We spent the next two sessions identifying and challenging Diana's
maladaptive beliefs (catastrophising, discounting the positives and personalising the effect of her weight on her social and professional life), Diana reported less hateful feelings towards herself as a result of this process and less feelings of hopelessness, and expressed gratitude to me for helping her to feel better about herself. Miss Diana started the next session by telling me that she felt guilty wasting my time. I explored this with her and she said that as long as she is 'this weight' any psychological intervention was a waste. I empathised with how dominated she felt by her weight and said that maybe we could look and analyze her assumption that unless she was less heavy she did not deserve my attention. She did not challenge me there, but did not attend her next session and sent me a letter instead. In the letter she said that she was grateful for what I taught her and the time I dedicated to her, but strongly felt that until her weight is sorted, there is no point in doing any psychological work. I was quite taken aback by her premature termination and was quite perturbed by not having vaguely anticipated it. My supervisor was supportive and reassured me that I have done all that was within my clinical capacity. He said it was quite common for eating disorders' clients to keep their routines a secret, to drop from treatment unexpectedly despite superficial compliance, and to deal with difficult emotions through their relationship with food rather than verbalisation. With hindsight, however, I feel that I probably had to spend more time consolidating the therapeutic relationship, regardless of the pressure of the goals and time limit of the therapy above. I think that the capacity to strike the right balance between these two dimensions is a skill that improves with experience and that in the case above I did not strike this balance right.

What do I think about this model? I like the fact that at least in theory an axis could be traced between the formulated clinical problem, the
goal of therapy, a plan to tackle it, therapy and an evaluation of results at the end. I think that in some cases a collaborative relationship between client and therapist is welcomed and the introspective, thought based, skill building method can work well with some clients and some presenting problems. I have however seen clients who could not benefit from this model and needed a preparatory explorative period before they could embark on any cognitive work. I am a little wary of the popularity of this model in the current climate of 'evidence based' driven choice of models and the bias that this criteria could insert into the world of therapy and mental health services. I am also wary about the infiltration of protocol based treatments (like the one described above for the treatment of binge eating disorder) seen by the NHS as the norm for 'good enough' solution to mental health problems.

Finally, this year was challenging in more ways than one, and I have learned a great deal about Psychology and about the complexities of working in the NHS and with other professionals. While CBT was unfamiliar to me a year ago, I have learned to appreciate its therapeutic potential and can surprisingly see myself applying it (a most unexpected development).

WHERE I AM NOW AS A PRACTITIONER?
My years as 'pure' psychodynamic practitioner are in the past. I do draw on unconscious responses within me and I think symbolically and am guided by the respect of this model to the 'frame' and the scanning of transference and counter transference, but I am also very aware of the limitations of this model in some cases, situations and phases within specific therapies. I have learned a lot from engaging with other models, and I think I work better when I feel free to step in and out of any model and recruit ideas from other models.
occasionally. I think that more than any specific model I am guided by the client and the way s/he respond to me and to whatever is generated in the room. Thus, even if I work with a client mostly in one model I might temporarily use ideas or skills from another model if it feels right in that specific moment. I might decide to explore things with the client more generally and encourage him/her to make links with the past etc. but then if something more specific arises I might move to focus on more specific investigation of thought patterns, or behavioural tasks to then move back to a more explorative mode. This sounds confusing, but my experience with several clients in the past was that flexibility was useful in 'unblocking' situations of impasse or facilitating more depth. I find that I work most creatively and am most effective when I am free to draw on more than one model and search for what works best.

I evaluate my practice through a mixture of structured and unstructured tools, (this depends also on the context in which therapy is taking place). In my current Placement we use the Clinical Outcomes in Routine Evaluation (CORE) at the beginning and end of therapy as well as the Beck's Depression Inventory (BDI) and Beck's Anxiety Inventory (BAI), in cases of depression and anxiety respectively. An important unstructured cue to the evaluation of outcome is provided by the client's feedback of how useful they found the therapeutic process, and whether they have acquired tools/skills that they can use once therapy is over. In cases of specific presenting problems (panic attacks for example), it is of course easier to assess whether the problem had been reduced in frequency or intensity.
AFTERTHOUGHTS AND PLANS FOR THE FUTURE

Training was not easy. It meant drastic change of life style and a need to swiftly acquire various academic skills. For once I had to endorse modernity and learn to use computers. I became a busy, stressed, always on the go person. In a way, it extracted a heavy toll from me, my husband and our three children. Everyone had to get used to me hardly ever being there. While it is too early to assess the full effect of these three years on us all, and I need to acknowledge that I did not anticipate the amount of work that will be involved, I think that on the whole we managed to cope with it reasonably well, most of the time. I am happy for taking up the challenge of this course, and I feel that I have better professional and academic preparation than I would have had without it.

I see the present moment as a sort of beginning really. I look forward to learning more and getting more experience. My plans are to try and find a job in the NHS initially, so that I could benefit from cross fertilization that is enabled by exposure to other professionals, and also get experience with a broad range of clients and clinical problems. I do not have clear priorities in terms of client group at the moment. I am interested in working with children but am also fully aware of how competitive this speciality is. I also see myself developing some private practice at some point. As far as therapeutic models are concerned, I am quite interested in the Cognitive Analytic Therapy (CAT) model, and feel that there might be some affinity between the way I perceive this model and the way my way of working seems to develop. I was also impressed and intrigued by the Gestalt workshops that we had as part of the teaching on the course, and might try some personal therapy with a Gestalt therapist at some point in the future, as I feel that it has a unique slant into therapy which I was not exposed to before. In general I do not feel that I know all there is to know in order
to understand and work effectively with patients and I see myself
continuing to acquire knowledge in various areas of psychology and
therapy. In particular, I am also interested in learning more about the
possible neurophysiologic dimension of psychological problems and
the effect of various psychological treatments on the way the neurons
in the brain respond. I am however aware that the specific service I will
hopefully end up working in, will dictate at least in part, some of these
future developments.

NOTES
(*) All clients in this document have been given pseudonyms in order to
maintain confidentiality
(**) The extract is taken from the 'Process report' available as part of the
attachment
(***) The name as well other revealing information was changed to
guarantee the anonymity of the presentation.
(****) T. stands for therapist
(*****P. stands for patient
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Introduction to the Research Dossier

Year 1: literature review

The review is entitled: 'Trauma transmission between mothers who are Holocaust survivors and their daughters'. The question I was trying to find an answer to by conducting this review, was whether or not 'second generation' daughters were in any way affected by being born to mothers that went through the war, and in what way.

I could not find a clear answer to my question. In fact I have discovered that there was no easy answer to this question.

I found that the 'answers' could be divided into different 'historical periods' according to the different views that dominated clinical and empirical thinking in different times.

I found plausible what seems to emerge as a possible integration of the different views. This idea seems to reflect current thinking on this topic, and states that what these daughters have 'inherited' from their mothers (trauma transmission) is some sort of fragility that makes them vulnerable to stress.

Year 2: Qualitative research

With some theory in place, I was eager to test things on the ground and explore the subjective experience of daughters of Holocaust survivor mothers. In the report entitled: 'Exploring the experience of women who were born to Holocaust survivor mothers: an interpretative phenomenological analysis study' I have described the interviews I have conducted with ten such women and the analysis of the data.
The six super ordinate themes that emerged from the analytic procedure capture some common feelings and qualities that daughters of Holocaust survivor mothers conveyed about the way they perceived themselves and their relationship with their mothers.

Some of the emotional difficulties that were alluded to by the women in the interviews, recalled concepts mentioned in the literature by the term ‘trauma transmission’.

**Year 3: Quantitative Research**

In this third study I wanted to turn my attention to the practitioners that might have to provide assessment and therapy, to women who were born to survivor mothers and experience distress. I wanted to test how the practitioners will formulate a hypothetical case which according to the literature and my qualitative study was typical to the anguish often experienced by women who are ‘second generation’ and is akin to PTSD.

By providing practitioners with three different vignettes, I created an experimental situation through which I could test some hypotheses that I had generated. The hypotheses were trying to predict the way practitioners will understand the clinical case presented in the vignette, and how they will conceptualise this clinical construct (assuming that the construct exists).
LITERATURE REVIEW

TRAUMA TRANSMISSION BETWEEN MOTHERS WHO ARE HOLOCAUST SURVIVORS AND THEIR DAUGHTERS

CONTENTS

A shortened version of the title suitable for the running head and abstract .......................... p. 91
Introduction ............................................................................... p. 92-96
Studies of clinical cases ................................................................. p. 96-102
Empirical studies of non-clinical population ............................... p. 102-105
Studies of non-clinical population under stress ......................... p. 106-109
Attempts at bridging the conflict between the results of clinical cases and empirical research .................... p. 109-112
Towards an integrative model of trauma transmission ............... p. 112-118
Conclusion ............................................................................... p. 118
References .............................................................................. p. 119-128
Appendix A: The use of self: reflections ...................................... p. 129-131
Appendix B: Notes for contributors of chosen journal ............... p. 129-131
Appendix C: Three most profitable internet searches
ABSTRACT
The purpose of this review is to explore the various ways in which trauma transmission between mothers who are Holocaust survivors and their daughters has been conceptualized. The early split between the findings of studies conducted with people from the clinical population and those obtained through structured empirical research studies with non clinical populations, is surpassed and a bridge between these opposing perspectives is offered. The particular vulnerability for PTSD of the non clinical population is discussed. Kellermann's view of the integration of various models, as the best way of approaching and understanding trauma transmission is presented, together with suitable supportive cases.
INTRODUCTION
The systematic, state-run effort to destroy all the Jews of Europe during World War II by Nazi Germany is commonly referred to as the Holocaust (Schiffrin, 2000). The Nazis killed European Jews as well as members of other groups like Gypsies and the handicapped. The Nazi effort to remove Jews from the world began with restrictions on participation in public life, continued with deportation to forced labour camps, and culminated in concentration and death camps. It ended when allied forces defeated the Nazis in 1945. At the end of the war, six million Jews were dead (Solkoff, 1982). The survivors, liberated from the camps were sick and traumatized. They had to face the fact that many of their family members were killed and their communities destroyed. The women who survived were struggling to recreate some sort of conventional life. Hasty relationships were formed in order to replace the lost family of origin and find some support. Many of these relationships were created with fellow survivors who were in a similar precarious situation. The children were born to parents who were often severely traumatized. This review will try to explore whether and in what way these children have inherited the traumas of their mothers.

Giller (2004) understands traumatic events as an extreme stress that overwhelms a person's ability to cope. In her view, a situation creates psychological trauma when it leaves the individual unable to cope when experiencing fear of death, annihilation, mutilation or psychosis. Several characteristics, however, are believed to exasperate the destructive potential of a potential traumatic situation. These are according to Giller that it was massive in scale, severe, repeated, prolonged and unpredictable. Also that it was inflicted by a person
rather than due to a natural disaster, and that the cruelty involved was intentional. All these criteria were fully present during the Holocaust. These massive stressors are seen as likely to produce emotions of overwhelming grief, terror, rage and anguish. The intrusion of the past into the present is one of the main problems confronting the trauma survivor. The intrusion may present as flashbacks, nightmares, or overwhelming emotional states. Survivors are likely to instinctively carry on protecting themselves from the impact of the trauma by remaining hyper vigilant, dissociated, avoidant and numb. These reactions might have been necessary and useful coping strategies at the time of the trauma but later interfere with the woman’s ability to live the life she wants. Giller (2004) talks about the physiologic changes that occur inside the body in times of hyper arousal and anxiety, specifically the wash of hormones such as cortisol that signal to ‘watch out’! When this happens repeatedly, the body learns to live in a constant state of ‘readiness for combat’ with all the distrust, aggression, hyper-vigilance and sleeplessness that entails. As scientists learn more about what trauma is, it becomes increasingly obvious that it is a complex mixture of biological, psychological and social phenomena.

Holocaust survivors, who were traumatized and became symptomatic, show a complex of psychopathological symptoms (Niederland, 1964, 1968; Krystal, 1968, 1978). These include anxiety, depression, memory disturbances, as well as a tendency to withdraw psychosomatic complaints and sleep disturbances. Their depression is partly due to the inability to mourn appropriately for relatives killed during the Holocaust. There are however, many authors who see this label as ‘offensive’ and oblivious to the complexities in survivor families (Epstein, 1979). Others acknowledge that many survivors show an unusual degree of psychic strength and resilience and have managed to energetically adapt to a new life in their country of immigration. (Jucovy, 1983).
A long interval had to be crossed before the emotional reality of the children of survivors gained attention by the scientific community. Powerful individual and collective defense mechanisms, like denial and repression, combined to ward off thinking about how and whether the trauma of the Holocaust affected the children of survivors. Some distance was necessary before mental health professionals were ready to deal with the consequences of the parental trauma on the offspring.

The first publications regarding the offspring of survivors came from Canada (Rakoff, 1966, 1969; Sigel, 1971, 1973; Trossman, 1968). Sources for the observations came from clinical material gathered from individuals in psychotherapy and from surveys conducted by interviews. Some of the common features identified in this group included conflicts arising from inflated parental expectations and the need to compensate the parents for their enormous losses.

The children, who are the focus of this review, were born into a complex array of emotions (Krell, 1979). On the one hand, they were a tangible evidence of one's survival and therefore very precious, but they were also born into a world that their parents experienced as a dangerous place. Many of these children were named after relatives who were killed, and such naming could have led to perceiving them as 'replacement children' (Krell, 1979). A confusing mixture of hope, despair, anger, and unrealistic expectations greeted the birth of these children.

There is a consensus in the scientific literature, that survivors had a distinct influence on their children. Both clinicians and researchers agree that the trauma suffered by Holocaust survivor parents, manifested itself in their children, and revealed itself either in
psychopathological symptoms or in specific character traits. (Last et al. 1981). There is however no consensus about how to understand the differences between clinical cases and empirical research, what was transmitted from mothers to daughters of survivors and how to conceptualize this vastly complex phenomenon. My aim in writing this review is to explore some of this complexity. I will start by describing what clinicians first and researchers later found in relation to the content of the transmission from Holocaust survivor mothers to their daughters. I will talk about the phenomena of research carried with non-clinical daughters of mothers from a Holocaust survivor population that nevertheless becomes pathological when exposed to stress. I will end by describing an integrative, and in my view promising, view of trauma transmission. This view proposes four different models of trauma transmission that can be used independently or in various combinations to shed light on this highly complex phenomenon. Critical analysis of the various research and clinical studies and implications for practice are tentatively offered.

While there are various ways of understanding the integrative approach (Woolfe et al. 2003), for the purposes of this review, integrative approach is understood to be is an on-going process in which the riches found in the therapeutic world and beyond, are integrated into an existing theoretical orientation. In other words, integrating contributions from the worlds of family therapy, social psychology and biology into the mostly psychoanalytic thought that dominated the discourse about the second generation in the past. Also, my approach is informed by seeing the locus of integration as taking place within the therapist or researcher (Clarkson, 1995). Hence, the emphasis is on the moment-by-moment use of self-in-relationship, in the understanding of the psychological phenomena under consideration. In that way what is examined is viewed from a slightly
constructionist perspective: as there is no access to absolute reality, all paradigms are merely tentative constructions of 'what is' (Gergen, 1997). The use of perspectives that offer helpful understanding to the matter under scrutiny is therefore seen as a welcome contribution.

This literature review will focus primarily upon daughters of mothers who are Holocaust survivors. The Holocaust is seen as a massive trauma and as such similar to other massive traumas that have occurred and might have affected future generations. For the purposes of this review I am going to include in the term Holocaust survivor, mothers who spent time in concentration camp, in forced labour camps, on the run, in hiding or as partisans during the German occupation of Europe in the Second World War. Offspring of Holocaust survivors will include those daughters who were born to mothers who are Holocaust survivors after the war and are also called 'second generation'.

**STUDIES OF CLINICAL CASES**

The early studies on children of survivors focused on families that referred themselves for psychological treatment, and it took time to realize that maybe the cause of the psychological distress of the children was linked to their parents being Holocaust survivors. Kestenberg (1972) devised and sent questionnaires to colleagues in several countries, inquiring about their experience of analyzing children of survivors, she learned from the responses that the link between the patients' problems and the history of their parent's persecution had never occurred to the clinicians. During the 80s, an unusual number of children of Holocaust survivors were seeking professional help. Based on clinical work with such patients, there were some clinicians (Barocas et al. 1980) who found similarity between the symptoms displayed by the children of Holocaust survivors and the 'survivor syndrome' described in the literature by Niederland (1964). These clinicians found
that the children of Holocaust survivors suffered from poor object relations, low self-esteem, negative identity formation and considerable personality constriction. According to Barocas et al. (1980), this population also exhibits increased vulnerability in stress situations and some temporary blurring of ego boundaries when confronted with experiences that evoke the Holocaust. Bergmann (1983) suggested a failure to achieve autonomy in adolescence and a certain dynamic within the family that made it difficult for both parents and children to separate from each other. He thought that the individuation process of the children was sometimes perceived by the parents as threatening, because it acted as another loss and reactivated the lifelong mourning these people were in the grips of. Some daughters of Holocaust survivor mothers developed acute anxiety, phobias, and panic attacks when faced with having to leave home or in any other way separate physically or symbolically from the survivor mother. Many of these second generation daughters suffered guilt about wanting to be different from their parents because their development of a separate sense of self was experienced by them as a narcissistic injury to the family’s precarious stability. Separation was further hampered by the need of the offspring to suppress any manifestation of anger because that was easily taken by the survivor parents as ‘being like the Nazis’ and provoked further guilt. Survivor parents continued to feel vulnerable and scared of being punished for the slightest manifestation of anger, they continued to emphasize to their children the need to submit in order to survive, promoting by this a masochistic style.

Barocas et al. (1980) found in their case load of patients who were daughters of survivors also sexual inhibitions as well as sadomasochistic imagery such as being raped by a Nazi. Bergmann (1983) reports cases in which the experience of the parent has a way of breaking into the
life of the child to the extent that it has been designated as a 'double reality'. These daughters lived in the real world but were also transported back into the Holocaust world of the parents, particularly in the presence of certain triggers. In fact Kestenberg (1983) talks about the second generation responding to an unconscious request by the parents to go back with them to live what the parents have not managed to process. She called this process transposition. The closer the child was to the psychotic end of the spectrum, the more such breakthroughs' occur and interfere with her life in the present.

Two studies with clinical populations that involved daughters of survivors will now be presented. The first one relates to orthodox Jewish patients requesting therapy from public psychological services in New York, and the other describes clinical cases seen in a private practice of a psychoanalytic feminist practitioner.

**Case studies within Hasidic and Ultra-Orthodox Jewish populations**

This project aimed to provide psychological services for survivors and their children, following a request for help from the Hasidic group in New York City in the autumn of 1974 (Siegel, 1980). This step of asking for help from outside sources is most unusual for this group that highly values its autonomy and privacy. This drastic step on their part reflects the severity of the problems that this community was facing. While describing the particular life style of this community is beyond the purpose of this work, it is important to remember that people in this group follow the practice of the Jewish religion very strictly, have a generally strong resistance to outside influence, and have strong mystical inclination and group loyalties. Also, whilst not necessarily psychologically minded, these people value all intrapsychic events like dreams and words, and have a culturally developed inclination to trust people who have a certain authority and are then seen as imbued with special powers. The dominant view of the Holocaust in this group is
that it was brought as a severe punishment for failure to follow Halachic order absolutely. These distinctive cultural characteristics have shaped group and individual responses to the Holocaust. Siegel, (1980) described the symptoms prevalent in this group. Many women, daughters of survivors, suffered from postpartum reactions. These included neurotic reactions like feelings of helplessness and depression, as well as psychotic states. All cases had a marked hysterical component that carried a secondary gain by allowing them to get permission to use birth control because of their difficulties. Another common symptom was described by Shapiro (1972) as 'symbiosis in adulthood' and consisted in a temporary psychotic reaction between women and their husbands as well as a more resistant variant of this illness. A third pathological manifestation found had to do with chronic pain-dependent behaviour patterns. This manifested itself by painful procedures as preparation for sleep, denigrating moral attitude toward themselves and accident proneness. These masochistic tendencies were exacerbated by the combination of rage and guilt often seen in this society. Some masochistically tinged sexual fantasies that involved Nazis have been elicited from many women who were daughters of Holocaust survivors. Identification with their passive mother-victim was also seen as being realized via such fantasy.

**Implications for treatment**

Siegel (1980) advocates brief and more often symptomatic treatment with this population. He agrees with Rabkin (1977) about the need for strategic treatment techniques. He emphasizes the importance of being attuned to the religious beliefs and customs of the Hasidic groups by the therapist without presenting him/herself as a threat to deeply held traditions. Also the women in these communities according to him are more psychologically aware and ready for
psychotherapy than the men and he explained this by women having fewer practical outlets in work and being burdened by many children to look after, which leaves them much more vulnerable especially after childbirth.

Case studies of second generation daughters seen by a feminist psychodynamic therapist

Vogel (1994) became interested in a number of female patients she was treating who had things in common. She felt that some of these women had a psychic trauma that originated in the patient’s caregiver who had experienced a traumatic event, in response to which her patient was now suffering inexplicable symptoms. These symptoms included fear, anxiety, depression, flashbacks of things never experienced, nightmares and obsessions with phenomena out of their range of experience. The notion that the trauma experienced by the parent can be a source of post-traumatic manifestations in the child was absent from the professional mental health discourse until the pioneering research of Danieli (1982). Vogel felt that Danieli’s observations were helping her to think about her patients. She was intrigued by Danieli’s observation that not all children were receptive to their mothers’ trauma in the same way. Vogel thought of gender as an important factor in the child’s vulnerability to the experiences of parental trauma. In Vogel’s experience these more vulnerable and open children were usually daughters. The group of six women, whom she saw as therapist, consisted of Jewish women, and all had mothers who have gone through major traumatic experiences. All the daughters experienced their traumatized mothers as unable to talk about their ordeal. The mothers thus became incomprehensible to their daughters. All the daughters knew was that something bad and unspoken-of had happened to their mothers. Vogel understood these patients as possibly experiencing the psychological effects of traumas
not their own. Vogel used the self-in-relation model (Jordan et al. 1991) to explain her findings. According to this model girls' sense of self develops via bonds of empathy and projective identification with the mother (a same-gender care-giver). Unlike boys, girls' sense of identity comes from their ability to connect and feel alike (Chodorow, 1978). The daughter's self-boundaries are more fluid, more open and more vulnerable to encompassing whatever the mother carries within herself. When the mother carries a trauma from which she must, for her own survival distance herself, the daughter is likely to absorb the trauma unknowingly. This way of thinking of the transmission of trauma seems similar to Schwartz's idea of direct nongenetic transmission of trauma. (Schwartz et al. 1994). This is a mechanism of projective identification which is seen as one of the ways in which the survivor parent tries to rid herself of terrible memories and the feelings associated with them (Davidson, 1992). Through the mechanism of projective identification, experiences of the mother become mental properties of the daughter.

**Vogel's recommendations for practice**

Vogel became interested to enquire about the traumatic experiences of her patient's parents, and to check whether the daughter has become the receptacle of the traumatic parental material. When confronted with a case of direct transmission of trauma, the therapeutic stance advocated by Weiss et al. (2000) needs to aim at identifying and encouraging a process of regression in order to uncover the 'near-identicalness' between the inner experience of the second generation and that of the survivor parent. The objective of this process is to alert the daughter to the existence of direct transmission from her mother's trauma in order to then facilitate differentiation.
A note about methodology of both clinical studies

A critique of these early studies is that they lack scientific rigour. Most are based on a clinical population or a small number of clinical case studies seen in psychoanalytic treatment. The result is a pre-existing hypothesis of pathology (Solkoff, 1981). As to Vogel's ideas about female offspring being more open and thus more vulnerable to the transmission of trauma from their mothers, there is no empirical evidence to suggest that more female than male survivor offspring are susceptible to their mother's traumas.

EMPIRICAL STUDIES OF NON-CLINICAL POPULATION

The study of clinical cases in therapy created a picture of a highly pathological population. More structured research design that compared a non clinical second generation population with control groups on the other hand, did not find a substantial difference in terms of psychopathology. A series of controlled empirical studies with non-clinical populations was trying to study the differences between groups of second generations participants and matched control groups along various variables. For example, Nadler et al. (1985) were trying to compare the tendency to externalize aggressive impulses in reaction to frustrating events, and correlated this tendency with the feelings of guilt; Weiss et al. (1986) wanted to check whether the symptoms displayed by children of survivors could be explained as an 'immigration effect'; Rose et al. (1987) wanted to observe the dynamics of the parent-child relationship in survivor families and the mechanisms by which trauma and psychopathology are assumed to be transmitted from Holocaust survivors to their children.

Methodologically these studies were trying to improve their sampling methods and use well validated reliable measures. Nevertheless, research into the transmission of trauma from parents to children is
problematic because of the complexity and the large number of variables involved (Zillberfein, 1996). The findings of these research studies outline what was described by Weiss et al. (2000) as ‘Indirect transmission’, in other words, specific traits that might be due to deficit of parenting skills of the survivor parent that affected the child. These traits however, do not qualify as proper pathology and might be biologically inherited to some extent (Rowland-Klein et al. 1998).

An empirical research exploring the quality of engagement between mothers and adult daughters
This research, conducted by Halik et al. (1990), was asking the following question: in what way, might the Holocaust experience be reflected in the relationship between a mother survivor and her daughter? The picture of the Holocaust family that has emerged in the literature included extreme forms of enmeshment, symbiotic devotion, blurring of boundaries, and disturbances in communication (Des Pres, 1976). An alternative view of survivor families (Leon et al. 1981) suggested that non-Holocaust dimensions such as being part of an immigrant group might account for these results. The absence of pathology in the findings of research with non-clinical groups does not preclude however, subtle differences in patterns of relating between survivors and their children. These patterns might eventually, as will be demonstrated later in the section about non-clinical population under severe stress, become problematic. The study in question is grounded in a systemic perspective (Bowen, 1978). This perspective sees maturity as a correct engagement between parental protective ‘bonding’ to the child and the adult child’s ability to keep intimate relationships with the parent as well as independence from it. In this study the focus was restricted to the relationship within the mother-daughter dyad. The
literature talks about daughters of survivors feeling torn between being protective toward parents they perceive as vulnerable, and feeling guilty in response to angry impulses toward them (Klein, 1973). Separation and individuation may suffer as a result (Podietz et al., 1984). This study matched three groups of participants, on country of origin, education, social class, and age. One group included daughters of Holocaust survivor women who immigrated to Australia from Europe soon after WWII; the two control groups consisted of daughters of European immigrant women who left Europe just before the war; and daughters of Australian-born women. All participants answered two questionnaires measuring maternal protectiveness and ‘personal authority’ (combination of intimacy and separation from the family of origin) in the family system, and a semi-structured interview assessing sociodemographics. Contrary to predictions, no significant differences were found on a measure of mothers’ protectiveness and care in their daughters’ first 16 years. It is however important to note that a significant number of survivor daughters reported in the interview lower levels of personal authority and individuation with their mothers, while at the same time they reported similar levels of intimacy with her. For Holocaust survivor daughters, then, the difficulty seems to be in achieving individuation but not in achieving intimacy. When thinking from a systemic point of view, both these skills (capacity to achieve intimacy as well as autonomy) are seen as needed in order to achieve separation from the mothers. As daughters of Holocaust survivors perceived themselves as less able to maintain a clear self-definition, this while not pathological in itself, might become problematic under certain circumstances. A tentative explanation for this phenomenon of delayed self-definition might be that daughters of survivor mothers need more time to explore and integrate the traumatic transgenerational legacy and historical imagery of the Holocaust that was passed to them, than would ordinarily be required. As relationships
between survivor mothers and their daughters were not characterized by dysfunctional results, these difficulties in balancing intimacy and individuation may be viewed as a style of relating rather than as a destructive function within the family system.

**Implications for treatment**

Counselling psychologists treating women who are daughters of survivors need to facilitate the working through of the integration of parental traumatic history by the daughter, and encourage separation and individuation from the survivor parent which might entail long and arduous work because of the guilt attached to it that was mentioned earlier in the section dealing with the findings of clinical studies of this review.

While empirical research could not find any significant difference between second generations non-clinical population and control groups in terms of psychopathology it identified specific character traits typical to daughters of Holocaust survivor mothers who were sampled from the general population. While these traits are not pathological in themselves, they might become problematic in specific situations and cause difficulties in establishing separation and autonomy, cause anxiety, as well as create difficulty in the expression of anger and in establishing satisfactory relationships.

**A note about methodology**

The sample for this study was selected from a population of a uniformly high socio-economic background and so these findings might not generalize to lower-class Jews. Also, the possibility that there were personality differences between the groups that may account for the results obtained cannot be ruled out.
STUDIES OF NON CLINICAL POPULATION UNDER STRESS

A line of research that identified situations in which the barrier between these two distinct groups (clinical and non-clinical populations) gets blurred, and daughters of survivors apparently free of symptoms become affected by the trauma (apparently dormant until that moment), is presented next.

A controlled study of cancer patients from a non-clinical second generation population

Baider et al. (2000) wanted to study female cancer patients who were second-generation Holocaust survivors, in an attempt to determine whether they react to their illness with more distress than was the case for cancer patients who were not daughters of survivors. The researchers were interested to ascertain whether daughters of Holocaust survivors may function adequately in their daily activities, but be unable to cope with the emotion of extreme stress or severe life threatening situations. More than 200 women diagnosed with breast cancer participated in this study. About half of them were daughters of Holocaust survivors and the rest were allocated as a control group. The refusal rate was very low, suggesting that the two groups may be adequately representative of women diagnosed with breast cancer. Methodologically, this study was trying to avoid Solkoff’s (1981) criticism of early research, namely, that of flawed sampling. The two groups had similar background characteristics in terms of age, education, family status, number of children, and socio-economic status. Also, most participants were daughters of immigrants, in order to take into account Solkoff’s (1992) view of the ‘immigrant effect’ as a potential contaminating factor. The participants had to complete three self-reports: the Mental Attitude to Cancer Scale; the Brief Symptom Inventory; and the Impact of Event Scale. While the two groups had identical mean scores on the Mental Attitude to Cancer Scale, the
daughters of Holocaust survivors had scores on the Brief Symptom Inventory and the Impact of Event Scale that were substantially and significantly higher and in the range of psychopathology. The two groups were identical in their ability to cope in a practical way with cancer but they differed drastically on the two measures of psychological distress. The basic hypothesis of this study, that the second generation Holocaust survivors will react emotionally with extreme distress to a threatening event like cancer, was confirmed. These findings recall those of another study (Yehuda et al. 1998) that studied a group of physically healthy second generation Holocaust survivors and a comparison group and found that their response to the same traumatic event was different, with the second generation group displaying significantly higher prevalence of current and lifetime Post Traumatic Stress Disorder (PTSD) than was the case in the comparison group. In Baider et al.'s (2000) study, while the functional adjustment to cancer among the daughters of survivors was as good as that of the comparison group, their psychological distress was significantly greater. These findings and those of Yehuda et al. (1998) suggest to us that what is transmitted from mothers who are Holocaust survivors to their daughters is in fact a vulnerability to PTSD.

The findings of this study present us with a population that is not clinical in terms of mental health but that nevertheless is at risk of displaying psychopathology when under severe stress. Although the second generation in general does not differ from others in terms of psychopathology, their latent vulnerability might become more manifest after an additional stress (Dasberg, 1987).

Implications for treatment

We learn from this study that daughters of Holocaust survivors are particularly vulnerable to psychological distress and should be regarded as a vulnerable population at high psychological risk. This
might be the case for the offspring of any severely traumatized parents like victims of war and forced immigration. Counselling psychologists need therefore to be particularly sensitive with these clients. They have to keep in mind that while these clients might seem to function adequately, they carry a risk of responding with a disproportionate amount of distress when having to face stressful situations. The reason for this is to do with a latent vulnerability to PTSD that was transmitted to them by the parent and might become active when faced with highly stressful situations. In such times, Kellermann's (2001) recommendations are to encourage free expression of feelings, thoughts, and associations by the client that may have been unspoken of previously. Also he advocates helping these clients to express their seemingly unjustified anger, anxiety, and depression and tease out the preconscious processes that continue to feed the transmission of trauma from one generation to another. Kellermann found that a combination of individual therapy with group therapy of various orientations (expressive forms of music, art, psychodrama and bibliotherapy) is particularly useful. These steps are in his view aimed at providing these daughters of survivors with opportunities to gain some insight into the roots of the trauma that was transmitted to them, which needs to be followed by a gradual process of working through and end with the process of reintegration.

A note about methodology
While very careful consideration was given to the methodology of this study by taking into account Solkoff's recommendations (1981, 1992), there are still some limitations to this study: first, most of the second-generation Holocaust survivors were born outside Israel, whereas the majority of the comparison group were born in Israel; secondly, the second-generation Holocaust survivors were in somewhat better medical condition. These differences might of course introduce some
bias into the results.

ATTEMPTS AT BRIDGING THE CONFLICT BETWEEN THE RESULTS OF CLINICAL CASES AND EMPIRICAL RESEARCH

While clinicians identified daughters of Holocaust survivor mothers as having problems of separation and autonomy (Barocas et al. 1980; Kestenberg, 1982; Levine, 1982), problems in the regulation of aggression (Freyberg, 1980), pathological identification with parents (Newman, 1979; Daniell, 1982; Kogan, 1989), depression (Newman, 1979; Freyberg, 1980), feelings of guilt and defective super-ego functioning (Levine, 1982; Bergmann et al., 1982), these findings cannot be generalised to the larger population of offspring of Holocaust survivors because they were based upon uncontrolled clinical samples (Brom et al. 2001). Non-clinical studies have attempted to confirm the clinical impressions and have focused on a variety of variables such as psychological symptoms (Russel et al., 1985; Rose et al., 1987), psychopathology (Weiss et al. 1986; Schwartz et al. 1994), personality characteristics (Leon et al. 1981; Zlotogorski, 1983; Nadler et al. 1985), and communication patterns in the family (Lichtman, 1984; Felsen et al. 1990). In these empirical studies, however, no significant differences were found between the offspring of Holocaust survivors and comparison groups on measures of psychopathology as assessed by either validated paper-and-pencil instruments or by structured diagnostic interviews. There were attempts to bridge this dichotomy and offer an overarching scheme within which both these extremes of the spectrum could find their place. An example of such an attempt is presented now.
An attempt to create a methodological bridge

Brom et al. (2001) devised a study that had the aim of bridging the gap between clinicians and researchers. They were trying to undo the divide between clinical research that consisted of systematic attempts to understand daughters of Holocaust survivor mothers referred for therapy and the non-clinical controlled empirical research that traditionally was focusing on daughters of Holocaust survivors from the general population irrespective of help-seeking behaviour. The challenge was to combine clinical sensitivity, normally part of clinical studies with strict adherence to methodological principles, normally applied in empirical structured research with non-clinical population. The solution to this challenge was to conduct a double-blind study, using therapists as measurement instruments. This is a new methodology. The researchers developed a clinical interview that attempted to study the long-term consequences of massive trauma upon the offspring of Holocaust survivors, as well as capture the therapists’ impressions of the women they interviewed. The authors conducted their study under very strict methodological conditions. For example, both interviewers and interviewees were unaware of the actual purpose of the study, the sampling of the population was random, experienced psycho dynamically trained clinicians conducted the assessments, a matched control group was used and quantitative scales were used to record clinicians’ impressions. The most outstanding finding of this study is the difference in interaction patterns between the daughters of Holocaust survivors and the control group. The daughters of Holocaust survivors had more problematic relationships with their parents, showed a greater tendency to enter into ambivalent relationships, had more difficulties putting their needs aside and attend to the needs of their children and their lives were more intertwined with the lives of their parents. These findings confirm the clinical impressions that the main difference between daughters of
Holocaust survivors and their peers is related to difficulties in separation from their mothers (see the negotiation of separation-individuation phase as described by Mahler, 1975). These findings also confirmed previous findings assessed by empirical research with non-clinical population that found no differences in psychopathology between the offspring of survivors and their peers. These findings help us to make sense of what seemed in the past as an insurmountable gap between the findings of clinical studies and those of empirical research. We can now assert that there are specific interactional patterns within the family of origin of the daughters of survivors that appear to have influenced the second generation (Lichtman, 1984) and higher indices of incomplete separation-individuation processes when compared to those of a control group (Zilberfein, 1996). Daughters of Holocaust survivors however, do not, as a group, exhibit more psychopathology than controls (Schwartz et al. 1994). While we acknowledge this, it is however important to remember that they are more at risk of developing pathology because of their particular psychological structure around separation-individuation issues. These specific patterns do not necessarily lead to psychopathology but they mean that what these daughters inherit from their survivor parent is an inability to shift appropriately between closeness and distance in their relationships, and this weakness might prevent them from recruiting enough social support in time of stress and thus leave them more vulnerable at those times. These findings might account for the fact that some daughters of survivors become pathologically affected by their mothers' trauma, some are symptom free but possess some specifically typical character traits and some are symptom free but are at increased risk of reacting pathologically to severe stressful situations because of the vulnerability they have inherited from their mothers to PTSD.
Implications for practice
As the interaction between daughters of Holocaust survivors and their partners might suffer as a result of the particular pattern of separation-individuation that they have inherited from their survivor parent, they might need help in managing ambivalent relationships and unhelpful patterns of relating with their children and parents. This might include a spell of family therapy or couple therapy in order to help them negotiate these relationships with more autonomy. Also under stressful situations this non-clinical but vulnerable population can become particularly distressed, and this might be a piece of preventive educational advice that might be given to them, so that they do not ignore this risk and abuse themselves unnecessarily.

Limitations of this study
Relatively small sample of women only, while the measures used were developed in cooperation with psychodynamic therapists and thus highly relevant and valid from a clinical point of view, their empirical validity needs to be further investigated.

TOWARDS AN INTEGRATIVE MODEL OF TRAUMA TRANSMISSION
The split between the observations of clinicians (that daughters of Holocaust survivors were suffering from emotional distress) and the failed attempts of researchers to confirm these observations with more objective and reliable instruments seem to become less sharp. In fact, it does not make much sense any longer to ask whether children of Holocaust survivors in general are more disturbed than others, but we need to continue and outline the specific characteristics of this clinical subgroup of Holocaust survivors and further understand the specific internal structure they possess and how various factors influence this particular trauma transmission they have inherited. In other words, according to clinical experience and empirical research, this clinical
population, compared with other sufferers of emotional problems, seems to have specific disturbances more or less focused on difficulties in coping with stress and higher vulnerability to PTSD.

While investigating whether and to what degree daughters of Holocaust survivor mothers have absorbed the traumas of their mothers, the need remains to further clarify what is transmitted and how it happens. (Kellermann, 2001). How can a trauma be transmitted from one generation to another? Could we think of it by borrowing images from the world of Physics and see it as a passage of information or energy between transmitter and a receiver?

I will follow Kellermann (2001) in tentatively trying to explore four theoretical approaches that have been offering a contribution towards the understanding of trauma transmission: namely, psychodynamic theory, sociocultural, family systems and biological models of transmission. These various ways of thinking about transmission contain the various ingredients that have been identified so far to influence the process of trauma transmission. According to this view trauma transmission in a child of a Holocaust survivor is a function of unconscious parental emotions as seen by psychodynamic theory, inadequate parenting, as seen by social theory, family enmeshment as proposed by family system theory and a hereditary predisposition as claimed by biological models. Whether hereditary, or environmentally inflicted, specific manifestations of trauma transmission can be explained as being determined by any or all of the above mentioned psychodynamic, sociocultural, family systems and biological factors or by a combination of these.

I will next describe each of these perspectives into understanding trauma transmission. I will also point to a study (mentioned above) in which a particular approach is offered.
Psychodynamic model of transmission

This model claims that emotions that could not be consciously experienced by the first generation are passed on to the second generation. The child thus unconsciously absorbs the repressed and insufficiently worked-through Holocaust experiences of the survivor parent (Kellermann, 2001). As seen by this model, the parent unconsciously externalizes the traumatic part of herself onto the child and the daughter becomes a reservoir for the unwanted traumatic parts of the mother. It then becomes the daughter's task to mourn and reverse the feelings of helplessness that actually belong to the mother (Volkan, 1997). Rowland-Klein et al. (1998) have proposed a form of projective-identification as a way to explain the mechanism in which the trauma is being transmitted: the mother projects Holocaust-related feelings and anxieties into the daughter and these are introjected by the daughter making her feel as if she herself had experienced the Holocaust, and causing her psychological distress. Throughout this process parents tend to displace their own repressed grief upon their children and then see them as 'memorial candles in Holocaust cape' (Wardi, 1992). Vogel's study mentioned above (see p. 100), in which she found signs of traumas in her patients that were actually not their own but experienced by their mothers, is an example of how transmission of trauma can be explained, namely, a projection of unwanted material by the traumatized parent and an introjection of it by the child who then displays symptoms of distress.

Sociocultural model of transmission

Transmission in culture is well described in social psychology (Heller, 1982). Social learning and socialization models of transmission focus on how children of survivors form their own images through their parents' child-rearing behaviour, for example various prohibitions, taboos, and
fears. In much of this literature, Holocaust survivors have been described as inadequate parents, bombarding their children with messages about how dangerous the world was and a sense of an impending danger, that the child may have absorbed. We may assume, however, that Holocaust survivor parents influenced their children not only through what they did to them in terms of actual child-rearing behaviour but also through who they were in terms of role models and the social context in which their life revolved. In the study mentioned above by Siegel (1980) (see p. 98), we can see an example of a phenomenon that can in part be explained as a transmission of trauma seen through a social model. The unique symptoms displayed by the Hassidic women such as post partum psychoses, hysterical reactions and a particular masochistic imagery can be seen as a socially constructed way of dealing with the trauma that was transmitted to them by their parents and can be fully made sense of only with this particular social model in mind. The treatment they were offered had to take this particular social context and their cultural peculiarities into account, in order to make the intervention effective.

**Family systems model of transmission**

Unconscious and conscious transmission of parental traumatization always takes place in a certain family environment. The more pathological Holocaust survivor families are described as tight isolated islands, in which parents and children are over-committed to each other. It is not surprising that problems around individuation and separation (Klein, 1971; Barocas et al. 1980; Freyberg, 1980) and attachment (Bar-on et al. 1998) arise. Parents like this, who care too much and who become overly involved and intrusive, tend to enmesh their offspring in the crossfire of their own emotional problems and bind them unto themselves in a manner that makes it difficult for the
children to become independent. Children in families like these often end up looking after their parents in a sort of role-reversal conceptualized by Metzger-Brown, (1998) as ‘defensive care taking’, and ‘enmeshment’ by Seifter-Abrams (1999). Much trauma transmission occurs through non-verbal, ambiguous and guilt-inducing communication (Klein-Parker, 1988; Lichtman, 1984) and especially through the ‘conspiracy of silence’ (Danieli, 1998). The subliminal mediating influence of parental communication style, through either over silence or over preoccupation (Sorscher et al. 1997), may be a major reason for the difficulty many daughters of survivors have when trying to connect their sensations of fear, sadness and vulnerability with actual memories of the experiences of their parents. The study mentioned above (Halik et al., 1990) (see p. 103), where the daughters of survivors were found to be less able to become autonomous, probably because of the more complicated images of trauma they had to process before being able to separate from the mother, is an example of phenomena that can be understood with the help of this model. This kind of enmeshment within the family is the way family-system -theory understands and explains the effect of the trauma and its transmission within the family.

**Biological model of transmission**

This model is based on the assumption that there may be a genetic and/ or a biochemical predisposition to the aetiology of a person’s illness, Volkan (1997). Perry (1999) carried this hypothesis further claiming that memories of fear can be carried across generations through physiological processes and manifest in the genome. While this model of transmission is open to debate, it provides another helpful theoretical context in which to locate the transmission of trauma. This model then claims that genetic memory code of a traumatized mother may be transmitted to the daughter through some electricochemical
processes in the brain. The neural organization of various memory
systems in the mother (for example hyper alertness) would lead to a
similar organization in the child. Van der Kolk et al. (1996) found a link
between the long-term effects on the neurochemical responses to
stress in traumatized parents and some biological vulnerability in the
child, and hence hypothesize that children of Holocaust survivors who
are born to severely traumatized parents would then be predisposed to
PTSD. This perspective into the understanding of transmission of trauma
could be seen as operating in the women diagnosed with cancer,
mentioned above in the study of Baider et al. (2000) (see p. 106),
where non-clinical population of daughters of Holocaust survivor
mothers, diagnosed with breast cancer were found to react to their
illness with pathological levels of stress when compared to a control
group.

Adelman (1995) interviewed twenty pairs of mothers, Holocaust
survivors and their daughters, about the mothers' memories of the
Holocaust. Through analyzing their narrative at different points of their
story, she was able to identify the particular way in which these
women's memory was organized. In fact, Adelman argues that these
women possessed two separate ways to encode memories: one for
traumatic memories and the other completely separate for non
traumatic memories. Adelman's findings show that these modes of
organization do not interfere with each other. Instead they exist side by
side. The traumatic material of the Holocaust is encapsulated in a
universe with its own unique regulation and definitions of self and
others. The daughters of survivors display regressive shifts in their
affective organization, when under the stressful conditions of recalling
the traumatic memories of the Holocaust. This regression manifests itself
in acute anxieties over separation phenomena. This does not intrude
however on a stable level of adaptation displayed when recalling non
traumatic memories. The biological model of transmission is congruent with these findings.

I am further reminded of Giller’s (2004) comment about trauma as a complex mixture of biological, psychological and social phenomena.

CONCLUSION

This review was trying to follow some of the literature dealing with the transmission of trauma from mothers who are Holocaust survivors to their daughters. The rift between clinicians and empirical researchers becomes less relevant and the current thinking is of some particular inner organization that in extreme cases can be the source of pathology as well as become pathological under stress, but is not pathological as such. There is still an ongoing attempt to understand what is being transmitted, how, by what kind of mother, and to what kind of daughter. Kellermann’s (2001) view of understanding this phenomenon through an integrative perspective is presented here as a flexible enough and comprehensive enough way to approach this complex phenomenon. While a lot more is left to investigate in relation to the aggravating and mitigating factors that intervene in this transmission of trauma, it is clear that the clinical population of offspring tend to present a specific 'psychological profile' that includes a predisposition to PTSD, various difficulties in separation-individuation and a vulnerability when coping with stress. I am wondering about the lack of studies carried out in England, comparing to the wealth of them in Israel and North America. This is surprising in the light of the large Jewish population of Holocaust survivors who settled in England after the war. Exploring the reasons behind this phenomenon might be an interesting enterprise in the future. I tend to support De Graaf (1998), however, in thinking that the problems met in families of Holocaust survivors have probably some universality to them, in common with those faced by children of traumatized mothers elsewhere.
REFERENCES


Schiffrin, D. (2000). Mother/daughter discourse in a Holocaust oral history: “because then you admit that you’re guilty”. *Narrative Inquiry, 10*(1), 1-44.


APPENDIX A
USE OF SELF: REFLECTIONS

My father is a Holocaust survivor and my mother is not. Like many other survivors, my father talked very little about his days in Auschwitz. I knew that he was in the camps and that he lost both his parents, two siblings and many other relatives, but I protected myself as a child, by thinking that he was old enough to cope with it when it happened. My father was not screaming in his sleep or conveying distress in any other obvious way. It was much later in my life that I realized how tortured he must have been at the tender age of fifteen. The enormity of what had happened and how awful it must have been for him and by implication for me became clear gradually.

I then became interested in learning more about what happened in the Holocaust and the effect it had on people like me - the so called 'second generation'. I read and asked a little but the search was always tinged with apprehension and done in secret. The appeal that the PsychD course had for me was partly in the chance it offered to conduct some research on this topic. It felt relatively safe to approach the subject under the aegis of academia.

Still, once started, my resolve to go ahead with this topic had to contend with the emotional impact of some of the literature on me. Most of the empirical research was easier to assimilate, due to its more structured stance, which created a protective shield and contained my feelings. The more descriptive material, on the other hand, produced floods of tears. At other times however, I felt numb which I think was a defensive way of dealing with the impact of what I was reading. Some of it was painful to absorb.
Together with my supervisor it was thought that as my mother was not a Holocaust survivor, focusing on daughters of mothers who were Holocaust survivors would prove easier and would facilitate much needed distance.

I forgot that my father lost two close female relatives in the war: his mother and his sister. I was named after his mother and heard relatively a lot about her as a person. The situation however was different in relation to the sister. This sister was 12 at the time of the Holocaust and was too young to be chosen as a labourer in the camps during selections. She was sent to the gas chambers and then got burned. On a conscious level this aunt was just a name. I felt that my father had guilty feelings in relation to her about surviving. He was just three years older than her, but old enough to be selected for work rather than immediate death. He survived. There were no official records about her fate. My father had to come to terms with the painful recognition of her death.

I never thought about this aunt much, but to my surprise, just as I was starting to collect material for the review, I had a dream about her. In my dream she did survive. We somehow found her and everybody was nearly sure that she was the lost sister. She took me in the dream to see her flat and I noticed that she must have had a very difficult life. She was living on her own, working and lonely and sad but had also something very dignified in her demeanor. Once in her tiny flat I spotted the presence of a broom and a dust pan in the corner and I pointed in their direction. She shook her head to say ‘No’ in response. Her hair looked like the hair of my middle daughter who is now twelve years old (the age this aunt was when killed). I understood this dream as some unconscious endorsement of this aunt that was lost and largely forgotten (despite being very active in my father’s unconscious
mind probably, which I must have picked up). Having a daughter of the same age, as well as starting to think of females in relation to the Holocaust for the purposes of my research, reawakened the dormant memory of this aunt that was turned into ashes. It all of a sudden became tangible to me that she existed and was killed and was not allowed to grow up and live her life and I cried and grieved for her which was maybe something my father was never able to do properly and fully before. In the dream we found her and despite the fact that her life was austere and difficult she managed to stay alive and to say no to becoming dust.

Searching about the Holocaust for this literature review helped me to bring back to life some dormant aspects of my history. It was a small celebration of the survival of my father despite the massive losses. It helped me to explore the different effects of this ‘worse than a nightmare’ past on the children of victims. While at times I felt that I was nearly trivializing something that was so imbued with suffering and loss and which essentially defies words, I also felt that the very attempt of studying this topic was one more triumphant step in a long journey of healing that I was accomplishing. While not fully recognizing any particular problems in the area of ‘separation-individuation’, which as the review shows are very typical to this group, I could identify with feeling that I was potentially more vulnerable when it came to coping with stressful situations, and could react with high levels of distress. This position is apparent in my endorsing the view of non-clinical population being nevertheless a population at risk when exposed to stress. I feel that exploring this topic through research is going to be another important step along the road of my process of individuation.
APPENDIX B

INSTRUCTIONS FOR CONTRIBUTORS OF THE CHOSEN JOURNAL (JOURNAL OF LOSS AND TRAUMA)
Instructions for Authors:

***Note to Authors: please make sure your contact address information is clearly visible on the outside of all packages you are sending to Editors.***

Submission of Manuscripts

Original and two copies of the manuscript should be submitted to John Harvey, Department of Psychology, University of Iowa, Iowa City, IA 52242-1407; phone (319) 335-2473; fax (319) 335-2799; e-mail: john-harvey@uiowa.edu. Authors are strongly encouraged to submit manuscripts on disk. The disk should be prepared using MS Word or WordPerfect and should be clearly labeled with the authors’ names, file name, and software program. A hardcopy printout that exactly matches the disk must be supplied. Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become the property of the publisher.

All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. All titles should be as brief as possible, 6 to 12 words. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 100 words. Avoid abbreviations, diagrams, and reference to the text.

Manuscripts, including tables, figures, and references, should be prepared in accordance with the Publication Manual of the American Psychological Association (Fourth Edition, 1994). Copies of the manual can be obtained from the Publication Department, American Psychological Association, 750 First Street NE, Washington, DC 20002-4242; phone (202) 336-5500.

Illustrations

Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- sized to fit on journal page
- EPS, TIFF, or PSD format only
- submitted as separate files, not embedded in text files

Tables and Figures

Tables and figures should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet. All original figures should be clearly marked in pencil on the reverse side with the number, author's name, and top edge indicated.

Proofs

One set of page proofs is sent to the designated author. Proofs should be checked and
returned within 48 hours.

Reprints and complimentary copies

The corresponding author of each article will receive one complete copy of the issue in which the article appears. Reprints of individual articles may be ordered from Taylor & Francis. Please use the reprint order form included with page proofs.
APPENDIX C
THE THREE MOST PROFITABLE INTERNET SEARCHES

1 AN: 2002-02544-001
DT: Peer-Reviewed-Journal
AU: Kellermann, Yael-PF
TI: The long-term psychological effects and treatment of Holocaust trauma.

2 AN: 2001-05592-011
DT: Peer-Reviewed-Journal
AU: Kellermann, Yael-PF
TI: Transmission of Holocaust trauma—An integrative view.
SO: Psychiatry-Interpersonal-and-Biological-Processes. Fall 2001; Vol 64 (3): 258-267
WEBLI: http://linfo.eg.net/LinkSourceLinking.aspx?game=article&issn=033-2747&volume=2001%7c%24%7c64&issue=3&date=2001&spage=258&title=Psychiatry%3eInterpersonal-and-Biological-Processes&article=Transmission%20of%20Holocaust%20trauma—An%20integrative%20view%20e in PsycINFO 2001 Part B.

3 AN: 2000-15849-005
DT: Peer-Reviewed-Journal
AU: Baiden, Lee; Peretz, Tamir; Haddad, Prima-Ever; Perry, Shtomil; Avramow, Rita; De-Kour, Atara-Kaplan

4 AN: 1998-95015-259
DT: Dissertation-Abstract
AU: Simon, Deborah Ann
TI: Guilt and achievement motivation among second generation Holocaust survivors: An exploratory study.
URL: AAI95019239
5 AN: 1992-12881-001  
DT: Peer-Reviewed-Journal  
AU: Rim-Y  
TI: Coping styles of (first- and second-generation) Holocaust survivors.  
SO: Personality and Individual Differences. 1991; Vol 12 (12): 1315-1317  

6 AN: 1990-98994-000  
DT: Author-Rated-Book  
AU: Hass-Aaron  
TI: In the shadow of the Holocaust: The second generation.  

7 AN: 1990-04533-001  
DT: Peer-Reviewed-Journal  
AU: Leventhal-Gilara; Oertel-Klarsa-K  
TI: A descriptive demographic and personality study of second-generation Jewish Holocaust survivors.  

8 AN: 1969-52933-001  
DT: Dissertation-Abstract  
AU: Fine-Greenberg-Rosalle  
TI: Factors contributing to the degree of psychopathology in first- and second-generation Holocaust survivors.  

9 AN: 1988-35954-001  
DT: Peer-Reviewed-Journal  
AU: Solomon-Zehava; Koniar-Moshe; Mikulincer-Mario  
TI: Combat-related posttraumatic stress disorder among second-generation Holocaust survivors: Preliminary findings.  
WEBLH: http://arc.0vid.com/webspins/previewBriefRecordsHidden.ws?selectedfields=AN%... 04/10/2004
Perception of self and parents by second-generation Holocaust survivors.


10 AN: 1988-23466-001
DT: Peer-Reviewed-Journal
AU: Keinan, Glora; Mikulincer, Mario; Rybicki, Abraham
TI: Perception of self and parents by second-generation Holocaust survivors.

11 AN: 1986-21816-001
DT: Peer-Reviewed-Journal
AU: Weiss,-Erwin; O'Connell,-Agnes-N; Sitter,-Roland
TI: Comparisons of second-generation holocaust survivors, immigrants, and nonimmigrants on measures of mental health.


12 AN: 1986-11838-001
DT: Peer-Reviewed-Journal
AU: Russell,-Axel; Plotkin,-Donna; Heavy,-Nelson

Search History

Search Term | Results
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#2 daughters holocaust survivors | 6
#1 holocaust second generation | 12


1 AN: 2001-03440-005
DT: Peer-Reviewed-Journal
AU: Brom, Denny; Kfir,-Reviaf; Dasberg, Haim
Ti: A controlled double-blind study on children of Holocaust survivors.
in PsycoINFO 2001 Part B.

2 AN: 1999-95004-085
DT: Dissertation-Abstract
AU: Tytell,-Ttora
Ti: Trauma and its aftermath: A differentiated picture of aftereffects of trauma in daughters of holocaust survivors.

3 AN: 1998-95024-169
DT: Dissertation-Abstract
AU: Lynton,-Sandra-Weikins
Ti: The effects of multiple trauma: An exploratory study of daughters of Jewish Holocaust survivors who themselves experienced childhood physical and/or sexual abuse.
4 AN: 1997-95002-470
DT: Dissertation-Abstract
AU: Schneider,-Geanie-Klapholz
TI: Transgenerational effects of the Holocaust: Levels of object relatedness and intimacy in adult children of survivors.
URL: AAM9840297

5 AN: 1991-04237-001
DT: Peer-Reviewed-Journal
AU: Halik,-Vicki; Rosenthal,-Doreen-A; Pattison,-Philippe-E
TI: Intergenerational effects of the Holocaust: Patterns of engagement in the motherdaughter relationship.

6 AN: 1985-25467-001
DT: Peer-Reviewed-Journal
AU: Nadler,-Arie; Kav-Venaki,-Sophie; Gleitman,-Beny
TI: Transgenerational effects of the holocaust: Externalization of aggression in second generation of holocaust survivors.
FTXT: PsyCARTICLES%20/Ovid%20http://gatewayovid.com/athens/ovidweb.cgi?
T=JS&PAGE=fulltext&D=ovid&NEWS=n&DBC=n&AN=0004753-198555000-00009

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1 AN: 2004-99004-155
DT: Dissertation-Abstract
AU: Gopen-Hyman, Amanda-Rachel
TI: The aftermath of the holocaust trauma across family generations: Family environment, relationship environment and empathy of the third generation.
URL: AAI310088

2 AN: 1988-51331-001
DT: Dissertation-Abstract
AU: Gertz-Kerri-R
TI: Psychosocial characteristics of children whose parent(s) survived the Nazi Holocaust and children whose parents were not in the Nazi Holocaust and implications for counseling children of survivors.

3 AN: 1982-70449-001
DT: Dissertation-Abstract
AU: Hanover-Lawrence-A
TI: Parent-child relationships in children of survivors of the Nazi holocaust.

QUALITATIVE REPORT

EXPLORING THE EXPERIENCE OF WOMEN WHO WERE BORN TO HOLOCAUST SURVIVOR MOTHERS: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS STUDY

CONTENTS

ABSTRACT p. 133

INTRODUCTION p. 134-136

METHOD p. 137-141

RESULTS p. 142-157

DISCUSSION p. 158-164

REFERENCES p. 165-167

Appendix A: information sheet for participants

Appendix B: consent form

Appendix C: demographic questionnaire

Appendix D: Table 1- demographics

Appendix E: notes for contributors of chosen journal

Appendix F: interview schedule

Appendix G: transcript of an interview p. 168-188

Appendix H: Table 2- super ordinate themes and sub themes for the group

Appendix I: Table 3- super ordinate themes and sub themes with examples from the transcripts

Appendix J: An example of a directory for a sub theme

Appendix K: letter granting ethical approval

Appendix L: use of self: reflections p. 189-192
ABSTRACT
The aim of this study was to explore what the experience of women who were daughters of Holocaust survivors and born after the war was like. Ten women who fulfill these criteria were interviewed. The data were analyzed using interpretative phenomenological analysis. Six superordinate themes emerged, conveying a taboo on communication within these families, and high degree of dissatisfaction with the mothering received, as perceived by the daughters. There are also themes of abuse and neglect, as well as evidence of 'direct transmission of trauma' (transposition) between mothers and daughters. Lastly, there is a higher than expected degree of pathology, in this group that was selected from a 'non clinical' population.
EXPLORING THE EXPERIENCE OF WOMEN WHO WERE BORN TO HOLOCAUST SURVIVOR MOTHERS: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS STUDY

INTRODUCTION

Children of Holocaust survivors have been the object of special attention by clinicians and researchers alike. There is an ongoing interest in trying to establish if and in what way the traumatic experiences of their parents affected them. At present however, the transgenerational effects of the Holocaust on the second generation remain controversial (Kellermann, 2001). While clinicians met in their consulting rooms people who suffer a variety of symptoms, empirical research found very little difference between the non-clinical offspring of Holocaust survivors and control groups, despite attention to methodological rigour. Some therefore claim that being such a diverse group, it defies generalization. Rieck (1994) even argues that the effect of the Holocaust as a strengthening factor was largely ignored and might be particularly relevant in some cases. When trying to conceptualize what was transmitted from survivors to their descendants and in what way, the idea of a dual non-genetic kind of trauma transmission was suggested. Two types of non-genetic transmission were described: indirect transmission and direct one. The indirect one is the result of a general deficit of parenting skills of the parents, which resulted from their past traumatic experiences and affected the child (see Weiss et al. 2000). The direct transmission, sometimes called Transposition, was described by Kestenberg (1982), Wardi (1992) and Kogan (1995) and described an intimate knowledge of trauma and endurance, that is typical of the second generation and perceives the offspring as being immersed in their parents' story. This means a process by which the offspring of Holocaust survivors live aspects of their parents' trauma as if they were their own. This view is by no means universally accepted within the academic community. For
example Hazan (1987) disputes the construct of ‘second generation’ altogether, and condemn it as stereotyping.

When writing my literature review (Abeles-Srebernik, 2004) I focused on the transmission of trauma between mothers who survived the Holocaust and their daughters. In trying to understand the specificity (if any) of this particular dyad, I found Vogel’s (1994) ideas very intriguing. In particular I was challenged by her view that was echoed also in Gilligan’s (2003) ideas. According to Vogel, women’s development can be described as progressing along a growing capacity for empathy and connectedness rather than separation and individuation. Vogel found this to enhance the permeability of ego-boundaries in women and between them. I thought of these ideas in relation to the relationship between daughters and mothers who were Holocaust survivors and wondered whether the daughters in this mother-daughter dyad might be particularly vulnerable to direct transmission from their mothers as a result. I was also wondering whether daughters of mothers who are Holocaust survivors will be more affected generally by belonging to this particular group and will show more pathology than is generally reported in the literature when dealing with non clinical groups. While I resolved to keep an open mind about the above and not be guided by what could be criticized as the tyranny of ‘mental constructs’, I felt inspired to look closer into the experience of daughters of mothers who are Holocaust survivors.

My aim in conducting this Qualitative research was to gain an insight into the personal experience of women who are daughters of Holocaust survivor mothers. In particular the study wanted to explore how and in what way they ‘share’ with their mothers the experience and memory of the mother’s trauma. Also, in the light of this, I wanted to understand more about how these women feel about negotiating...
separation from their mothers. I formulated the following research questions:

- What does it mean to be a daughter of a mother who is a Holocaust survivor?

- How do daughters of Holocaust survivor mothers come to terms with what they perceive of their mother’s war time ordeal?

- What is the reported relationship between having a mother who is a Holocaust survivor and the experience of daughters when trying to carve an independent life for themselves?

Because of the sensitivity of this topic, I expected the interviews to generate a complex mixture of defenses, feelings and unconscious responses both in me and in the responses of my participants, and so I felt that locating this study within psychodynamic theory will be appropriate and will facilitate the understanding of the data that might emerge.
METHOD

Sampling procedure and participants

Being unclear regarding the number of women who meet the inclusion criteria in England (being a daughter of a mother who survived the Holocaust and was born after the war); it felt that an aggressive recruiting campaign had to be launched, to guarantee maximum exposure to potential participants. This was carried out via an ad in a major Jewish weekly (The Jewish Chronicle); ads in newsletters of various synagogues; ads in public libraries in Jewish areas and fliers distributed in various Jewish institutions (schools, synagogues etc.) I was contacted by many potential participants, who phoned and emailed me to express interest, ask for further information and volunteer to take part. Following some preliminary selection I met potential participants in order to explore further their suitability and willingness to go ahead. Participants were provided with ‘An Information Sheet for Participants’ (see Appendix A) to read and use as a ‘spring board’ for further clarification. As soon as they were clear about the study’s aims, procedures and confidentiality guidelines, I asked them to give their consent by signing a ‘Consent form’ (see Appendix B) in order to confirm that they felt comfortable to go ahead. Following this, participants were asked to complete a ‘Demographic Questionnaire’ (see Appendix C) which helped to gather basic information about them and ensure that they fulfilled the criteria for this study.

Ten participants were selected, and pseudonyms were given to all of them to preserve anonymity. The biographical data of the 10 participants are presented in Table 1 (see Appendix D) 1

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1 See 'instructions for authors' of chosen journal 'Women & Therapy' (Appendix E) for rules regarding presentation of tables
Procedure

Data were collected through interviews. I devised a semi-structured interview to explore the experience of women who were born to Holocaust survivor mothers (see Appendix F for the full interview schedule). In constructing this interview I followed the guidelines suggested by qualitative researchers (Smith et al. 2003), as well as obtained inspiration from interview schedules used by other researchers on this topic (Hass, 1990; Prince, 1999; Kellermann, 2001) I piloted the interview with one participant and as a result realized that some of the questions were ‘multiple questions’ and my pilot participant found that confusing. I modified this for the rest of the interviews, mostly in the way I was actually behaving during the interviews. That is, I tried to stick to one sub question at any one time. All interviews were conducted in English apart from the one with Nelly. The interview with her was carried out in Hebrew and then translated by me to English. Interviews lasted between one and two hours. The interview with Emma however lasted four hours. It had to be interrupted on several occasions as Emma got very distressed. She needed to have several ‘breaks’, have a drink or just switch the tape off and chat on unrelated issues. I reminded her of her right to withdraw from the interview, but she declined and insisted on carrying on. Another incident worth mentioning took place during Edith’s interview. She greeted me with a tape of her own, saying she wanted her daughter to have a record of her story. Half way through the interview her husband joined us and contributed his own perspective on certain questions, saying that as he shared a house with his mother in law for twenty four years, he had an important contribution to make. I asked him politely to leave after a while, explaining that I was interested in the daughter’s perspective for this particular study. I have kept his words distinctly separated from the rest of the interview in the transcript. Interviews took place in either mine or the participant’s houses, apart
from the interview with Nelly that took place in a quiet coffee shop. All interviews were tape recorded and then transcribed verbatim (see Appendix G for the full transcribed interview of 'Sharon') The reason I chose her interview out of all ten, is that I found it to be a good representative of the views that emerged in most interviews, as well as being rich in interesting information.

**Analytic approach**

I have decided to use Interpretative phenomenological analysis (IPA) as a method of analyzing data. The rationale for preferring this method of analysis lies in its concern with exploring and understanding how participants are making sense of their world and the meaning that certain experiences hold for them (Smith, 2003). With this knowledge in mind it seemed particularly suitable to use IPA in order to explore how women who were born to Holocaust survivor mothers, experience themselves and the relationship with their mothers.

IPA assumes that although language has its limitations in providing access to a person’s inner world, there is some meaningful relationship between participants’ accounts and their inner experience, and it is the aim of the analytic process to extract this meaning (Smith et al., 1999). IPA however, acknowledges the impact of the interaction between the researcher and the participant and the necessarily interpretative aspect of research, and recognizes that all findings are essentially tentative (Willig, 2001). The epistemological position taken with this approach is that of critical realism (Bhaskar, 1989), in other words, affirming physical reality while at the same time recognizing that its representations are affected by various factors such as social and individual factors.
Analytic procedure

The analysis started with several readings of each transcript. As I became more acquainted with each transcript, I began to note on the left margin of each transcript some initial thoughts, observations, comments and anything significant or interesting in the text. In allowing myself to 'brain storm' in relation to the text, I tried however to be constantly mindful of the aim of this study. The next stage was to label on the right hand margin the themes that started to emerge and there was an effort to use abstract concepts to capture the sense of what was conveyed in the text. Throughout this process I was trying to form in my mind some initial regrouping of ideas and themes that were appearing in more transcripts. The third stage required a long and arduous process of amalgamating and regrouping themes that were found across the group into an organized system of super ordinate themes clustering relevant sub themes. In order to facilitate this process I constructed a list of themes for each participant and assigned her a particular colour. I made sure that each theme was accompanied by the page numbers of the place in the text where supportive evidence could be found. With ten different colours for ten different participants I started to move themes around and form groups. It became gradually obvious that certain groups clustered together and contained most colors, representing most participants. Groups that were not easily subsumed into other groups or contained too few participants were dropped or kept as an example of participants who represented qualities that were exceptional. Throughout this process constant reference was made to the text to guarantee that the opinion of the participants rather than what I thought they meant was kept (see Appendix J for an example of the 'directory' I have compiled for sub themes. In this case the directory for the sub theme 'difficult to talk about', forming with other sub themes the super ordinate theme of 'communication is diluted by a taboo' is presented). This was a difficult
and long process. The ten participants formed a very heterogeneous group, and it was not easy to find commonalities between them all. I made sure that themes were discarded unless at least seven participants expressed ideas in line with the theme considered. Six super ordinate themes emerged at the end of this process.

Evaluation
In order to evaluate this study, the guidelines for 'good practice' as suggested by Elliott and his team (see Elliott et al. 1999) will be adopted. In other words it will have to be confirmed that special care was taken to own one's own perspective (being a daughter of a Holocaust survivor father in this case); that the sample was situated (by providing a table for demographics); that understanding was grounded with illustrative data; that credibility was provided by using multiple qualitative analysts (supervision); that coherence was maintained throughout; that emphasis was put on general rather than specific research tasks and finally that this study resonate with the reader.
RESULTS

Biographical data
There were 10 female participants, of whom three were in their late thirties, one in her mid forties, two were fifty years old and four were in their early to mid fifties. Six participants were born in England, one in America, one in Israel and two in East Europe (Poland and Czechoslovakia). Of the participants who were born in countries other than England, three immigrated to England over thirty years ago and one fifteen years ago. All participants were permanently residing in England at the time of the interview.

One participant was an only child, three participants had one sibling, four had two siblings and two had three. Two participants knew about half siblings from one of their parents’ first marriage who died in the camps. Three participants had only female siblings, four had only male siblings and two had both.

One participant had completed eleven years of education. All others have completed at least thirteen years of education with six participants completing at least 15 years. Regarding qualifications, one participant had obtained GCSEs and a further diploma, two have acquired A levels, six have obtained a degree one of which had a masters degree and four a post graduate diploma. One participant described herself as having no profession. There were two teachers, one counsellor, one social worker, one homeopath, one working in marketing and three involved in administrative work. Two participants were not working at all at present, one teacher was working as a secretary, and all others were working in their respective professions.
All participants described themselves as Jewish. Of those two claimed to be 'spiritual but not religious', one 'not religious', five 'moderately religious' and two 'orthodox'.

Eight of the participants were married at the time of the interviews, one of them remarried. Two were divorced. Eight of the participants had children. Three participants had twins, (two with a further third child). Four participants had two children and four had three. The ages of the children spanned from five months to thirty years old.

Six of the mothers were still alive and four dead. The mothers were born between the years of 1912 and 1937, making the oldest still alive 79 years old and the youngest 68. One mother went through the war as a young child, four were in their middle childhood, two were adolescents, two in their early adulthood and one was an adult. As far as country of origin is concerned, six were from Poland, two from Hungary, one from what was then Czechoslovakia and one from Austria. The experiences of the mothers during the war vary considerably. One came to England on her own with the 'Kinder Transport', two were in hiding, another one in hiding as well as on the run, and six were in slave labor camps two of which were in concentration camps as well. Three participants left East Europe during the war, three shortly after the end of the war and four left at least ten years after the war, in conjunction with the arrival of Communism.
**Emergent themes**

The interviews were very involving and satisfying to conduct. There was a spectrum of presentations, experiences and feelings. Participants displayed a large variety of perceived relationships with their mothers and a range of feelings about how much being a daughter of a Holocaust survivor was seminal to their life and psychological make up. Long deliberations were needed in order to distil these very diverse and complex human experiences into themes. Six main super ordinate themes emerged from the analytic procedure, and although there were some intra- and inter-individual inconsistencies these six super ordinate themes were generally consistent throughout the group. The reader is referred to Table 2 in Appendix H in which an outline of these main super ordinate themes, with their sub-themes is provided. Appendix I shows a similar table (table 3) with examples of quotations, which illustrates how the themes are grounded in the text.
Brief presentation of key findings

Most participants found that it was difficult to talk about the Holocaust with their mothers. They, could however, recall incidents in which they felt bruised and shocked by inappropriate disclosures of information thrust upon them. This state of affairs was experienced by most participants as influencing the general communication in the family, negatively. Despite a great variety of life styles, most participants conveyed some common traits which they linked to the need of the family to deal with the aftermath of the Holocaust. Most participants confessed to sharing with their mothers certain compulsions, a strong work ethos but also some pervading mistrust they could all identify. On the positive side, however, they were able to acknowledge that the Holocaust background had also some beneficial influence on them. The women I interviewed felt that their birth had a meaning to their mothers, within their world of survivor hood. They felt a demand to accomplish various tasks, as well as an unconscious invitation to reverse roles with their mothers and look after them. Being a daughter of a survivor seems to be a challenge in terms of making sense of the mother's personality and the relationships with her. Daughters perceived a difference between their mother's interactions with them as opposed to her interaction with their brothers. Various aspects of the mother's escape had to be understood by them as well. Daughters felt 'short changed' emotionally by their mothers, when compared with other people, and they seem to struggle with a complex 'cocktail' of feelings towards their mother, made of guilt, admiration and sometimes inability to match up to a mother perceived as a heroine. Most participants found the relationship with their mothers difficult, unsatisfying, and frequently emotionally and physically abusive. It seems that what many of them 'share' with their mothers is the experience of being abused. Most daughters were talking about a struggle to break free from a difficult environment and were resolved to
be different from their mothers. Unfortunately, despite the fact that participants were recruited from a non clinical population, in some cases some of them developed symptoms.

Because of the restriction on words in this report I will only develop four of the six super ordinate themes, and provide some illustrative quotations to support these themes. The super ordinate themes I am going to discard are 'Living with the aftermath of the Holocaust' and 'Daughter's attempt to make sense' While all themes are important, I feel that by extracting these two the flow will get least disturbed.

**Communication is diluted by a taboo**

Most participants described how awkward and difficult they found discussing the Holocaust with their mother.

Sharon sums up this feeling when she says:

> I mean when I had asked it's just been like stone wall...so much [effort and yet a feeling that]...I can't get the answers

The account of Rose conveys her anguish at having many unanswered questions and yet her sense of how difficult it is for her to ask and get a clearer picture of what her mother's experience was:

> I never felt it was a case of saying: “but where was this train?” Well I think I probably knew where the train was going, but have forgotten, or “what time of year was it?”[when the mother was deported] or “what was your mum doing?” I didn't ever...you know...my mum isn't that... (pause)...approachable in that sense.
The difficulty most participants found in talking to their mothers about this topic was not however shared by Molly:

I know quite a lot. Umm, not that she would ever volunteer any information, but if you asked she would always say

The difficulty around being more open about the mother’s experience during the Holocaust is compounded by various incidents in which daughters remember being psychologically bruised by their mothers following a comment made by the mother in relation to her experience. Molly’s story is an example of what was a common experience of many participants:

It was Sunday, and the radio was on, with the news...and they started reporting from one of the famine areas...and they were really going into detail, and I’ve just gone: “I’m going to turn it off I can’t eat and listen to this” and my mother [had] gone very angry and said: “I’ve eaten when people have been hanging dead above my head, you know”...and I burst into tears...and then she was very upset, and was very sorry she’d said it and whatever

Unlike Molly’s mother who seem to have had an unguarded moment where some powerful memory surfaced in an inappropriate way, Daniella seem to have been exposed to traumatic material on a more regular basis:

What other than the fact that they will sit around the table and talk about the most horrific things...with their friends [from the same background], and I don’t think we were suppose to hear it, but they would talk about it, as I said, you know, just the way me and you would talk about going to see a movie
The combination of overall difficulty to talk about the parent's experience and the inappropriate infiltration of bruising comments or fractions of information into the daughter's awareness might be at the root cause of what many participants describe as a general lack of communication between daughter and mother. Edith's words seem to capture what was described by many participants:

Very few things of any importance were discussed...it was only everyday things that we talked about

And later:

It wasn't that kind of relationship where we sat down and discuss things, or anything that was more about feelings or personal things.

The role of children in the life of a survivor
Daughters feel that it was important for their mothers to have children, but at least some of the motivation for it seems to be intertwined with the mother's process of reacting to her trauma. Daniella's words convey this feeling of the role she was assigned

I don't think she wanted me, and I don't think she wanted other children. I think she wanted my oldest sister, because that was 'a spit in the eye' for the Germans: "we did survive" you know, we are breeding another generation of Jews" so that was very much a spit thing

Molly did not experience being unwanted and yet she also felt that having her had to do with a response to being abused
I know that I meant something very specific…you know…I mean it was the ultimate revenge [on the Nazis], if you like, of my family that you [they] recreated and that…so I think that is what it meant to her…the recreation of family

There seem to be pressure on daughters to display heroic skills. Being vulnerable is perceived as a dangerous position to be in and daughters are expected to not show weaknesses. While some daughters (like Molly) seem to be able to deliver this kind of impeccable functioning, other daughters (like Rose) have found it a bruising experience. Molly says:

My mother would say to me, you know: “Go to school” and I’d say: “I’m not very well” and she would say:” If you are not well they [school] will send you home…You’ll be fine…don’t think about it “ and so there was that slight element of pressure

Rose’s experience was less gentle:

We were an extension of her. You know. So our problems weren’t very important [in her eyes] we were lucky. We were alive kind of thing…she is very much (with determination) “Get on with it. Get on with it, do it, don’t do it, don’t worry about it.” and that is her mantra…and I am someone who is quite a worrier

Most participants felt that in some way they were called to take a ‘parental’ role with their mother, provide her with the mothering she missed on or rescue her in some way. Sharon conveys her confusing feelings about this:

I think she still harbors the feelings of a six year old inside her [the age mother was when separated for good from her mother] So
what chances do we have...and I feel like I am kind of a better person, I could have been a bigger person and got over her crisis and be a kind of a mother to her, I can't explain it.

Emma conveys the same feeling colored by pain:

She would stand in the kitchen and cry, and say the names of her sisters that were killed, and she would say to me (crying): you have my mother's name

On becoming a victim and trying to break free
Many participants were talking about difficult, unsatisfying and sometimes abusive relationships with their mothers. This is accompanied by great difficulty for daughters to break away from this not very healthy environment and create a separate life for themselves. The difficulty in the relationship between daughter and mother is described across a spectrum, spanning from lack of warmth and intimacy (Sharon, Edith, Emma, Ruth) to covert hostility (Catherine) and open rejection (Daniella, Nelly). Daniella describes an experience of painful rejection:

I remember climbing into her lap, and hugging her, and she basically took my arms off her neck and pushed me away, she said: “You are too big for that”

Catherine describes a relationship with her mother where her mother is trying to control her. She doesn't seem to be openly critical about it, as she sees herself as someone who needs to be disciplined:
She was very strict...so I would hide it, then she would find out...and...it depends...so many things I did that were naughty and she’d find out

And later:

If it wasn’t for the fact that she is my mother...I wouldn’t have any sort of communication with her because we are completely different

Not all participants seem to describe this difficulty. Jenny describes how reassuring she finds visiting her mother, on a regular if rushed basis:

I’d rush in as I’m always late...have a quick sandwich...rush to the hair dresser...rush back for a few minutes...but I think I would miss it if I didn’t have that going on

In this 'ritual' the daughter seem to form a reassuring 'anti-phobic' ritual in which unlike mother’s experience who was separated for good from her parents she can locate her mother.

Molly seems to describe a rather mature and good enough relationship with her mother:

But also, it was close enough for us to have disagreements

Most daughters had to come to terms with certain less than perfect aspects of the mothering they have received. Sharon described her sense of frustration:

When things don’t go well she is fantastic, [but] you want to share good things with your mother...you know you have a mother...
must say, I often feel the irony that I have a mother but I can't be with her like a mother

Daniella felt so deprived of mothering that she had to look for surrogate mothers, and her words express what she was yearning for but could not receive from her own mum:

I don't really like the mother she was. I don't think she had any mother in herself... Those other women...I could see the relationship that they were having with their children. There seemed to be far more love, umm, and I think [they were] more respectful of them [their children] as individuals.

Again this is not universal. Jenny and Edith felt good about the mothering they had received in terms of practical looking after and Molly seems to have experienced a loving, capable mother who was also able to trust her.

Much of the stories told by the daughters are about deprivation and unmet needs. Emma's account evokes a sad reality of emotional deprivation.

I would try and cuddle up to her, I think I was looking for warmth, and would feel that she was cold, unavailable and unattractive, even though she was attractive

Julia reflects on how she never felt that her developmental needs were met and how exploited she felt:

There was no sort of chats, and no...there was no talking, no understanding...that's what I felt really, that I played this role of being a good girl, and that was it. That was my role.
Most participants report more or less frequent incidents of emotional abuse. (In two cases combined with physical abuse by their mother). Some of the abuse was located within ‘Holocaust imagery’ such as food, abandonment and sadism. Nelly’s story focuses on the cruel animosity her mother had for Nelly’s weight which was ironically the result of ‘forced feeding’ by the mother. Her mother was scathing of her weight up to the end of her life:

> My mother...I arrived to see her in hospital just before she lost consciousness...she was already slipping in and out of consciousness, and in one of these moments [of clarity] she told me: “You will always be fat...you will never [again] be slim” I was so shocked...she was dying and that was all she could tell me...and after she died...several weeks after her death, I couldn’t stop eating

It is clear from Nelly’s story that food was used in order to express anger and frustration, a kind of attack on both herself and the mother. Some of the emotional abuse takes place when daughters are seen through the mother’s world of Holocaust images. Daniella’s mother used to accuse her of being a Nazi for example:

> Usually if they wanted to punish us, you know, they would say things like, umm: “Why are you killing me? You are worse than a Nazi”

Daniella reflects further in the text on being sent away by her mother, following the death of her father. She experienced this as a rejection:
She just pushed everybody away, which I told her was the worst thing that she could have done...I told her: “Don’t you have to keep the family together?” but she just pushed everyone away.

Most daughters had to struggle quite a lot in order to separate from their mothers and a situation that was not entirely healthy. Some (like Emma) had to physically go away to live in another country while others (like Sharon) have gone through the same process on a more subtle psychological level. These are Emma’s words:

I wanted to go away from Israel, away from my family...I have great sensitivity, I need a degree of relationship...I was twenty one when I left Israel. I could not bring friends home... (crying) I was so ashamed of them.

Sharon describes another facet of the struggle that many daughters seem to have had to go through, in order to liberate themselves from the psychological shackles that were keeping them hostages.

I just think: “It’s not my fault that I was born after you” [her mother] you know, it’s not my fault that, you know, I’m her daughter and I feel like I should have been making her life better. And I probably just not making it any better at all [anyway]. I can’t help it. I can’t help it.”

When trauma is transmitted to daughter

Most participants were conveying some confusion around the boundary between themselves and their mothers. Some of these merging states were benign. Molly is an example of someone who is motivated by an internal identification to achieve on behalf of her
mother. In her case this is however, compatible with her ambitions and range of her capabilities on the whole. In other symbiotic situations like Nelly’s this is a more malignant state of affairs. Molly says:

She always wanted, you know, to get a qualification [which was not possible because of the war] so I guess I was doing that [social worker training] on her behalf...in some ways...so that was very important...she was pleased...I definitely felt that I had some obligation to make them happy

Nelly represents cases of symbiotic relationships that were less innocuous and had more negative repercussions on the well being of the daughter:

She [mother] had to prove that she and her children were just as good [as other people] so what happened was that the way [she felt that] they looked down on her she transferred to me and looked down on me...I don’t know...it was complicated and destructive for me.

Another phenomenon that regularly emerged was that part of the symbiosis with their mothers took a specific kind of identification where daughters felt inside themselves as if they have actually shared some of the mother’s experiences during the war, despite being born after it ended. Sharon is a good example of this:

I often actually think that I can imagine, like physically imagining it. I’m imagining being, because I’ve seen the flat as well, and everything. I think I spend a lot of time doing things like that...imagining, what it must have been for a five-six-seven-eight year old.
Nelly described disturbing phenomena of how she internalized her mother's fear of being caught by a Nazi officer and how that got projected into the relationship between her and her mother and is still affecting her:

*I'm terrified of policemen...even to this day...she [mother] used to say that I was bad and she wanted to take me to prison. For many years I used to stir away and take a side way if there was a policeman in sight.*

Despite not being a clinical group, most participants had some psychological difficulties for which they had to seek professional help at some point in their life; Emma could not commit to any long term projects, feeling that she needs to be 'on call' in case her mother needs her; Julia developed a compliant passive personality and suffered from panic attacks before therapy helped her to separate from her mother; Edith is still assailed by guilt feelings for abandoning her mother when she got married, despite living in the same house with her mother until the mother died. Here are two examples of symptoms developed by daughters when the separation from their mother failed to occur: Sharon revealed a terrible moment of self destruction. This is particularly poignant in the light of her revelation that her maternal grandmother took her own life just before the 'Ghetto' was liquidated.

*I had this guy that I was crazy about, and I thought we will end up getting married but then he left me. (crying) that was when I was trying to take my life...when I asked him why he just said: "it's your family"*

Rose developed separation anxiety and refused to go to school at the age of thirteen. She as well was in need of professional help:
When I was thirteen I went through...what I think of now...looking back on it was probably nervous breakdown. It wasn't ever called that. But I just stopped...I couldn't go to school...I couldn't sleep, you know...really bad...Apparently, people who were 'school refusers', it's often people who feel in their subconscious, [that] they should be looking after their mother.
DISCUSSION

Limitations and value of the study
The inclusion criteria used in this study specified that the mother had to be a 'Holocaust survivor'. I feel that it was too general a category and resulted in participants with a wide variety of maternal experiences. This made the group very heterogeneous and quite challenging to analyze. Future research on this topic might consider more selective inclusion criteria in order to generate less complexity. Also the small number of participants (ten) does not allow this study to be generalized to the population of 'daughters of mothers who are Holocaust survivors'. The tool employed (semi-structured interview) seems to have generated rich and interesting data. I feel that it was particularly suitable in trying to study women with this background. It generated an intimate enough environment in which participants felt comfortable to open up and talk about this sensitive topic.

While versatile in their stories, six super ordinate themes eventually emerged as a result of the analytic procedure. These six super ordinate themes capture some common feelings and qualities that daughters of Holocaust survivor mothers conveyed about the way they perceived themselves and their relationship with their mothers.

Theoretical implications
Participants described limited communication on the topic of the Holocaust with their mothers. This was however punctuated by comments that participants found shocking and bruising. Participants describe a sense of 'taboo' around the mother’s Holocaust experience which they felt left communication in the family generally impoverished. Theoretically this state of affairs could be explained by the concept of trauma and the defenses created in order to protect the traumatized person from experiencing overwhelming anxiety of
anihilation. By remaining dissociated from the experience, hence unable to talk about it, the mothers try to protect themselves and maybe the daughters from being flooded by painful memories. There are however moments in which the wall of silence seems to be punctured by material that the daughters find intrusive. This might happen when the defenses crumble momentarily because of a particularly strong association. Giller (2004), talks about people who repress their traumas, but that occasionally experience intrusive flashbacks or strong emotions occasionally. The participants seem to refer to this combination. The impoverished communication participants talk about is also in line with the outcome of massive repression. This finding supports extant literature. For example Wardi (1992) found that survivor parents generally told their children very little about what happened to them because of the great pain involved.

When talking about their everyday life, participants seem to report a range of typical traits. These traits include compulsions around food, excessive interest in current affairs, a strong investment in work and professional accomplishments and cautiousness in relation to other people. These typical traits could be understood in the context of a need to defend against feelings of vulnerability. The theme 'living with the aftermath of the Holocaust' seems to gather what most participants feel is typical to their life style. It is connected in my view to the need to function despite anxious and wounded feelings. Some of the features described by the participants convey however an encouraging outcome those participants could relate to their position as daughters of survivors. In particular they felt more resilient and sensitive to issues of social justice.

I understand these traits as an attempt to deal with trauma in terms of defense mechanisms and personality traits. The above are adopted in order to combat feelings of insecurity and vulnerability that still plague
survivors and their daughters as a result of their collective trauma. The gains reported by this group seem to be the result of an assimilation of the lessons that can be learned from this chapter of history. What was identified by participants seems to relate to the psychoanalytic concept of 'Defense mechanisms'. Participants seem to tell us about strategies adopted by their mothers and themselves in order to help them to go on living despite some ongoing feelings of the danger of annihilation.

An important constant conveyed by all participants were feelings regarding the particular role they had to fulfill in their mother's lives. Daughters felt that their arrival had a role to play in their mother's healing process and her response to being persecuted. All daughters felt bombarded by conscious and unconscious expectations from their mothers. The common denominator was that in their eyes, their mothers saw them as extensions of themselves. They talk about expectations spanning from nothing beyond physical survival to heroic attitudes and fulfillment of the thwarted ambitions of their mothers. Daughters were also feeling invited to 'mother' their mothers who quite often were left orphans at an early age and were vulnerable. These findings seem to recall what was defined by Wardi (1992) 'memorial candles'. In her view many children of survivors were unconsciously expected by their parents to fulfill the void created by their massive losses of family members in the Holocaust. Thus, there was an expectation that these new babies will somehow miraculously repair the 'rupture' in the parent's life and the severed chains of their family and community. The mother according to this gives her 'memorial candle daughter' the task of infusing content into the emptiness inside her and unconsciously lumber her daughter with a responsibility towards the mother. This responsibility can interfere with the daughter's freedom to accomplish her own developmental tasks.
Participants' stories are full of reflections on what their mother is like and her various idiosyncrasies. It is as if participants are trying ‘to make sense’ of their mother. For example, participants who had male siblings identify a distinct difference between the ways their mother was relating to them as opposed to her way of relating to the brothers. There was an attempt on behalf of participants to understand the mother’s peculiarities and conflicts in the light of being a survivor. Furthermore, they felt that when it came to their mother, ‘the best had gone’ or that their mother was somehow unable to be as generous with them as she was with others. Finally, they seem to convey an intricate mix of feelings towards their mother that had to be managed, made of admiration, guilt and negative competition. In some cases the mother was perceived as heroic and they felt ‘in her shadow’. The effort that daughters were willing to invest in explaining some very complex personality traits of their mothers was impressive. This implied a large amount of time and energy, spent on thinking and trying to understand their mother. This investment in trying to make sense of the mother and her functioning, points towards a struggle on the part of the daughter to deal with what was described by researchers as ‘transposition’ (see Kestenberg, 1982; Wardi, 1992; Kogan, 1995). This term describes an intimate knowledge by which the offspring of Holocaust survivors live aspects of their parents’ trauma. The daughters in my study seem to be affected unconsciously by transposition. The sub theme ‘daughter’s attempt to make sense’ gathers evidence of their more conscious effort to rationalize unconsciously perceived traumatic material that they share with their mothers through transposition.

Most participants talk about the relationship with their mothers in terms of frustration and withholding of love. Mothers are perceived as unable to relate emotionally to their daughters reject and exploit them; expect
them to convey no vulnerability whatsoever and lack empathy. In some cases the emotional abuse is accompanied by physical abuse. This picture of 'psychopathic' traits (lack of empathy) portrayed by the daughters' perception of their mothers, is accompanied by a wish to escape from a situation they experience as abusive or shameful. Anna Freud (1961) described a specific defense mechanism called 'identification with the aggressor' in which in order to control the humiliation and pain of being abused the victim identifies with the aggressor and then is able to stop feeling a victim. Sadly, if the accounts reflect accurately what happened, it seems that this mechanism is operating quite often between mothers who are Holocaust survivors and their daughters. The mothers who went through horrific experiences of abuse and trauma go on abusing their daughters to some degree. The struggle of many daughters to 'get away' from their mothers, either psychologically or physically, can be conceptualized as a response to the abusive environment with their mothers, but also as an unconscious impulse to reenact a flight from a dangerous situation in the Holocaust.

There is a substantial presence of daughters who seem to have been unable to separate from their mother and their mother's trauma enough to guarantee well being. Many of them describe a difficulty in individuating and developing themselves in the present. Daughters seem to internalize their mother's experience and they identify with her unconsciously to create difficulties in separating the mother's terrors in the past from their life in the present. Some reference was made before to the process of 'transposition'. This conceptualization is helpful in understanding this reality of maternal trauma transmitted to a daughter and interfering with the daughter's well being. There were various accounts of symptoms that daughters of Holocaust survivor mothers have developed at some point in their life. They encompass
separation anxiety, phobias, compulsions, depression and relationship problems. As the participants were chosen from a non clinical population, the high presence of pathology might raise some questions. It might be the task of future research to investigate this and find out whether the higher than expected morbidity in this study relates to the exclusivity of the female gender it studied and how representative of this population my sample was. An interesting hypothesis might be suggested at this point. Could the higher morbidity found in this non-clinical female sample be explained by the femaleness of both mothers and daughters? I am referring to the feeling of many participants that there was something more exposed and intense in their relationship with their mother that was not shared by their brothers (see sub theme 'difference between daughters and sons' of the super ordinate theme 'daughter's attempt to make sense'). This was conceptualized by Vogel's (1994) view, that the mother daughter dyad was particularly vulnerable to transposition.

**Implications for practice**

The findings of this study have implications for practice. As daughters found communication between themselves and their mothers particularly problematic, it might be helpful to adopt a more proactive approach, than is usually the case, and enquire about the traumatic experience of the patient's mother, thus facilitating an open non threatening communication on this topic. Counselling Psychologists treating women who are daughters of survivors need to aim to facilitate the 'working through' of integrating the parental traumatic history into the daughter's narrative of her life, and encourage separation and individuation from the survivor parent. This might entail long and arduous work, because of the guilt that some daughters might feel in relation to their mothers.
Particular attention must be paid to an assessment of whether the daughter has become the receptacle of the traumatic maternal material. When confronted with a case of direct transmission of trauma (transposition) the therapeutic stance advocated by Weiss et al. (2000) needs to aim at encouraging a process of regression in order to uncover the 'near-identicalness' between the inner experience of the daughter and that of the survivor mother. This is done in order to alert the daughter of the existence of direct transmission from her mother’s trauma in order to facilitate differentiation. The findings of this study alert us to quite a common presence of emotional and even physical abuse that daughters of Holocaust survivor mothers seem to endure. There might be a need to address this abuse within the therapeutic relationship and help daughters to rebuild their self esteem and facilitate the expression of anger, anxiety and rage that might feed the transmission of trauma and sadism from one generation to another. Finally, as seen in this study daughters of mothers who survive the Holocaust are particularly vulnerable to psychological distress and should be regarded as a vulnerable population at high psychological risk. Counselling psychologists have to keep in mind that while clients might seem to function adequately most of the time, they carry a risk of responding with disproportionate amount of distress when having to face stressful situations. This is due to a 'latent vulnerability to PTSD', that was transmitted to them by the mother. In line with Kellermann’s (2001) recommendations daughters need to be encouraged to freely express feelings, thoughts and associations that were not expressed yet.
REFERENCES


APPENDIX A:
INFORMATION SHEET FOR PARTICIPANTS
INFORMATION SHEET FOR PARTICIPANTS

Title of the study: Exploring the experience of women who were born to Holocaust survivor mothers: an interpretative phenomenological analysis

Who am I?
I am a ‘Counselling Psychologist in Training’ interested in conducting a study about daughters of Holocaust survivor mothers, as part-fulfilment of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. I am also a daughter of a Holocaust survivor parent.

Who am I looking for?
I am looking for women who were born after WWII to mothers who are Holocaust survivors, and are happy to take part in this study. I am looking for a so-called ‘non-clinical’ population, so your GP does not need to be contacted. If you might be that person, please take some time to read the following information carefully and think about it before making a decision.

Who is organising and reviewing this study?
I and my supervisor Dr. Adrian Coyle (dept. Psychology, University of Surrey) are organising the research. The University of Surrey Ethics Committee have reviewed it.

What is the purpose of the study?
To explore what being a daughter of a mother who went through this experience is like. While the effect of the Holocaust on the children, the so called ‘second generation’, was widely researched, there is a lack of focus on the particular aspect of being a daughter of a mother who is a Holocaust survivor. I hope that by undertaking this study, we can better understand what, if anything, might be specific to daughters’ experiences and also the ways in which daughters’ experiences might...
What will taking part involve?  
If you decide to take part you will be given this ‘Information Sheet’ to keep. We will meet and discuss the interview procedure before I will ask you to complete a short ‘Demographic Questionnaire’ and read and sign a standard ‘Consent Form’. The next step is for you to take part in an interview about your experience of being a daughter of a mother who is a Holocaust survivor. The location and time of the interview will be arranged between us at a time and place that will be convenient for us both. The interview will take between three quarters of an hour and one and a half hours. Its semi-structured nature means that the questions are used as starting points for discussion. Hence, its duration will depend on how much you wish to discuss the various topics. The entire interview will be tape-recorded, but at the end of it we can switch the tape recorder off and talk about what it felt like, if you so wish.

What are the rights of participants?  
You are free to withdraw at any time if you wish, and you don’t have to provide a reason for your decision. All identifiable information will be amended to ensure that no individual participant will be readily identifiable to others in the research report. The tape recording will be transcribed, but all names, places and other identifying information will be changed for this purpose, in accordance with the ‘Data Protection Act’, 1998. The tape will be kept locked away until the research is completed. It will be destroyed at that point which is by the 25th of July of this year 2005.

What are the possible disadvantages and risks of taking part?  
The only potential disadvantage may be that you experience some level of distress at speaking about what might be potentially painful and difficult to think about. If this occurs during the interview, it will be stopped immediately and if it occurs after the interview, I will be happy to be available to talk to you on the phone about your experience. I will also be happy to provide you with details of a group that is formed by people who belong to the ‘Second Generation’ where you can find support and carry on the kind of discussion we have started. The leader of this group will be informed about my study and happy to be put in contact with you if you express such a wish to me.
What are the possible benefits of taking part?
Apart from the financial reward, offered to participants in acknowledgement of their contribution, some women might find that this experience is cathartic for them or helps them to feel in touch with an important part of their identity and history. Other women might feel satisfied to be part of an effort to learn as many lessons from the Holocaust and its effects on subsequent generations as possible, and to improve our knowledge about the best way of providing help for women who belong to this group.
At the end of the interview, participants will be paid 50.00 GBP plus expenses. Also they will be provided with a stamped addressed envelope and a Form that they can send to me if they wish to get a summary of the results of this study.

If you would like to accept my invitation to take part in this study after thinking it through, or you wish to find out more information about it and ask questions, please use the following details to contact me or my supervisor:

Tel: 0208-458-6848
Mob: 0788-1947-114
Email: leorabeles@aol.com

Supervisor: Dr Adrian Coyle
Tel: 01483-686896

Or write to this address:
Leora Abeles-Srebernik
Counselling Psychologist in Training
Department of Psychology
University of Surrey
Guilford
Surrey GU2 7XH

THANK YOU FOR YOUR ATTENTION AND IF YOU DO DECIDE TO TAKE PART, I HOPE THAT YOU WILL FIND THIS A SATISFYING EXPERIENCE.
Appendix B

CONSENT FORM

I grant my consent to participate in a research study conducted by Leora Abeles-Srebernik, a trainee on the PsychD Counselling Psychology course in the University of Surrey who is supervised by Dr. Adrian Coyle a Senior Lecturer, employee of the same University. I understand that the researchers are interested in exploring the experience of women who were born to Holocaust survivor mothers. I have read and understand the Information sheet provided. I have been given a full explanation by the researchers of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result. I understand that I will be asked to complete a simple questionnaire and then to attend an interview for one hour approximately. I also understand that the interview will be recorded on tape.

I agree to comply with any instruction given to me during the study and to co-operate fully with the researchers. I shall inform them immediately if my well-being is affected in any way. It was explained to me that the material covered in the interview may be upsetting at times, and that the researchers will be available to discuss my feelings with me on the phone, after the interview, if I so wish. Also, the details of a "support group" for people who belong to the 'second generation' will be given to me, so that I can approach them and further discuss the issues that are going to be raised for me by this interview. The researchers will contact this group via their web site (info@secondgeneration.org.uk) and inform the leaders of the group about their study and about the potential need of participants to approach the group for further support. It is my understanding that I am entitled to get a summary of the study after completion if I so wish by returning the stamped addressed envelope with the completed form that I will
receive together with my Information Sheet for this purpose.

I understand that all personal data relating to participants is held and processed in the strictest confidence, and in accordance with the Data Protection Act [1998]. I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice. I acknowledge that in consideration for completing the study I shall receive the sum of 50.00 pounds. I recognise that the sum would be less, and at the discretion of the Principal Researcher, if I withdraw before completion of the study.

I understand that in the event of my suffering a significant and enduring injury as a direct result of my participation in the study, compensation will be paid to me by the University, subject to certain provisos and limitations. The amount of compensation will be appropriate to the nature, severity and persistence of the injury and will in general terms, be consistent with the amount of damages commonly awarded for similar injury by an English court in cases where the liability has been admitted.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of participant
[BLOCK CAPITALS]  

Signed  

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Appendix C

DEMOGRAPHIC DATA QUESTIONNAIRE

Thank you for agreeing to take part in this study. Before we go on to the interview, it would be helpful to get some basic information about you such as your age, occupation etc. The reason that I would like this information is so that I can show those who read my report the range of women that I have managed to interview. This information that you give will never be used to identify you in any way, as this research is entirely confidential. Please feel free to not answer questions you feel you do not want to answer. Please answer the questions you are happy to answer, by writing on the dotted lines or by ticking the right answer when there is more than one alternative to choose from.

1. Age: .................................

2. Sex: .................................

3. Place of birth: ...........................

4. Age when emigrating to England if born elsewhere..........................

5. Place in the family: First born/ not
   
   Number of siblings..........................

6. Education: highest qualification achieved..........................

   Number of years spent in education..........................

7. Profession: ...........................

8. Current occupation: - work..........................

9. .......
9. How would you describe yourself in terms of religion:
   - Jewish/ -Other/ -Not applicable
   Are you -Very religious/ -Moderately religious/ -Not religious/ -Spiritual but not religious


11. Do you have children?.................................
    If yes how many and what sexes............................

12. Is mother still alive:.................................
    Mother's age:..............................................
    Mother's place of birth:................................
13. Mother's Experiences during the Holocaust: - Concentration camp
    - Slave labor camp
    - On the run/Partisan
    - In hiding
    - Kinder Transport
    - Combination

Please specify................................................................................................................

14. When did mother leave East Europe?.................................................................

THANK YOU VERY MUCH FOR YOUR CO-OPERATION
APPENDIX A: Information sheet for participants

INFORMATION SHEET

Title of research study: An investigation into the conceptualisation of trauma transmission between generations by psychologists and therapists

Researcher: Leora Abeles-Srebernik, 3rd year Doctoral Counselling Psychologist in training at the University of Surrey, Department of Psychology, School of Social Sciences

Supervisors: Dr. Adrian Coyle, Surrey University, Department of Psychology, School of Social Sciences
Dr. Jason Ellis, Surrey University, Department of Psychology, School of Social Sciences

Dear Professional:

If you are a qualified psychologist or therapist, registered with an established organization (BPS, BACP, BABCP, BPC or UKCP) and not employed by the NHS, you are invited to participate in this research study. Please take time to read the following information carefully and feel free to contact us if you have any questions or comments to make. It is important to be clear on what the research is about as well as what it will involve.

The purpose of this study is to find out how psychologists and therapists understand women who display an unusual form of stress response. We are interested in women who exhibit disproportionate distress and some symptoms of Post Traumatic Stress Disorder (PTSD) in response to apparently trivial incidents. The women under consideration live an otherwise functional life and share a highly complex family dynamic in their family of origin.

What will happen if you take part?

If you decide to take part, you would be asked to complete a Demographic questionnaire asking for some information regarding age, gender, professional status, theoretical orientation etc.
APPENDIX A: Information sheet for participants

You would then be invited to read a ‘Vignette’ in the form of a letter written by a fictitious GP, referring to you a fictitious client named Sara, for therapy. You will be asked to spend some time imagining this client and writing in a space provided a short comment to describe your immediate impression of her. You will then be asked to complete a questionnaire by circling the answers that describe most accurately your degree of agreement with various statements about Sara.

The process of reading and completing the forms attached will take approximately 10-15 minutes to complete.

If you would like to take part in my study, I would very much appreciate it. Please send the completed form back to me in the stamped addressed envelope provided. We interpret your decision to complete and send the forms back to us, as a form of consent to take part in this study. All responses will remain anonymous. Your comments about the vignette will help us to get some sense of your immediate impression of Sara, and your responses to the questionnaire will be pooled for statistical analysis and analyzed using SPSS (a computerised statistical package). Individual responses will be unidentifiable. You will be sent a brief summary of the findings at the end of the study if you wish. The University of Surrey Ethics Committee has given a favourable ethical opinion to this research study.

-Many thanks for your time and cooperation-

If you would like further information about this study, please contact:

Leora Abeles-Srebernik  
Counselling Psychologist in Training  
Department of Psychology  
University of Surrey  
Guildford  
Surrey GU2 7XH
APPENDIX B: Demographic questionnaire

Background/demographic information form
Thank you for participating in this research study. We would ask you now to read and complete the following information about yourself. The information will not be used to identify you in any way but will help in the data analysis. Kindly answer all 9 questions

1) What is your gender? (please tick the appropriate answer)
   Male ______
   Female ______

2) How old are you ______ years

3) Which of these best describes your current status?
   Married ______
   Divorced ______
   Separated ______
   Single ______
   Living with a partner ______
   Widowed ______
   Parent ______

4) How would you describe your ethnic origins?
   Choose one section from (a) to (e) and then tick the appropriate category to indicate your ethnic background*.

   (a) White
      British ______
      Irish ______
      Any other White background, please write below

   (b) Mixed
      White with Black Caribbean ______
      White and Black African ______
      White and Asian ______
      Any other mixed background, please write below

   (c) Asian or Asian British
      Indian ______
      Pakistani ______
      Bangladeshi ______
      Any other Asian Background, please write below

Please Turn Over
APPENDIX B: Demographic questionnaire

(d) Black or Black British
Caribbean
African
Any other Black background, please write below

(e) Chinese or other ethnic group
Chinese
Any other, please write below

*The format of this question is taken from the 2001 UK census.

5) What is your highest educational qualification? (please tick the right answer)
(a) None
(b) GCSE(s)/O-level(s)/CSE(s)
(c) A-level(s)/AS-level(s)
(d) Diploma (HND, SRN, etc.)
(e) Undergraduate
(f) Postgraduate Masters
(g) Postgraduate Doctorate

6) How many years have you been practicing? (please write below)

7) What Professional body/ bodies do you belong to? (tick the right answers)
(a) BPS
(b) UKCP
(c) BACP
(d) BABCP
(e) BPC

8) How would you describe your main theoretical orientation?
(a) CBT
(b) Psychodynamic
(c) Humanistic/Person-centered
(d) Integrative/Eclectic
(e) Other (Please state)

9) What is your current occupation? (please write below)

THANK YOU VERY MUCH FOR COMPLETING THIS INFORMATION QUESTIONNAIRE
Please read the following referral carefully

Dear [Your Name]

Re:  Mrs. Sara Bear (DoB 28.01.1961)  
6, Woodside London NW11 6HH**

Sara Bear is 45 years old and the eldest of three siblings. Her mother who is a Holocaust survivor is still alive and her father died of heart attack five years ago. Sara is married and a mother of two boys (aged 14 and 12 years). She is teaching history in a local secondary school and had no mental health problems in the past.

Sara came to see me today and shared with me two areas of concern. The first relates to a minor road accident that happened two months ago near her house, shortly before she arrived back from work. Sara remembered two slightly battered cars and smell of smoke. She insisted however that this incident precipitated what she described as 'becoming a mess'. Sara reported that, shortly after the incident, she started to have sleep problems. In particular, she started to wake up every night and lay awake for hours on end. Mostly she would wake up with a start by vivid nightmares featuring trains, smoke, and skeletons.

During the day, Sara complained of feeling anxious, exhausted and on edge. She is unable to relax and has a 'startle response' to everyday noises. Sara confessed to feeling less and less confident to venture out of her house and admitted to often being lost in thoughts of death. She told me that she feels increasingly detached from her husband, children, pupils and colleagues and would like to take time off from her commitments.

The other issue I have discussed with Sara is her relationship with her mother, who moved to live with her after losing her husband (Sara's father). Her mother was diagnosed with cancer six months ago. Sara spoke of a difficult relationship with her mother who was a Holocaust survivor, and told me that she felt unloved by her mother as a child. However, she always felt very responsible for her mother's well-being. Sara was determined to look after her mother single-handedly and declined an offer of professional help. Sara became very emotional when she talked to me about her mother's poor prognosis and insisted that 'death was not an option' when it came to her mother. She told me, however, that her husband finds her commitment to the care of her mother excessive. He has also expressed concern about how she will react to her mother's possible death. According to Sara, both her husband and sons feel that she is consumed with worries, is neglecting them and needs help. Sara feels that she needs help with her sleeplessness and nightmares but does not share their critical view of her attitude to her mother.

Sara would like me to refer her for therapy. She would consider private therapy as this would allow her to negotiate an open-ended contract with the therapist.

Yours Sincerely

Dr. George Herbert (GP)

*the word Holocaust did not appear in the version sent to participants
**name and address are fictitious
Sara Bear is 45 years old and the eldest of three siblings. Her mother who had a traumatic childhood is still alive, and her father died of heart attack five years ago. Sara is married and a mother of two boys (aged 14 and 12 years). She is teaching history in a local secondary school and had no mental health problems in the past.

Sara came to see me today and shared with me two areas of concern. The first relates to a minor road accident that happened two months ago near her house, shortly before she arrived back from work. Sara remembered two slightly battered cars and smell of smoke. She insisted however that this incident precipitated what she described as 'becoming a mess'. Sara reported that, shortly after the incident, she started to have sleep problems. In particular, she started to wake up every night and lay awake for hours on end. Mostly she would wake up with a start by vivid nightmares featuring trains, smoke, and skeletons.

During the day, Sara complained of feeling anxious, exhausted and on edge. She is unable to relax and has a ‘startle response’ to everyday noises. Sara confessed to feeling less and less confident to venture out of her house and admitted to often being lost in thoughts of death. She told me that she feels increasingly detached from her husband, children, pupils and colleagues and would like to take time off from her commitments.

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Sara would like me to refer her for therapy. She would consider private therapy as this would allow her to negotiate an open-ended contract with the therapist.

Yours Sincerely
Dr. George Herbert

*the words 'childhood trauma' were not included on the version sent to participants
**name and address are fictitious
APPENDIX E: Control vignette*

Please read the following referral carefully

Dear [Your Name]

Re: Mrs. Sara Bear (DoB 28.01.1961)
6, Woodside London NW11 6HH**

Sara Bear is 45 years old and the eldest of three siblings. Her mother is still alive, and her father died of heart attack five years ago. Sara is married and a mother of two boys (aged 14 and 12 years). She is teaching history in a local secondary school and had no mental health problems in the past.

Sara came to see me today and shared with me two areas of concern. The first relates to a minor road accident that happened two months ago near her house, shortly before she arrived back from work. Sara remembered two slightly battered cars and smell of smoke. She insisted however that this incident precipitated what she described as ‘becoming a mess’. Sara reported that, shortly after the incident, she started to have sleep problems. In particular, she started to wake up every night and lay awake for hours on end. Mostly she would wake up with a start by vivid nightmares featuring trains, smoke, and skeletons.

During the day, Sara complained of feeling anxious, exhausted and on edge. She is unable to relax and has a ‘startle response’ to everyday noises. Sara confessed to feeling less and less confident to venture out of her house and admitted to often being lost in thoughts of death. She told me that she feels increasingly detached from her husband, children, pupils and colleagues and would like to take time off from her commitments.

The other issue I have discussed with Sara is her relationship with her mother, who moved to live with her after losing her husband (Sara’s father). Her mother was diagnosed with cancer six months ago. Sara spoke of a difficult relationship with her mother, and told me that she felt unloved by her mother as a child. However, she always felt very responsible for her mother’s well-being. Sara was determined to look after her mother single-handedly and declined an offer of professional help. Sara became very emotional when she talked to me about her mother’s poor prognosis and insisted that ‘death was not an option’ when it came to her mother. She told me, however, that her husband finds her commitment to the care of her mother excessive. He has also expressed concern about how she will react to her mother’s possible death. According to Sara, both her husband and sons feel that she is consumed with worries, is neglecting them and needs help. Sara feels that she needs help with her sleeplessness and nightmares but does not share their critical view of her attitude to her mother.

Sara would like me to refer her for therapy. She would consider private therapy as this would allow her to negotiate an open-ended contract with the therapist.

Yours Sincerely
Dr. George Herbert (GP)

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*the word control was not included in the version sent to participants
**name and address are fictitious
1. Sora is not in touch with her anger
2. I feel that Sora has a great difficulty with empathy
3. Sora is displaying an exaggerated response to a stressful situation
4. I get the impression that Sora behaves as if she is dying of cancer
5. Sora feels she needs to protect her mother
6. I believe that Sora’s distress is due to stress
7. I think that the accident triggered distressing memories
8. It is clear to me why Sora became distressed
9. I believe that Sora’s mother expected Sora to look after her
10. Sora is displaying an exaggerated response to a stressful situation
11. I feel that Sora has a great difficulty with empathy
12. Sora is not in touch with her anger

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Appendix F: Survey/Attitude Questionnaire
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<th>Slightly Disagree</th>
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<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>7</td>
<td>= Strongly Disagree</td>
<td>= Moderately Agree</td>
<td>= Slightly Agree</td>
<td>= Neither Agree</td>
<td>= Slightly Disagree</td>
<td>= Moderately Disagree</td>
<td>= Strongly Disagree</td>
</tr>
</tbody>
</table>

Interpreted in this manner that all 56 questions are answered.
Level of agreement. There are no right or wrong answers. and the answers that occur to you spontaneously are the ones we are following your reading of the vignette, please complete the following questionnaire by circling the number that best corresponds to your

Appendix E: Survey/Attitude Questionnaire
38. I feel that Sara needs to examine her issues of boundaries.
37. Sara's reaction to the accident is completely predictable.
36. I feel that Sara's commitment to her mother is abnormal.
35. I believe that Sara was always prone to anxiety.
34. My understanding is that Sara is trying to prove something.
33. It looks as if the accident evoked some unconscious material.
32. I think that Sara wants to guarantee her mother's love.
31. I feel that Sara might soon die.
30. I believe that Sara is becoming like her mother.
29. Sara's mother comes across as too dependent.
28. Sara is unable to see herself as an adult.
27. It's not clear why Sara dreams about smoke, flames, and skeletons.
26. Without the stress, Sara could have remained symptom free.
25. It looks like Sara feels that her mother's pain is her own pain.

The following questionnaire, please complete the following questionnaire by circling the number that best corresponds to your response:

1 = Strongly Agree 2 = Moderately Agree 3 = Slightly Agree 4 = Neither Agree/Disagree 5 = Slightly Disagree 6 = Moderately Disagree 7 = Strongly Disagree.

Note: Kindly ensure that all 36 questions are answered.
APPENDIX G: Letter granting ethical approval
05 June 2006

Mrs Leora Abeles-Srebernik
6 Woodside
LONDON NW11 6HH

Dear Mrs Abeles-Srebernik

**An investigation into the conceptualization of Holocaust trauma transmission between generations by psychologists and therapists (EC/2006/34/PSYCH)**

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: **05 June 2006**

The final list of documents reviewed by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>14/03/2006</td>
</tr>
<tr>
<td>Summary of the Project</td>
<td>14/03/2006</td>
</tr>
<tr>
<td>Research Proposal</td>
<td>14/03/2006</td>
</tr>
<tr>
<td>Information Sheet</td>
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<tr>
<td>Background/Demographic Information Form</td>
<td>14/03/2006</td>
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<tr>
<td>Vignettes 1, 2 and 3</td>
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<tr>
<td>Questionnaire</td>
<td>14/03/2006</td>
</tr>
<tr>
<td>List of Support Organizations</td>
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<td>Insurance Proforma</td>
<td>14/03/2006</td>
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<tr>
<td>Your Response to the Committee's Comments</td>
<td>30/05/2006</td>
</tr>
<tr>
<td>Amended Vignettes 1, 2 and 3</td>
<td>30/05/2006</td>
</tr>
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</table>

This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons.
You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

[Signature]

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
   Dr A Coyle, Supervisor, Department of Psychology
   Dr J Ellis, Supervisor, Department of Psychology
SUPPORT ORGANIZATIONS

1. Samaritans
Tel: 08457 90 90 90
Email: JO@samaritans.org
Helpline for people in distress

2. Mind
Tel: 0845 766 0163
Email: www.mind.org.uk
MindinfoLine offers callers confidential help on a range of mental issues.

3. Women Institute for Incorporation Therapy (WIIT)
Tel: 1-800-437-5478
Email: recovery@wiit.com
Offers treatment for psychological issues as well as other women's trauma issues: depression; bipolar; abuse; trauma; survivor; dissociative disorder; PTSD, etc.
APPENDIX I: Notes for contributors: ‘Social work in health care’ journal
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Social Work in Health Care

The Journal of Health Care Social Work
A Quarterly Journal Adopted by the Society for Social Work Leadership in Health Care

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Edith J. Baerwald Professor of Community and Preventive Medicine, The Mount Sinai Medical Center, New York, NY

Associate Editor: Goldie Kadushin, PhD
Associate Professor, School of Social Welfare, University of Wisconsin-Milwaukee, Milwaukee, WI

Professor Emerita, of Social Work, Hunter College School of Social Work, and Adjunct Professor, Mount Sinai School of Medicine, New York, NY
Managing Editor: Andrew Weissman, PhD
Associate Professor, Department of Community and Preventive Medicine, The Mount Sinai School of Medicine, New York

Founding Editor: Sylvia S. Clarke, MSc, ACSW
Consultant, Department of Social Work Services, The Mount Sinai Hospital, New York, NY

SUBSCRIPTION RATES PER VOLUME

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ABOUT THE JOURNAL

Keep current on the vital health care issues with one of the premier journals in the field!

The reason that Social Work in Health Care remains one of Haworth's top ten accessed

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Journal topics include:

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- ambulatory care
- euthanasia
- genetics
- geriatrics
- HIV/AIDS
- pediatrics
- women’s health
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Social Work in Health Care is edited by Gary Rosenberg, PhD, one of the most respected leaders in health social work. This creative, lively journal brings you the most important articles on research, leadership, clinical practice, management, education, collaborative relationships, social health policy, and ethical issues from the most respected experts in the field. The journal's special issues comprehensively discuss a single pertinent health care theme.

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- integrating the health and mental health needs of the chronically ill
- new options for senior housing and social work practice
- long-term care
- hospital social work
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Product Details:

ISSN: 0098-1389 Electronic - ISSN: 1541-034X SKU: J010V42

Current Volume:
Volume 42, No. 1—Fall 2005.
Volume 43, No. 1—Spring 2006. (4 issues per vol. / 2 vols. per year).

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within the text is discouraged. Words should be underlined only when it is intended that they be
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Cover page: Important — Submit a cover page with the manuscript, indicating only the article title
(this is used for anonymous referencing).
Second "title page": Include a regular title page as a separate document. Include the title again,
plus:

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- an ABSTRACT of about 100 words (below the abstract provide 3-10 key words for
  indexing purposes)
- a header or footer on each page with abbreviated title and page number of total (e.g., pg
  2 of 7)
- an introductory note with authors' academic degrees, professional titles, affiliations,
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  other credit

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- dangling modifiers
- misplaced modifiers
- unclear antecedents
- incorrect or inconsistent abbreviations

Also, check the accuracy of all arithmetic calculations, statistics, numerical data, text citations, and references. INCONSISTENCIES MUST BE AVOIDED. Be sure you are consistent in your use of abbreviations, terminology, and in citing references, from one part of your paper to another.

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APPENDIX J: an example of qualitative data provided by participants
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<td>Concentration camp &amp; Slave labour camp</td>
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APPENDIX E

INSTRUCTIONS FOR AUTHORS

Title of Journal: Women & Therapy
An Open Memo to Men: A Brief Reflection on Reprographics
Miriam L. Voge1

Gender as a Factor in the Transgenerational Transmission of Trauma
Suzanne Shier

Affairs in Community Lesbian Relationships: Approaching and Avoiding the Work of the Middle Years
Karen Gold
Laura Amster1

In Feminist Counselling Practice: The Construction of Survivor Identity
"I Know What It Means But It's Not How I Feel"
Ellen Cole
Ester D. Kohlmann

EDITIORIAL

CONTENTS

1994
Number 2
Volume 15

Therapy for Women
Appendix F

INTERVIEW SCHEDULE

Note: The tense of some questions will be amended if the participant's mother is no longer alive

1. Details of mother's Holocaust experience that the daughter knows about

*How much do you know about your mother's experiences during the Holocaust? (prompt: how did you find out, how old were you then, was it gradual or a specific occasion, how often does she talk about it, never, all the time, do you ever ask, how does she respond when you ask, how does it feel to ask, have you ever wanted to know more, less)?

2. The overall atmosphere at home as daughter was growing up

*How would you describe the atmosphere at home during your childhood? (Prompt: happy, sad, hectic, cold, warm, calm, preoccupied, restricted, etc.)

*Can you describe your mother as a person when you were growing up: her moods, interests, likes, dislikes, etc. Has she changed much over the years?

*Can you describe your mother's relationships with various people as you were growing up (prompt: close warm relationships, distant, suspicious ones, different with different people, in what way and with who, who do you feel that she was able to trust, include various people like: partner, close family, extended family, friends, colleagues, neighbours, strangers, who do you feel that she was able to trust)?

*Can you think of an early memory that you have of your mother? Can
3. Relationship with mother

*How would you describe your relationship with your mother? (Prompt: Close, distant, open, guarded, friendly, formal?)

*How often do you see your mother? Talk to her on the phone? Can you describe a typical interaction between you? Do you feel that you see her enough? Too much?

*What do you feel about her expectations from you? Can you think of anything about you that she is most proud of? Most critical about?

*Is it possible to explore your relationship with your mother in terms of emotions that you have when thinking about her? (prompt: Do you often feel angry with her? How do you feel about that? Can you confront her? Compassion, bitterness, admiration, protectiveness, etc.)

4. How do daughters of Holocaust survivor mothers come to terms with what they perceive of their mother’s war time ordeal

*How aware were you as a child of her past? Can you remember how it made you feel towards her as a child?

*How aware are you now of her moods generally? (prompt: when she seems to be in a bad mood, troubled, happy, satisfied)?

*Can you guess how her past had affected her? How do you feel about this?

*Can you describe the interaction between you and your mother when you were a child and things in your life did not go well? What about now?

*Do you feel that your knowledge (or lack of knowledge) of what your mother’s experience was, affects the way you see her? If yes, in what way?
5. How the daughter perceives herself in relation to her mother

*How much in common would you say there is between you and your mother? In what way are you similar? Different? To what extent do you feel that you share an outlook on life? On people?

*How close do you feel to your mother? How much of her Holocaust experience can you share and understand?

*Can you speculate on what having you, might have meant to your mother? Do you feel that her Holocaust experience had affected the way she was as a mother? If yes, can you guess in what way?

6. Daughter’s experience of herself as growing up and becoming more independent

*Could you describe the flavour of the relationship between you and your mother during your adolescence? (prompt: What was her attitude to you going out, having friends, going away, moving out, etc.)? How free did you feel to rebel when you were an adolescent?

*What did you feel about her involvement with you, in relation to that of the non survivor mothers of your friends? (prompt: Did you feel more/less controlled, did she trust your judgement, was she clingy, did she not care, did you never feel you wanted to compare her with anyone else, etc.)?

*How similar do you feel that you and your mother are as adults? What about any major issues that you agree/ don’t agree on? How do you feel about the guidance that you were able to enjoy from her when in need to make important decisions? How important is her view/opinion for you now?

*How do you feel that being a daughter of a survivor affected you, in terms of strengths and weaknesses? Anything in particular that comes to mind in terms of who you feel you are today as a person?

——Tape recorder being switched off——

THANK YOU VERY MUCH FOR TAKING PART IN MY STUDY.
APPENDIX G

TRANSCRIPT OF ‘SHARON’ (1)

EXPLORING THE EXPERIENCE OF WOMEN WHO WERE BORN TO HOLOCAUST SURVIVOR MOTHERS: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS STUDY

R: (2) So how much do you actually know about your mother’s experiences during the Holocaust?

P: (3): Relatively little, although in latter years, and also in different points in my life I have discovered things, not through her, but... just as...I don’t know what level do you actually want me to go in to

R: Just as much as you want to really---

P: yeah, for example I was 10 when I was at ‘Heder’(4) and the teacher, I remember him very well, told...I learnt of the Holocaust, was my first introduction, for the first time, and I remember coming home in the car, telling my parents because I thought they didn’t know about it, and my mother turning around saying:
   - “Well I know about it”
   - “Well how do you know about it?”
She said: -“Because I was there”
And I...because at 10 years old you can’t even hear an accent...I didn’t even know my mother wasn’t born in England...That was all she said...you know she looked very tense...so, I’d say even up until I was twenty I really didn’t know that much about what her experience [was] at all...and now, now she would go to schools and talk, but I will never discuss that with her ...She did write a book about it. It was published. It was...somebody kind of...she was ghost writer or something ...yeah...and I only read it after my second child was born...my husband read it...when...for me it was difficult because it didn’t sound like my mother writing it, because her... the person who had written it was using a language, like color in a language I know my mother, she doesn’t necessarily use. So it felt like someone else’s story. And I’ve also... in my mid-twenties and then about three years ago we went back to Poland, so

R: With your mother?
P: First time with her and with the person who wrote the book about her and the second time with all my brothers, my husband, my dad, and we went to see the couple of Polish friends that saved her, and also they were given a reward for ‘righteous gentiles’ (5), so we were there for that, and to retrace the steps of my mum and to go to the camp. There were a lot of us. We were about...we had to hire a coach, because of the extended family and everything...so yeah...

R: The reason you had to learn about it indirectly and not from your mother was because you never asked or because she---

P: I had ...I had...I mean when I had asked it's just been like stone wall...so much...I can't get the answers...

R: She made you feel that... 'Don't go there'

P: Yeah, kind of and then our relationship is not great, so we don't have that kind of relationship where we can talk about things that actually mean much.

R: Have you ever wanted to know more?

P: I think I would like to know more because I kind of...my feeling now is that we have the relationship we have because of her experience, and that if she could see that, and we could talk about it, it will make the relationship better. But what’s good is that since I've had the children, her relationship, especially with my oldest...the three years old, they have a fantastic relationship, and she will see him as often and as long as she can. She’s actually, you know, she will ring up, she wouldn’t ask how I am or anybody she just ask:

-“Can I speak to Avi?” (6) The relationship you know...and I'm actually very happy for that

R: So she is a better grand mother than a mother

P: She is a fantastic grand mother, yeah

R: How would you describe the atmosphere at home during your childhood?
P: Tense. Strict. Really my memories...very revolved around food...I remember six o'clock dinner, you had to eat everything...it's very very tense. Very tense. I just remember it being very strict and very disciplined and food being...I feel that this was the most important thing...my mum was compulsive, compulsive compulsive....being picked up from school, I remember from a very young age: -"What did you have?" "Did they give you the milk today?" "Did you drink the milk?" "What did you eat today?" you know like really...."they didn't give it to you late?" "Did you have your share?" Very...if I ever had potato which there weren't very many but I remember once, it's really funny how you remember things I can't have been more than eight or nine, I was really happy because we had fried eggs with chips and I really enjoyed it and mum went: -"What they give you no meat??" That's for me that was really nice, fried eggs and chips...and I have to be careful with my children, I can see that I can be compulsive with food

R: Do you think that she was hungry during the war?

P: Yeah. Yeah. I don't think the family [where she was hiding] tried to starve her or anything but I think that they were very low on food. She does describe one incident where she was given an orange for her birthday, her seventh or eighth birthday, and she wasn't allowed to share it. My parents, their relationship was very strained. And now, that I am kind of older and a mother and all the rest of it, and I just wonder, you know if you actually don't have so much of a model, to see how relationship actually work, or what makes a good relationship, or what makes a happy family...She had a lot of anger....I did ask her at one point why she had so many children, why did she have children, because I think I realized that she was very unhappy...and she said she laughed at Hitler's face!...I was old enough to understand that Hitler had existed, but that comment really haunted me...She's now got ten grandchildren but is she happy?

R: Did she lose anyone in the war?

P: Yeah, her mother. She committed suicide in the Ghetto the night before it was liquidated. Yeah. She was 31. My mother was five or six. Her father survived. He arrived in Israel. I don't know the story. We have just visited him in America. He was in a near camp and then there was a day when the Christians will go and take flowers to their dead relatives and he took a pot with him on the
train and I don’t know the details but he managed to get out, another identity, and all that. And I don’t know at what stage he left my grandmother, and if my grand mother had already committed suicide, and I don’t know when my mum found out...my grand father, he did business with non-Jews and he obviously had a very good non-Jewish connection, and my mum, because we went back to Poland with my mum to the Ghetto, and we saw the window with the wooden flanks, and she remembered them moving one of the flanks off so that my grand father could (sigh) push her through, so that they could pick her through...she remember them being so small that she could hardly fit through. That was the last time she saw her mother. She was in hiding for five or six years. For most part it was a flat in Warsaw, some of the time it was in the countryside, mostly in Warsaw in a flat, and she just did not leave the flat. She did not go to school. She used to carry notes to the priest, with the Resistance, because the family was with the Resistance. They lost...one sister was just a bit older than mum, and mum remembers that she was very resentful of her because she took attention from her, but then there was another sister that was about twenty one, and she got caught with some others and got shot. And they still kept my mum...part of the family was found to be in the Resistance and they still kept my mum. Even after the war they said that she could go on living with them, or they could get her on a boat that went to Palestine. She decided to go to Israel when she was eleven, but she could have easily stay with them. She was on the first boat. The first group of orphans that went to Israel. Her father went to the Kibbutz that she was on and when he saw her he did not believe it was her. He thought it was her cousin who was the same age. So much time had passed and so much growing up...She stayed on the Kibbutz and he was busy trying to rebuild his life. I know she has a lot of resentment about that time as well, I think he married shortly after and she didn’t like her step-mother, he’s married now fourth time. And they never really meet. He went to America and she came to England. She came on her own. She came to study. She was teaching and that’s how she met my dad. She never really went to University.

R: Can you describe your mother as a person when you were growing up, her moods, interests, likes, dislikes...Has she changed much over the years?

P: Yeah, she had changed a lot. As I was growing up...her children were her life! I don’t really remember her having any other
interests. I think it was almost too much. It was, I think that she thought that we were so self contained, we didn’t need anybody else. I remember this feeling that I wanted friends to play and she would say:
-
"Why do you want friends you’ve got your brothers to play with" you know, that kind of intensity. And it was very isolated. We lived somewhere that was not near a bus station or a train station, or there was always dependency on being picked up or being dropped off and being...I don’t remember having that many friends. I mean laughter friends, I don’t mean trouble friends. Has she changed? I think a lot perhaps has changed... for the better for her, was becoming more involved with the Holocaust survivor group. Like connecting with that and actually realizing that there were other people who had actually gone through her type of experience or obviously had some terrible experiences in their lives and they’ve also started a family. They made my mother feel very wanted. So there is a sense...She was quite controlling when we were growing up. Maybe she can’t so much now as we are living our lives now.

R: Can you describe your mother’s relationships with various people as you were growing up? Who could she trust?

P: With my father very fraught. They are still together though (laughing). Actually a lot of people she doesn’t talk to: with her, my father’s father, with my mother’s father, a lot of it to do with...kind of...the way...I just remembered that my mum’s father lived in America, my father’s father lived in Israel, when the one from Israel arrived she would go out of the house, when he...a lot of it had to do with help and support. They didn’t...my father’s father was German and my mother’s father was Polish. There was this terrible snobbery. My father had marry beneath him or something...I think that his father...they were very poor, and I think that my mother really really struggled with that, because her father gave what he could...because of him we actually went to a very good school...because he had gave mum the money to send us. A lot of it was around money and the school and with neighbors? We didn’t have a lot to do with neighbors. One family was Anti-Semitic. It wasn’t a very Jewish street. She could not trust anyone! No!

R: So apart from her children was there anybody else that she was close to?
P: Something very sad happened to her when she first came to London, because she was befriended by an older Jewish couple that she met through the 'Shul' (7) and her father gave her some jewelry or something when she came over, and she, the story is weird... but I really sense that it is true... I really do... so she asked this couple what she should do and how she should look after these jewels and they offered to look after them for her, and she trusted them and did not take it to a bank and they stole them and never gave them back. And this was like an old Jewish couple... you know... and that was the Jews! So she would not trust a soul. To the point where even now with my husband I find myself, I keep telling him:

"Why did you tell him?" "Why did you have to tell him? And I can see it in myself. Not to this extent. Not that my husband got bad judgment, you know, he doesn’t, this is normal, but I can not trust.

R: Can you think of an early memory that you have of your mother?

P: I don’t have happy memories. Everything is sad with her I always see sadness. A lot of my memories are to do with her silence, if she was angry she would just go silent, like punishing me that way, and then by the time you start talking to her you can't remember why the argument happened in the first place. So, I don’t know at what stage I realized that our family... we were just different... friends of mine, it was just more relaxed, in their houses. You could just sense. I think I was quite young when I picked up on this. I definitely picked something different to my brothers. If I try to have this conversation with my brothers they will go: “You know Sharon, what are you talking about, it wasn’t that bad”, you know, it’s interesting. I was the only girl out of four, it must have been difficult for her once I’ve reached five six, having to see, you know we were living our lives, where nothing was a problem. I could go to school, she never went to school, and I could do all those things that she could not do, run out in the street. You know, whatever it was I was still having a normal time... or having free childhood, I wouldn’t say normal but I was in theory free. Yeah. I just remember arguments, I remember my mother shouting:

"At least you have a mother!" .... And I just go:

"Why where is yours?" you know, and I remember all my friends going to their grand parents and, now I understand there are a lot of people who are East Europeans but all the people I was
brought up with were just English English English, you know, they all had grand parents...I just remember thinking: "Why were they so different to us?"

R: Can you think of anything that she told you that stand out in your mind?

P: She had told me things like being with her mother [the Christian one that looked after her], and the train had been stopped by Nazis, and they were with guns looking for Jews, and my mum remembers this Nazi pointing a gun at her, she would have been five six, seven years old:
-"Are you Jewish?"
And she remembers the guy, she says she still have nightmares with his eyes, his green eyes she says, he had beautiful green eyes and the mother just turning around saying:
-"Of course she is not Jewish"
Someone who she knew as a child as she was walking down the street saw her, started to shout: "Jew Jew Jew!" but a lot of Polish people, strangers to her, huddled around that girl, basically to hush her up. She was lucky. Those are the kind of things that stand out from the stories that she told me. I remember the shock when I thought I was telling my parents something they did not know, you know that kind of arrogance you have as a child, you've been learning something, you think, oh you know and just the shock that my mother was ...every time it was the shock that she was there and then shock because this was happened... and then...what was this? How did this happen? How am I here? I am not cross with my mum but I am very young like..."who am I?" and she was like:
-"You are Sharon" and I am like:
-"How did I get here?" Nothing related to her story because I had no idea, but I feel I sensed something...

R: How would you describe your relationship with your mother?

P: Not close, Very guarded. I think there's a terrible sadness on both our sides about it, but neither of us can do anything that seems to change it. We really can't. My husband is a very good kind of bringing everyone together. He comes from a very close family. Very close, very communicative family, I mean, so contrary to ours, I think he's quite ...but now he understands it more, he really tries his best, he kind of brings us gently...because my mum...for us to kiss each other is very...so he'll, we'll be at the door and he will go:
"Kiss your daughter, kiss your mother" you know, he will...and I'm 38 for god's sake, you know, and we can't kiss each other. I was saying to my husband: "I am scared if we'll have a daughter", because who is to say I can do any differently, you know, I hope I could because I don't have her...her traumas. My husband and I went to some counselling because there were definitely relationship problems, and a lot of stuff came out. I think I was repeating things I had seen in terms of blanking, the counselor said it was quite interesting, it's almost like I go out of my way to make this relationship a very good one, to the extent that if I feel like this is not enough I take it quite badly.

R: How often do you see your mother?

P: Because of Avi, we will see each other at least once a week, but there is very little communication, it's quite amazing, every time I see her it strikes me, every time there will be some kind of argument. She will pick him up from school, and she typically, I would say bring him back by four and she will go:
- "Why so early?" "Especially now that Shabbat does not come early" and I go:
- "Mum, I need to give him Dinner, I need to give him a bath. He actually never slept there and I am not sure why because I will not have a problem with that, I don't know...I think that also might be a case of her thinking I wouldn't have it and me thinking I'm not going to ask...so

R: Do you talk to her on the phone?

P: Not, unless it's an arrangement to do with Avi.

R: Can you describe a typical interaction between you?

P: Passing on information. She will say that Avi had his lunch. A lot of it is around food. My mum will go:
- "Avi was really good he ate three viennas, and you know, but that said my mum can be very good. When I had like certain crises, very good in crises. And then we could talk a bit more. I think she can relate a bit more to crisis, I don't think she can relate to happiness. She is a survivor, she has been there and she knows how to deal with it, and she will love me unconditionally and she is supportive. And in that kind of situation I know she is there, but I'll never be able to go on the phone:
- "Ho mum I'm so happy, married or life generally"
R: She can only relate to you when things don’t go well

P: When things don’t go well she is fantastic. You want to share good things with your mother...you know you have a mother...I must say, I often feel the irony that I have a mother but I can’t be with her like a mother.

R: Would you like to see your mother more often?

P: I constantly struggle with the relationship that we have, constantly struggle that the same patterns repeat themselves, and my husband said to me:
-“Just accept it, accept it and you’ll be happier for it” So I did. I suppose I could...I think I’m trying to do something about it, like actually confronting it or talking about it, I think I’ve tried once: I took her to Spain, I did an MBA and they were very supportive, you know, even though I moved back home, because I couldn’t afford to carry on renting, you know she was very good, she was like cooking, and like you know there’s always meals and she was...it was very good, and I took her to say ‘thank you’ or whatever, and I wanted to talk about it and she was going like:
-“That is ridiculous, that’s how it is...”she could not understand what I was talking about. I think that her perception of me is that I am very difficult daughter, doesn’t appreciate her mother...I would imagine the kind of conversations she has with her Holocaust survivors friends: I imagine like...you know in a way my mum she’s got four children, none of them go into drugs or alcohol or anything, to be fair, in our different fields we are all quite successful, not to be proud of and they all married Jewish, I nearly married a none Jew and I remember having a conversation with him because I was brought up Reform, in a house that really didn’t see much ‘Jewishkeit’(8) nothing, and I remember saying to this guy:
-“Our kids will be Jewish” and he said:
-“No, they will be half half” and me going:
-“No they can’t because I am Jewish” and when he just said that it just suddenly dawned on me...the relationship broke up within two weeks after that. I’ve now gone to the other extreme [by marrying an orthodox Jew]. I do feel more at home observant than I do non observant and I don’t know why that is.

R: What do you feel about her expectations from you?
P: I do feel like I never met them! Whatever they were I could never reach them. And I think my brothers feel like that as well. I mean I married late and there was a point where she was kind of: "What is wrong with you?" I remember I was thirty four when I got married which in any circle is late. And I think partly because I just didn't know how to...there was an inability to kind of know how to connect. My brothers are happy. It's very interesting because they have kind of the same role model, there's no reason...I was always wondering if I had another sister, whether she would have been the same or whether it's just me.... But you know credit to my mother in a way, is that she was ambitious for us, in her way, because she pushed in her way, we did struck, because my father isn't ambitious, he would have been quite happy for us to go to...at the time it was quite rough, it was to go up to the Primary school. We went to primary comprehensive which was fine, but then there was the secondary follow on school but it was rough where we were, and if we had gone there we wouldn't have had the opportunities that we have and she really pushed us to go to the school that was a really beautiful Jewish boarding school. We all got there on scholarships, you know, and I think she wanted the best for everybody. But she didn't want me to go to University. She really didn't want me because she wanted me to be married at eighteen.

R: There were mixed messages

P: Very mixed messages. I think it was different with the boys, but for me there was this guy, my childhood sweetheart at school, very sweet, very nice, very rich, and she really wanted me to marry him. And I refused. It just didn't feel right to me and I wanted to go to University and I went there, I didn't want to be dependant on anyone and I wanted to have a career, and it's kind of spiral that goes out of control: if you are a woman and you want everything and you fight against your mother's kind of old fashion...which I am probably now just as old fashion...If I think of my daughter....I'd hate it...to go through all that with her. It's very hard if you want to mix the two together. Some people have he ability...

R: What was she most proud of?

P: My kids. She kind of picked up on it as I was growing up, she said to me once: "I can't believe you are so maternal" She means it she had this view that I ...I think she kind of thought that I wasn't going to get
married, I don't think that she realized that there was stuff going on there. She just assumed that I wasn't maternal, whereas inside I was like yearning to have a family and yearning to have that normality and all the rest of it. It just wasn't coming my way... it's a very interesting question actually... actually I have no idea... I think at the time I thought that maybe some of my career, may after my MBA when I landed a job, it was kind of allowed me more financial freedom and I think she was actually:
-"I can't believe Sharon actually did it" I don't know if that was proud or just disbelief, I don't know. There seems to be an aura of disappointment, you know, I feel, my mum looks at me she is disappointed in me

R: Is it possible to explore your relationships with your mother in terms of emotions that you have when thinking about her?

P: Real sense of pity, but I don't think this is a good thing, or I don't think, you don't want to pity your mother. Actually I feel sadness, about her, I thought anger, which I hate having, because I know it's not her fault, that it happened to her but then I think to myself, but then you bring people into the world, it's a responsibility, and I think, now that I have the sons, the boys, I really want... you know when I was getting married to Peter (9) I said to him:
-"What do you want to get out of life, what do you really really want "And I went:
-"Seriously, I want a house full of laughter" and it comes back to us all the time! Because the truth is when you've got, you know I love it when there are kids running around the house and creating chaos, and laughing... there is nothing better...does that makes sense? When you genuinely see people enjoying people's company for what it is, and just... sorry... that's not answering your question... I keep diverting, sorry but... there is a pity and there is guilt. I feel guilt that I should have been a better daughter, but I can't! I don't know now how to access it, and I kind of let Peter be the great new son as opposed to me being a better daughter. And the anger is a problem. I know it's a problem because whilst you are angry you still think it can change. If you are angry it's because there's hope. You want it to be XYZ... why can't it be like. It's very interesting being married to Peter because he just says:
-"well it is what it is" and I could not see it before. So I was much angrier before...

R: Could you confront her?
P: No, no...I tried that once and...it's a mute point...I just...What could I say to her? Because the truth is because I think if you confront you expect to change someone but now what can I have? Can I really have a conversation with my mum? I want to have just a trivial conversation with my mum...I want to be able to pick up the phone say:
-"Hey mum, guess who I saw in the Supermarket today that really made me laugh?" That kind of conversation, or you know,

R: Do you ever go shopping with her?

P: No, for my Wedding dress, that's it. We never really go for coffee or, unless there is some tragic crises and then we'll go somewhere. When I was young I kind of was in my own world. You know, I knew it wasn't quite right, and I couldn't work it out and it was just what it was. Mum was just in a bad mood most of the time, you know, it's that kind of ...perception

R: How aware were you as a child of her past? Can you remember how it made you feel towards her as a child?

P: Yeah. I mean. It brings back that conversation about "At least you've got a mother" was definitely somewhere when I was between five and ten. But I didn't realize then that she had a different past to the one I had, she just mentioned about not having a mother but it didn't mean much to me...I didn't really understand why...I just knew that she was different to other mothers. Other kids' mothers and then she had no brothers or sisters. She was an only child and that was the point.

R: How aware are you now of her moods generally?

P: Vary. But then I only see her that often so it's only when I see her...yeah...after Avi was born, I went back to her house with Avi because we had some work done to our house and there was no space for all of us and with a new baby I just thought I'll move back to my parents' house, then I was there for a couple of months and I was very aware they would not talk to each other, the way she talks to him, quick to jump to conclusions, yeah, not good communication to say the least. Really not good communication. Nothing would be talked through like normal.

R: Can you guess how her past had affected her?
P: Yeah very much! I think I am very sensitive to that. To why she is the way she is now. That's why I feel guilty, I feel angry, but it's almost like I can really understand why she...what she'd been through, why she is acting a certain way, but I still feel that we need...children as well is a responsibility in its own right. At some point one has to move on! It's interesting when you hear other survivors speaking. I remember once I heard this lady survivor speaking, she would have been roughly the age of my mum, a bit older, and she really had dealt with it, you know, and it made me feel bad because in a way I think if my mum had found herself in a different circle or had gone to therapy or counselling, with the right counselor, she could be in such a different place!...I have said to my mum...when I went to my counselling, my marriage, and I have only been married for a very short time, hits a very bad thing, that we had a serial of terrible things happened, not terrible but Peter lost his job and we were due a baby and the house, we just started a big renovation, I was diagnosed with a thyroid condition which makes you almost go up and down. So it was a very hyperactive thyroid. There were a lot of things going on and we basically just didn't cope at all. And...I have lost my train of thoughts...I told my mum about the counselling because we were just going to split, because it was just very unbearable. And there was this amazing counselor, I am so amazed by her, I was telling my mum, I was begging her to go to her, for her own...she was the third person we went to. The first two had we stayed with those two we would have now divorced." That's how scary counselling is!" During this time I was very close with my mum, we talked a lot! A lot!

R: Because it was crises.

P: It was a crisis and her daughter was terribly upset, and she could relate to that! But then when we started clearing up and things started like, you know, amazing stuff went on with those counselling sessions, umm I really talked to my mum about going and she said:
-"What can I change? How can I change?" But I still think if she went there she would have picked up a lot.

R: Can you describe the interaction between you and your mother when you were a child and things in your life did not go well?

P: She was good in crisis, I'm trying to think as a child, If I had a problem with a friend...a...a...I knew that if I told her something, later in anger she would use it back in my face

R: So she wasn't safe
P: No, she wasn't safe. I didn't really confide in her with stuff... Now she is very good with problems. She swings into action. It brings her to life.

R: Do you feel that what you know of your mother's experience during the Holocaust affects the way you see her? If yes, in what way?

P: It's very hard, because in my mother's experience the tragedy was of course that she was thrown away... thrown apart from her family, but this other family which she had brought her enormous love, in fact she would talk about her second mother or other mother or whatever, incredible love and adoration. It was a very hard decision between going on the boat, not even knowing if there was any family alive or staying in Poland with this family. Yeah, I think a lot of the way, all these number of things could have happened to her, the decisions she had made... I do find myself thinking about it quite a lot. I suppose it's quite a selfish thing, because I find it quite bizarre that I will be alive at all... if it wasn't for... Hitler, this is what I'm saying to Peter, that He is our 'shciduch maker' (10) because I would not live in England, I still do not feel English, I was brought up here, I don't feel English at all. I'm looking at Avi and I'm looking at Shlomo (11) and I'm just thinking: -"What are the chances?" "What are the chances?"... [For them to have born], actually, you know it really got to the point where I really thought I wasn't going to get married or have children. Actually I find it miraculous. Why some people's journeys are so much harder? You know, your father, your mother... I question these things the whole time.

R: How much in common would you say there is between you and your mother? To what extent do you feel that you share an outlook on life and on people?

P: I think there are scary similarities, and I think there are behaviors which we share. All the things I don't want. Just the intensity, the compulsiveness, the mood swings, I used to amaze myself; I didn't really realize I was doing it, and how I handled arguments. The idea of talking through an argument was bizaaarre... I could ignore Peter for days. I thought it was pretty normal. Peter, he comes from a really communicative environment, and he didn't like it. It's really interesting, you know when you realize that there are other ways... it sound stupid but... but... to... to yeah... Don't think that I totally look down on my mum, I do see my mum as
someone who gives an incredible amount. You know, there is obviously the side of her I'm not talking about, because I'm not troubled by it, you know people who know my mum when they talk about her, they talk about her very warmly, and they see that she'll give anything for the children and her grand children. You know it's interesting; I used to think that Peter's grand mother was not a good grand mother because she didn't want to be with the kids so much, you know, my mother is obsessive about it. She will drop everything. If you say, I might have to do something and I can't get to ... I can't say: -"Are you doing anything..." -"Why?" And then she goes: -"Well if you want I can do it, I can do it do you want me to look after your kids?" I can't have a conversation; she will never say... Even when I was going on labor, like every night she was on call, she was ready, and actually I was two weeks late, When I went into labor and I'd speak to her on the phone and I'd say: -"Mum, I think you have tickets for the theatre tonight" She said: -"OK I'm not going it's OK" As it happened I did go into labor but or even if it's not crisis with the kids but she will be there for the kids

R: That comes first

P: Yeah. Yeah. I mean it might not be fair on my father; sometimes they've got an arrangement. But no, she would drop everything. I can never remember her saying: -"No. I can't I am busy" the way Peter's mum very easily, which I find strange: -"No I can't I am doing a course, or I've got Bridge and I'm doing... She's got her own life and I'm like... For my mother her grand children are the center of her life. Yeah

R: How close do you feel to your mother? How much of her Holocaust experience can you share and understand?

P: I can't share it with her at all. When I think about it, I really don't think I understood what Jewish was until... you know, if I try and think about how I've learned things about her, how I've learned to understand my identity or who I want... I remember, we were coming back in the car, it was with one of my brothers, the one who is now a workaholic, and one of the neighbors cars was parked on our driveway, and my mother said to us could we just go off and ask them to move the car, we went there, and I remember this woman answering, calling her husband:
"Ben, Jews want us to move our car" To me I did not know what a Jew was. I remember my mum like having tears coming down her face. And I was like:

"What's wrong what are Jews what is wrong with Jews?" They never told me I was Jewish! You know, even when I see Avi, a three year old, in my head, I feel really happy that he already knows he is Jewish. I think this is probably a bit of an obsession, because he really understands, the meaning of being a Jew and the significance. It completely turned around. But I also remember once, I don't know why I remember these things, there's clearly a reason why I remember certain things, I was kneeling by my bed like this [Christian praying position] and my mum comes in and she goes:

"What are you doing?" I must have been doing it for ages, and I'm like:

"I'm praying" Because I must have seen it on television or in a book, "that's how you pray" And she goes:

"Don't pray like that Sharon" And I go:

"So how do you pray?" And she goes"

"In bed, lying down". So some things, they never used to pray or say the 'Shema' (12) or anything, but I was clearly needing to pray!

R: it was very confusing

P: Yeah. Now with Avi, I'm telling you this is like a therapy session, talking away, every night that I put him to bed I'm saying the 'Shema' with him, you know, I'm stroking his hair, it just feels...And it was very sweet because when he was a bit younger we went out and the baby-sitter said he was asking to do something saying:

"Shhhhhmmm" He kept asking her to do the "Shema"

R: It had come full circle

P: Yes you are right, it had come full circle.

R: Can you sometimes feel that you understand what she went through not through talking to her, just---

P: Yeah. Yes I do. I often actually think that I can imagine, like physically imagining it. I'm imagining being, because I've seen the flat as well, and everything. I think I spend a lot of time doing things like that, imagining, what it must have been for a five- six seven- eight year old. Yes I do. In fact I think I relive it. I am obsessed by the Holocaust by the way, I will think about something
to do with the Holocaust almost everyday. Everyday. Yeah. And I'll do it from all different perspectives: from books I've read, from footage I've seen, from my mum's experience, and I don't know what makes thoughts come into my head, but it's always flashing. I think it's terrible for me because I just find myself looking at the situation today in Europe and thinking that we are heading in the same direction. I extrapolate it and I exaggerate, and I am obsessed. We are having again Anti-Semitic academics, you know doing things like boycotting, you know, their version of boycotting Israel, that's not very nice! Lots of things like that happening, building up to it, it didn't just happen over night!

R: It happened to your mother so it can happen again

P: Yeah! Anyway I do want to live in Israel in any case

R: Can you speculate on what having you, might have meant to your mother? Do you feel that her Holocaust experience had affected the way she was as a mother? If yes, can you guess in what way?

P: I think, you know, that there was a difference between having me and having the boys. And I think that her having boys was great, but I think that having a daughter, I don't think she planned to live her life through me but I think she couldn't help it. I think that's why our relationship had broken down. I think she think I should be much more grateful than I am. In her head. All these things I have that she didn't have. But what she doesn't understand is that even though I have it, I don't have it. It's a terrible feeling to know you have a mother, but not being able to have a relationship with your mother. What our relationship is not a mother-daughter relationship! It's very ironic. I feel very sorry for my mum in that sense, you know, that side of her life, she lost her mother, which to lose a mother, to know from a very young age that your mother took her own life, you know, can you ever get over that? I don't know. And my mum is 72; I think she's still harbors the feelings of six years old inside her. So what chances do we have... and I feel like I am kind of a better person, I could have been a bigger person and got over her crisis and be a kind of a mother to her, I can't explain it. There's guilt, because I feel like I should have been more sympathetic to her, but I feel like I was, but it's just... it was relentless. It was relentless. To the point where I think I got to the point where I said:
"I also have a life, I'm also entitled to happiness, "I shouldn't be so unhappy because you have felt unhappy" "We've got all the opportunities to be happy, so let's be happy" This is what happened, you know, that at that point I just think: "It's not my fault that I was born after you" , you know, "it's not my fault that" , you know, "I'm her daughter and I feel like, I should have been making her life better, and I probably just not making it any better at all. I can't help it. I can't help it! And the way I feel is I wanted to give to my children. I've become obsessive like that, I wanted to take a step back and do the best I can for my children, without living my life through them, I don't know if I'll do a better job but I know how unhappy I was as a child and I don't want them to be unhappy children, I really want to bring up happy children. I want them to be able to bring up functional families.

R: Could you describe the flavor of the relationship between you and your mother during your adolescence?

P: I wasn't allowed. I have such a lot of anger about it because I wasn't allowed out at all. Everyone I know went on Israel Summer Camp. Everybody I know. Until this day they will talk about their experiences when they were sixteen years old. My mother and father did not let me go on any of these things. My only social life which is why I loved Boarding School was at Boarding School. Then I'd come home on holiday. I wasn't really allowed out. I mean it was strict beyond ...pathetic...and inside of me I was a very social person. I think you will get children who are very social and who are not, I know, inside of me I really wanted to have friends, and I really wanted to be out and about. I wasn't a shy little thing. I really wasn't. And I just wanted to go out. And then when I did go out it was like, this whole dependency, because we weren't near anywhere, like we're here that you are just two seconds from the tube, you know, I've still got such anger. I actually have a lot of anger about that, because I think, they are very important years in your life, to build a relationship, not talking about boy friend girl friend, just experience of life and... it's really wrong, it's really wrong...

R: Could you rebel?

P: Really rebel? I don't think I really ever have. I just think for me the rebellion was this angry side of me that I just didn't let it go. I went through a stage, I mean, I went through a stage, it was much later,
When I was living on my own, I was just doing things that they would not approve of. By that point I didn’t know really where life...what life was meant to be like and I was just going for instant gratification whenever and wherever it came. I was just a bit empty and lonely, but they didn’t even know about it.

R: What did you feel about her involvement with you, in relation to that of non survivor mothers of your friends?

P: She was much more controlling; she did not believe I had judgment. She was just very controlling. From the age like very young, kind of like Primary school and then she used to call this friend of mine bloody Clara (13). She sent me to the school, there was a girl called Clara and she thought that she was common, she used to call her 'bloody Clara' and I used to tell her: "But you sent me to this school, and these are like the people in the class" – "Why are you talking to ‘bloody Clara’?" That’s how she used to talk about her, but also very like...what right has she, if she has sent me to this school, what right has she to tell me who out of that class I can befriend with?

R: How similar do you feel that you and your mother are as adults? Could you rely on her for advice when making an important decision? How important is her view for you now?

P: Certainly as adults I see some of her behaviors. I think a lot of mothers-daughters like will talk about that, it’s just for me it’s just a bit of a worry, because they are quite excessive. I will never come to her with a problem because she is so harsh; she is so cutting, it’s better not to give her that opportunity, so that she doesn’t see the disappointment in my response. Yeah. I think some people look for the worse in other people, and I think other people give people the benefit of the doubt. I don’t want to be like her, because you’ve got to give to everyone the benefit of the doubt. I blame everything on the Holocaust, but I’ll never know, I think she’s got so much anger and so much lack of trust and so much betrayal and resentment, so much ‘shit’ had happened in her life, that when things are the way they are...even with friends of mine, you know, or flat mates, she will say: -"She’s still not working, she’s still not married?" you know, not like: -"She is looking really good" My dad also, they both pick up on these things. She was always looking; it’s like I can almost know what she will think of a certain situation. My mother could not believe that I was having problems getting relations, because for
certain reasons... no, she wouldn't think that my issues with relationships have anything to do with my learning of relationships [from my family]. I tell you, I really found it hard to like my mother at that point. Really do. (Crying) I was so upset that my mother had misread me so badly. I do believe that she did play a role in the fact that I didn't get married earlier... but she wouldn't see that as a factor at all. How can you be expected to get married younger if you do not understand yourself at all? At All? You are still wondering: -"Why would I want to get married?" I was asking myself that question a lot. Awful. I swear. My brothers didn't seem to have problems, How come they didn't get it like they saw the same things? How come, they just didn’t?

R: How do you feel that being a daughter of a survivor affected you, in terms of strengths and in terms of weaknesses?

P: I think it made me unhappy but also able to shut it off. I think it’s more a strength than a weakness, literally almost shut it off like almost kind of, forget, not forget but cut it. I got let down by a friend and I really can’t face confronting it, I could cut that person out and get on. It is terrible.

R: It is the survivor, maybe your mother had to do the same thing to get on with life

P: Yeah. Weaknesses are inability to make the real kind of friendships. I have made some lovely friends. I really do, but I think I’ve been trashed by people along the way because of my inability to be in relationships, I don’t know, and friendships, I don’t think it’s that straight forward for me, I’m just, I haven’t got that ‘happy go lucky’ self that I would like. Things have got an intensity that I don’t like but that is just part of me. It’s amazing with Peter because he really is the other side of the coin. He is like a child that was very sociable by nature and was totally free to do what he wanted, yeah? If you walk in the street with him he knows everybody, everyone knows my husband. Nothing works him up. I am very conscious that I and my mum have very few friends and I am very conscious that my husband has loads. Also, I had this guy that I was crazy about, and I thought we will end up getting married but then he left me. (Crying), that was when I was trying to take my life.... When I asked him why he just said:

-"It’s your family..."
R: Anything in particular that comes to mind in terms of who you feel you are today as a person?

P: I’m still trying to work it out, swear to God, I really am. I’m finally getting a bit closer. I feel very Jewish, Davka (14) Jewish though. And to me it’s more than just a label. I need to understand it in more depth. I was brought up at Reform Shul, Which I hated; it was just a competition for the best outfit. The Orthodox community I find very warm. I know this might be a bit naive but there is a kind of warmth and an acceptance that I find in that community.

NOTES:

(1) This is a Pseudonym, used for the purpose of maintaining the anonymity of this participant
(2) Researcher
(3) Participant
(4) Sunday school for Jewish children
(5) Non Jews who helped to save Jews during the Holocaust
(6) This is a Pseudonym, used for the purpose of maintaining the anonymity of this paper
(7) Synagogue
(8) Jewish culture and tradition
(9) This is a Pseudonym, used for the purpose of maintaining the anonymity of this participant
(10) Hebrew word for ‘match maker’
(11) This is a Pseudonym used for the purpose of maintaining the anonymity of this participant
(12) A Jewish prayer
(13) This is a Pseudonym used for the purpose of maintaining the anonymity of this participant
(14) In defiance in Hebrew
### Appendix H

Table 2: **MASTER TABLE OF THEMES FOR THE GROUP**

<table>
<thead>
<tr>
<th>1. COMMUNICATION IS DILUTED BY A TABOO</th>
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<tbody>
<tr>
<td>Difficult to talk about</td>
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<tr>
<td>Shock on discovery</td>
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<tr>
<td>Lack of communication</td>
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<tr>
<th>2. LIVING WITH THE AFTERMATH OF THE HOLOCAUST</th>
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<tbody>
<tr>
<td>Like mother like daughter</td>
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<tr>
<td>Compulsions in the family</td>
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<tr>
<td>Need to locate badness</td>
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<tr>
<td>Work ethos</td>
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<tr>
<td>Gains</td>
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<thead>
<tr>
<th>3. THE ROLE OF CHILDREN IN THE LIFE OF A SURVIVOR</th>
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<tbody>
<tr>
<td>On having children</td>
</tr>
<tr>
<td>Expectations from daughter</td>
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<tr>
<td>Role reversal between mother &amp; daughter</td>
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<thead>
<tr>
<th>4. DAUGHTER'S ATTEMPT TO MAKE SENSE</th>
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<tbody>
<tr>
<td>Difference between daughters and sons</td>
</tr>
<tr>
<td>A portrait of a survivor</td>
</tr>
<tr>
<td>Trying to understand mother</td>
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<tr>
<td>Mother is more available to others</td>
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<tr>
<td>Admiration, guilt, and living in mother's shadow</td>
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<thead>
<tr>
<th>5. ON BECOMING A VICTIM AND TRYING TO BREAK FREE</th>
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<tbody>
<tr>
<td>Difficult relationships</td>
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<tr>
<td>Thoughts about the mothering received</td>
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<tr>
<td>Daughter's needs unmet</td>
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<tr>
<td>At the receiving end of abuse</td>
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<tr>
<td>Struggle to separate from mother</td>
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<tr>
<th>6. WHEN TRAUMA IS TRANSMITTED TO DAUGHTER</th>
</tr>
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<tbody>
<tr>
<td>Symbiotic relationships and no separation</td>
</tr>
<tr>
<td>Imagine it in the body</td>
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<tr>
<td>Daughter developing symptoms</td>
</tr>
</tbody>
</table>
Table 3: **Six superordinate themes and their subthemes (with relevant quotations from transcripts)**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>1. COMMUNICATION IS DILUTED BY A TABOO</strong></td>
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<tr>
<td><strong>Difficult to talk about</strong></td>
<td>&quot;because obviously even after all these years it's still difficult...there was nothing they wouldn't tell me but of course they expected me as a child maybe to ask more than I did&quot; (Jenny)</td>
</tr>
<tr>
<td><strong>Shock on discovery</strong></td>
<td>&quot;every time it was the shock that she was there and then the shock because this was happened&quot; (Sharon)</td>
</tr>
<tr>
<td><strong>Lack of communication</strong></td>
<td>&quot;my feeling now is that we have the relationship we have because of her experience, and that if she could see that, and we could talk about it, it will make the relationship better&quot; (Sharon)</td>
</tr>
<tr>
<td><strong>2. LIVING WITH THE AFTERMATH OF THE HOLOCAUST</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Like mother like daughter</strong></td>
<td>&quot;we are similar in that we both don't like changes...we don't like new things&quot; (Jenny)</td>
</tr>
<tr>
<td><strong>Compulsions in the family</strong></td>
<td>&quot;in my household food is very important...I think a lot about food... that is really obsessive in our household&quot; (Nelly)</td>
</tr>
<tr>
<td><strong>Need to locate badness</strong></td>
<td>&quot;being in cotton wool, but always...but there's something bad...just around the corner&quot; (Julia)</td>
</tr>
<tr>
<td><strong>Work ethos</strong></td>
<td>&quot;they [parents] both thought that if you worked hard and you were determined...that's what you should do&quot; (Molly)</td>
</tr>
<tr>
<td><strong>Gains</strong></td>
<td>&quot;I think it possibly made me a stronger person, in terms of knowing what my mother went through&quot; (Daniella)</td>
</tr>
<tr>
<td><strong>3. THE ROLE OF CHILDREN IN THE LIFE OF A SURVIVOR</strong></td>
<td></td>
</tr>
<tr>
<td><strong>On having children</strong></td>
<td>&quot;I did ask her at one point why she had so many children...and she said she laughed at Hitler's face!&quot; (Sharon)</td>
</tr>
<tr>
<td><strong>Expectations from daughter</strong></td>
<td>&quot;she did control us in that way of implying that only the best is good enough, but she wouldn't have to say that&quot; (Rose)</td>
</tr>
<tr>
<td><strong>Role reversal between mother &amp; daughter</strong></td>
<td>&quot;that they might need me any moment...I was always the most capable one...that if anything I was the strongest&quot; (Emma)</td>
</tr>
</tbody>
</table>
### 4. Daughter's Attempt to Make Sense

**Difference between daughters and sons**  "I think that her having boys was great, but I think that having a daughter, I don't think she planned to live her life through me but I think she couldn't help it" (Sharon)

**A portrait of a survivor** "by the time she came out she was a broken person, it was like replanting an old tree" (Edith)

**Trying to understand mother** "my mum is so controlled, that I've always wondered...if she stopped that control...what will be underneath" (Rose)

**Mother is more available to others** "she will be very fun loving, very charming...and she'll be all that to strangers...none of that really appeared for us" (Daniella)

**Admiration, guilt, and living in mother's shadow** "I don't know how I would have behaved or survived something like that" (Catherine)

### 5. On Becoming a Victim and Trying to Break Free

**Difficult relationships** "she looked after us physically, but it was completely devoid of any personal touch...and then she wanted it to become personal but by then, it could not really last" (Nelly)

**Thoughts about the mothering received** "I can't say that my mother was really my mother for me" (Daniella)

**Daughter's needs unmet** "it was very much about 'off you go' ...that was the opposite of what I needed to hear" (Rose)

**At the receiving end of abuse** "I think that because there was no communication about feelings there was also no physical communication whatsoever apart from the beating" (Nelly)

**Struggle to separate from mother** "I also have a life, I'm also entitled to happiness, I shouldn't be so unhappy because you have felt unhappy" (Sharon)

### 6. When Trauma is Transmitted to Daughter

**Symbiotic relationships and no separation** "Nothing has ever changed or developed...everything is the same at the age of three, ten, fifteen" (Julia)

**Imagine it in the body** "most of the children of Holocaust survivors I have spoken to share the parents' pain in a way, umm, of what they went through, umm, I feel weepy now even just thinking about it, you know, that this is my parents" (Daniella)

**Daughter developing symptoms** "I used to get scared to leave the house in case I come across something that looked to me anti-Semitic" (Nelly)
SHARON  DANIELLA  NELLY  EMMA  CATHERINE  MOLLY
ROSE  JULIA  EDITH  JENNY

DIFFICULT TO TALK ABOUT

Information withheld (p.1) Difficult to comprehend (p.12) Very little information from mother (p.2) Mother doesn’t talk about it (p.1) Mother drops comments (p.2) Knows quite a lot (p.1) Regrets for not knowing more about pre-war life (p.5) Mother wanted to protect daughter (p.21) More unknown than known (p.1) Mother not approachable to answer (p.2) Never talked about (p.1) Mother drops snippets (p.1) Mother didn’t talk much (p.1) Mother would drop fragmented comments (p.3) Holocaust was not discussed (p.4) Regrets not asking more (p.4) Mother didn’t like to talk about Holocaust (evoked uneasy feelings of shame guilt and pain? (p.23) Daughter regrets not knowing more about mother’s ordeal (p.23) Mother not sure how much and what to tell daughter (p.2) I know the basics (p.3) It’s known but it’s not talked about...it’s there (p.4) They wanted us to get the basics, not details (p.4) She didn’t really speak (p.3)
APPENDIX K

LETTER GRANTING ETHICAL APPROVAL
## APPENDIX K: Content analysis – qualitative illustration of categories by means of representative quotations from the data

**Sara’s difficulties formulated by professionals**

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>GROUPS</th>
<th>GROUPS</th>
<th>GROUPS</th>
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<tbody>
<tr>
<td></td>
<td>Holocaust group</td>
<td>Childhood trauma group</td>
<td>Control group</td>
</tr>
<tr>
<td>Problematic attachment &amp; unresolved separation from mother</td>
<td>'Poor childhood attachment experiences, now influence her need to over-care for her mother'</td>
<td>'Issues concerning her relationship with her mother do not appear to have been resolved. I would hypothesize that the quality of her early attachment has left her feeling unsafe'</td>
<td>'Sara is insecurely attached to her mother and therefore is excessively clinging in her relationship'</td>
</tr>
<tr>
<td>Ambivalent feelings, repressed anger &amp; guilt</td>
<td>'Issues to discuss: split (ambivalence) about relationship with mother; duty to protect/care for mother versus feeling unloved'</td>
<td>'Sara is actually very angry with her mother for not parenting her. She can't admit the anger to herself; she over compensates with care. Perhaps she actually has wished her mother dead and feels guilty about this and tries to keep the mother alive'</td>
<td>'Sara seems to need to compensate for her own repressed, maybe angry, certainly ambivalent feelings towards her mother, by acting as her only carer and refusing help'</td>
</tr>
<tr>
<td>Role reversal between Sara &amp; her mother</td>
<td>'Attempting to be mother to own mother (saviour) during mother's illness'</td>
<td>'As 1st child she may have felt more responsible to look after her mother in the hope that if she made her [mother] better, that she in turn would be loved'</td>
<td>'I would be interested in Sara's own need to look after and rescue her mother'</td>
</tr>
<tr>
<td>The impact of family narrative regarding the past</td>
<td>'I would investigate how much she has absorbed from her mother's account of her Holocaust experiences'</td>
<td>'How much does she know of her mother's history-what has been shared?'</td>
<td>'I would be interested in Sara's experience of her parents being damaged (trigger event to battered car)'</td>
</tr>
<tr>
<td>States of distress passed on to Sara</td>
<td>'I wonder about possible unexpressed grief? Her mother's in relation to the Holocaust'</td>
<td>'Her story reminds me of those children of WWII victims: a lot of unspoken material from the parents, generating guilt &amp; anxiety in the offspring'</td>
<td>'I would want to explore what is continued with her preoccupation with death'</td>
</tr>
</tbody>
</table>
**APPENDIX K: Content analysis – qualitative illustration of categories by means of representative quotations from the data**

### Sara’s difficulties formulated by professionals

<table>
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<tr>
<th>CATEGORIES</th>
<th>GROUPS</th>
<th>quotation</th>
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<tbody>
<tr>
<td><strong>Susceptibility to PTSD</strong></td>
<td>Holocaust group</td>
<td>'A possible formulation is that Sara’s mother experienced extreme trauma that she was unable to think about, leading her to be emotionally distant/unavailable towards Sara when she was young (thereby leaving Sara to find it difficult to cope with distress)'</td>
</tr>
<tr>
<td></td>
<td>Childhood trauma group</td>
<td>'I feel that it is likely that the recent car accident has reactivated earlier trauma'</td>
</tr>
<tr>
<td></td>
<td>Control group</td>
<td>'Sara was traumatised by the visual stimuli from the accident. Maybe something subconscious was triggered. This made her feel vulnerable &amp; threatened triggering anxiety &amp; symptoms of PTSD'</td>
</tr>
<tr>
<td><strong>Developing symptoms in response to stress</strong></td>
<td>Holocaust group</td>
<td>'Moderate PTSD following Road Traffic Accident (RTA). Sleep disturbance, reactive depression, and anxiety also adjustment difficulties apparently out of proportion'</td>
</tr>
<tr>
<td></td>
<td>Childhood trauma group</td>
<td>'Sara has explained her anxiety about her mother’s imminent death onto a fairly minor road accident. She is showing symptoms of PTSD in nightmares, startle response &amp; sleep problems'</td>
</tr>
<tr>
<td></td>
<td>Control group</td>
<td>'She also shows signs of a possible perfectionist type trait personality. She obviously feels out of control &amp; is not coping'</td>
</tr>
<tr>
<td><strong>Other:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>life span challenges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angst about mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>losing control/feeling unsafe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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'Sara feels she is losing grip & wants/needs to be in control of things'  
'Her mother’s cancer diagnosis may have triggered possible feelings of helplessness'
Having read the 'vignette', we will appreciate it if you spent some time describing in the space provided below your first impression of Sara and her difficulties.

PLEASE FEEL FREE TO TURN THE PAGE AND COMPLETE THE QUESTIONNAIRE EVEN IF YOU CHOOSE TO WRITE NOTHING IN THE SPACE BELOW

A possible formulation is that Sara's mother experienced extreme trauma that she is unable to articulate. This trauma, which she has suppressed over long periods, led her to be emotionally distant or unavailable/unpredictable towards Sara when she was young. Sara's mother's stories of distress are likely to have been formed with some details about the trauma, and Sara will have taken in this information from her mother, friends, history books, etc. Thus, for Sara, stress & fear & distress are associated closely with memories of the trauma. So then, she herself experienced a mild trauma, it triggered these memories. Just like her mother, she has not learned how to process these experiences. She remains troubled by them. She is in a conflict situation where on the one hand she wants to protect her mother, but on the other hand, she needs her own needs to be met & her own distress to be understood. The key may be to allow her to articulate her primary memories in more detail, thereby allowing her to make the links with her mother's experiences and allow her to both process & cope with these traumatic events.

PLEASE TURN OVER

At
memories
24 June 2005

Mrs Leora Abeles-Srebemik
Department of Psychology
School of Human Sciences

Dear Mrs Abeles-Srebemik

Exploring the experience of women who were born to Holocaust survivor mothers: An interpretative phenomenological analysis (EC/2005/38/Psych)

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 24 June 2005

The list of documents reviewed and approved by the Committee is as follows:-

Document Type: Application
Dated: 11/04/05
Received: 18/04/05

Document Type: Research Proposal
Received: 18/04/05

Document Type: Information Sheet for Participants
Received: 18/04/05

Document Type: Consent Form
Received: 18/04/05

Document Type: Demographic Data Questionnaire
Received: 18/04/05

Document Type: Interview Schedule
Received: 18/04/05

Document Type: Letter to Participants
Received: 18/04/05

Document Type: Your Response to the Committee’s Comments
Dated: 06/06/05
Received: 10/06/05
This opinion is given on the understanding that you will comply with the University’s Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethic Committee
Dr A Coyle, Supervisor, Department of Psychology
APPENDIX L

EXPLORING THE EXPERIENCE OF WOMEN WHO WERE BORN TO HOLOCAUST SURVIVOR MOTHERS: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS STUDY

Use of self: reflections

It is never easy to write or research anything connected to the Holocaust. Yet I often felt that I was going to do it in some form one day. Maybe like many people who belong to the second generation I felt that I owed it to the generation of my parents (father in my case). They had to survive and somehow gather the strength to have us and bring us up as best they could, we (second generation) could think about it. As I am writing this I realize that I use plural tense and talk about generations. What is that about? Is it easier to think about this as part of a group? Is there some comfort in thinking collectively?

I have chosen to study daughters of mothers who survived the Holocaust. This was close enough but not identical to my own situation (daughter of a father who survived the Holocaust), and seemed the right balance in terms of allowing some distance needed to remain relatively objective. As I was interviewing my participants however, I become aware of another more unconscious interest. As shown in the group of my participants, Holocaust survivors mostly marry other Holocaust survivors. I think I had a curiosity of what sort of mother I did not have. I suppose it made me think about what I gained and lost by having one parent who was a Holocaust survivor and another from a different background. One thought that occurred to me is that it might have provided me with more flexibility to get absorbed but also
gain some distance from this difficult topic. I was wondering whether it prompted me to go back and conduct this research as I was simultaneously ‘in and out of it’ by identifying with one parent who was a Holocaust survivor but also with another who was not.

A question I could never answer in the past was: How come they (Grandparents and others) did not get out in time? I always felt slightly detached from their situation, thinking that it could never happen to me nowadays. As I was working on my transcripts however the bombs exploded in London. For several days I was in a situation of fear and confusion and ‘not knowing’. It was clear that there might be other potential incidents and yet the context probability and degree of risk were unknown. I was faced with having to carry on prescheduled responsibilities, having at time to take the underground or pass through central train stations, thinking that there might be some risk that I was taking, and yet feeling uneasy about canceling appointments or changing my plans substantially. While I am not claiming to have been in anything similar to the situation in Europe before and during the war, it provided me with a taste of the bewilderment that my grand parents were in when rumors started to circulate (that was before global communication through television and the internet came about) and they had to make important decisions, saddled with responsibilities for five children and no obvious safe haven to escape to. I also experienced the twilight zone of ‘hoping it will not happen to me’ and ‘feeling silly’ to take drastic measures in case nothing happens. As a result of reviewing Holocaust stories, while going through a mini scare myself, I do not feel superior to my grandparents any more. I do not feel different from them for becoming victims and not getting out in time. I can see that I
could have easily ended up blown away in an underground carriage, just because on that day it felt relatively safe to take the underground and carry on the journey life's circumstances dictated.

As for the results of my study, I was quite shocked by the amount of abuse daughters reported to have suffered at the hand of their mothers. It was something I did not expect and was mortified to encounter. I guess that I too was a little blinded by my own admiration for my father and his sister and brother. I was often in awe thinking of their remarkable resilience. Like one of my participants (Molly), they seem to have somehow managed to be perceived by their children as able to keep the perpetrator part of themselves and the traumatic part of themselves away from their children. As my study shows, this was the exception. I don’t know how representative of the population my sample is, but I find myself intrigued by this phenomenon: What made a minority of Holocaust survivors able to not go on and abuse their children or embroil them in their trauma?

Finally, I have enjoyed carrying on this qualitative research, and specially interviewing my participants. I regret not having had more time to select better the women that approached me or define better the inclusion criteria. Also I would have loved to interview more women. It felt sad to send away some very good potential participants. It did feel at times as if we belonged to some ‘secret sisterhood’ and I felt deeply touched by their stories. As the new threat of Al Qaeda is being transmitted in the evening news, I feel particularly scared, having encountered the daughters of mothers who were surviving trauma and torture. I hope that history is not going to unfold in ways that will produce mass
disruption and another generation of victims scarred by it and in need of psychological help. I always felt that 'if you were clever enough' it was more possible to avoid 'mass tragedy' but as I said before I have lost this defensive conviction now and am more than ever feeling vulnerable and aware of how destructive and lingering the consequences of cruelty and torture are.
ABSTRACT

The study tested the way professionals conceptualise Holocaust trauma transmission. 75 psychologists and psychotherapists, divided into three groups responded to standard questions and formulated the difficulties of a fictitious woman called Sara depicted in a vignette. The hypothesis that professionals receiving the ‘Holocaust’ vignette will obtain significantly different scores on the questionnaire in relation to the other groups was not confirmed. None of the independent variables was significantly predicting scores obtained on the questionnaire. The results of the qualitative data, however, were mixed, with professionals who received the ‘Holocaust’ vignette using some of the categories that form the construct of ‘Holocaust trauma transmission’ substantially more than the other two groups.
AN INVESTIGATION INTO THE CONCEPTUALISATION OF HOLOCAUST TRAUMA TRANSMISSION BETWEEN GENERATIONS BY PSYCHOLOGISTS AND THERAPISTS

CONTENTS

INTRODUCTION p. 195-205

METHOD p. 205-215

RESULTS p. 215-226

DISCUSSION p. 227-233

REFERENCES p. 234-237

APPENDIX A: Information sheet for participants

APPENDIX B: Demographic questionnaire

APPENDIX C: Holocaust vignette

APPENDIX D: Childhood trauma vignette

APPENDIX E: Control vignette

APPENDIX F: Survey/attitude questionnaire

APPENDIX G: letter granting ethical approval

APPENDIX H: a list of 'Support Organizations' for participants

APPENDIX I: notes for contributors: ‘Social work in health care’ journal

APPENDIX J: an example of qualitative data provided by participants

APPENDIX K: content analysis- categories and illustrating quotations

APPENDIX L: use of self: reflections p. 238-241
AN INVESTIGATION INTO THE CONCEPTUALISATION OF HOLOCAUST
TRAUMA TRANSMISSION BETWEEN GENERATIONS BY PSYCHOLOGISTS
AND THERAPISTS

INTRODUCTION

Children of Holocaust survivors have been the object of special attention by clinicians and researchers alike. There is an ongoing interest in trying to establish if and in what way the traumatic experiences of their parents affected them (Kellermann, 2001). The literature about the 'second generation' consists of clinical, as well as empirical investigation and their findings are somewhat different (Rowland-Klein, 1998). Most clinical studies report the offspring of Holocaust survivors as displaying pathological characteristics. These results contradict the findings of controlled studies that compared members of the second generation with groups from the general population. While not displaying more emotional problems as a group, offspring of Holocaust survivors seem to have typical characteristic difficulties when they do become symptomatic. Both clinicians and researchers seem to agree that members of the second generation struggle when coping with stress, and that they possess higher vulnerability to Post Traumatic Stress Disorder (PTSD) when compared to the general population (Kellermann, 1999).
When trying to explain what was transmitted from survivors to their children and how this vulnerability to stress in the offspring can be explained, both genetic and non genetic channels of transmission have been considered. The biological model of transmission is based on the assumption that there is biochemical predisposition to the aetiology of a person's illness. Memories of fear can thus be carried across generations through physiological processes and get 'picked up' by the child's mind (Volkan, 1997).

Yehuda et al. (2000) conducted empirical research in which they demonstrated that low cortisol levels in children of Holocaust survivors were significantly associated with both PTSD in their parents and lifetime PTSD in the offspring. The idea of physiological aspects to trauma transmission is interesting, especially when thinking about the daughters of mothers who were traumatised, and thus were exposed to intrauterine effects of maternal stress. This aspect however is not going to be further developed in the present study.

In trying to conceptualise trauma transmission with the help of non genetic models, the idea of a dual non genetic kind of transmission has been suggested: indirect and direct (Schwartz et al. 1994).

Indirect transmission is based on social learning and socialization models of transmission. It deals mostly with more conscious transmission between parent and child that is easier to trace through empirical
tools. According to this model of transmission, children of survivors form their views and values with the help of their parents' child-rearing behaviour, taboos, and fears. The exaggerated worries of such anxious parents may thus convey a sense of impending danger to the child that may influence the way the child learns to perceive the world. In comparison with psychoanalytic theories that focus on unconscious influences, social learning theories emphasize conscious effects of parents on children. This indirect transmission is allegedly, the result of deficits in the parenting skills of the parents, which is the product of their past traumatic experiences and affects the child. The basic idea that underlies this approach is that the suffering of the second generation is not necessarily the result of trans-generational transmission of the specific trauma endured by the parent, but the unfortunate outcome of being raised by people who are still consumed by the trauma they have endured and are thus unable to look after their children in a satisfactory way (Weiss et al. 2000). Felsen (1998) claims that Holocaust survivor parents were limited in their capacity to offer a safe environment to their children, due to the effect of being traumatised. Shafat (1994) asserts that, as a result of their many losses, the parents expected their children to compensate them for the pain they endured, which the children could not fulfil. This made the offspring feel a failure and negatively influenced their self-esteem and capacity for intimacy. Indirect transmission is thus mostly the product of dysfunctional upbringing by parents who were traumatised,
and it is not different from other kinds of parental influences, except for
the specific themes common to this group, like problems with
separation, expression of anger, and distrust of strangers.

Direct transmission, on the other hand, is more unconscious and was
identified in clinical studies which were mostly conducted by
psychoanalysts. This kind of transmission was sometimes called
used this term to describe an intimate knowledge of trauma and
strength that is typical of the second generation. This term describes
the offspring as being immersed in their parents’ story. This means a
process by which the offspring of Holocaust survivors live aspects of
their parents’ trauma as if they were their own. They develop the
tendency to go ‘back in time’, descend into the ‘time tunnel’ and
explore their parents’ past. By doing this they become more aware of
their parents’ suffering and losses and feel responsibility to heal them.
This process involves also a reversal of roles between them and the
parent. Thus, the children think and behave in disturbed ways that are
similar to the disturbed ways of their parents. They live in a world full of
Holocaust imagery, and their dream life is penetrated by nightmares
related to the Holocaust. In extreme cases these individuals come
across as if they themselves have been in the camps (Weiss et al. 2000).
This process was described by some authors (Davidson, 1992; Rowland-
Klein, 1998) as a process of projective-identification through which the
parents try to rid themselves of painful memories and feelings and their children absorb them and act from them. In some instances a specific child in the family is designated for this psychological role and Wardi (1992) referred to this child as ‘memorial candle’. Direct transmission is a result of the infiltration of mental themes and emotions from the parents’ mental structure into that of the second generation. It is a forceful process, in that under these conditions, which are largely unconscious, the development of the child is impaired, and the child becomes mentally enmeshed with the survivor parent. These children of survivors attempt to help their parents to heal themselves despite a cost to themselves. (Kellermann, 2001). By over identifying with the traumatised parent, these children develop mistrust of other people and hyper vigilance. These attitudes might have been adaptive in the parent’s life in the camps, but persist in the child’s life despite becoming maladaptive in the present. The trauma which is transmitted to these offspring interferes with their sense of security and reality.

In recently conducted qualitative research (see Abeles-Srebernik, 2005) 10 women who were daughters of Holocaust survivor mothers were interviewed about the way they experienced their mothers and her trauma. After an analysis of the data a theme of ‘when trauma is transmitted to daughter’ was identified, closely describing what could be synonymous with direct transmission.
Weiss et al. (2000) understand the complex reality of trauma transmission as captured by a combination of these two components. From their experience it seems that indirect and direct transmission are the two extremes of a spectrum. That is, both forms of trauma transmission seem to be present in the mental structure of the second generation, but individuals differ according to the relative dominance of one of these mechanisms. Communication from the survivors to their children is sometimes explicit and at other times more subtle and hinted at. Irrespective of communication style, transmission occurs so that the child attempts to process the parent's experience, both consciously and unconsciously.

In looking at the transmission of trauma between mothers and daughters, it is intriguing to consider Vogel's (1994) view, that women's development can be described as progressing along a growing capacity for empathy and connectedness rather than separation and individuation. This, according to Vogel (1994), enhances the permeability of ego-boundaries in women and between them. Women thus are going to be particularly vulnerable to direct transmission. Another interesting aspect of Vogel's (1994) study is that her participants were all daughters of women who were traumatised in the Holocaust and elsewhere but according to her, all the daughters experienced their mothers as incomprehensible. They understood that something bad happened to their mothers, but did not know the
details. They were however highly aware of their mothers' suffering, and despite feeling that their lives were objectively good; they felt constantly persecuted by images of major disasters.

A broad use of the term ‘PTSD’ provides a common language for diagnosis and assessment of trauma victims, including Holocaust survivors (Baranowsky et al. 1998). The first criterion for determining PTSD proposed by the DSM-IV (APA, 1994) however, has to be adapted when applying the category to offspring of Holocaust survivors so that, rather than having experienced trauma in person (as the original definition required), the individual is expected to have shared the horrific memories, fears, and losses to which another person responded with horror, terror, or helplessness.

In research conducted by Solomon et al. (1988), the vulnerability of healthy children of Holocaust survivors to PTSD was established. The researchers compared Israeli soldiers who were children of Holocaust survivor parents with a control group on PTSD measures. Both groups took part in the same combat situation and were perfectly healthy before the beginning of hostilities. Offspring of Holocaust survivors reported a greater number of PTSD symptoms (intrusive memories, flashbacks, hyper alertness, numbness and cognitive impairment), that lasted longer when compared with soldiers whose parents were not Holocaust survivors. These results were important in conceptualising PTSD latency or greater susceptibility to PTSD among the second
generation when confronted with major stressors. Danieli's (1980, 1981, 1982, 1985, 1998) finding that Holocaust survivors' children who are otherwise healthy often react with severe psychopathological responses (i.e. anxiety) when exposed to stress pointed in the same direction.

The study mentioned above (see Solomon et al. 1988) reiterates the results of another study on trauma transmission that looked at children of a population traumatised by a context other than the Holocaust. Rosenheck and Nathan (1985) looked at secondary transmission of trauma in the children of Vietnam veterans and observed similar effects of trauma transmission in children of fathers with combat-related PTSD. They suggested the term 'secondary transmission' in order to suggest the transmission of trauma between Vietnam veterans suffering from PTSD and their offspring. These two studies (Solomon et al. 1988, and Rosenheck and Nathan, 1985) prove that children of survivors (Holocaust or Vietnam War) will exhibit PTSD significantly more often than matched-controls and that transmission occurs in traumatised populations.

In light of Rosenheck and Nathan's (1985) findings, there is some controversy among researchers in relation to how specific Holocaust transmission is. For example DeGraaf (1998) talks about a general consensus among researchers that the psychopathology displayed by
children of Holocaust survivors is not at all unique and he states that the problems encountered in families of Holocaust survivors are now believed to be similar to those found in families in which the parents have been traumatised elsewhere.

Hazan (1987) is even more forthright in her claims that relating to someone according to his/her generational belonging amounts to stereotyping and is the result of narrow mindedness. Aleksandrowicz (1973) also has doubts in relation to the existence of trauma transmission between Holocaust survivors and their children. Following the analysis of a large number of families of survivors in Israel, he concluded that the children of Holocaust survivors were no different as a group from controls.

It is therefore important for counselling psychologists to understand further how specific Holocaust trauma transmission is. It might be interesting to enquire whether professionals understand certain symptoms displayed by daughters of Holocaust survivor mothers as a specific strand of trauma transmission (conceptualised by the term 'Transposition'), the result of parental non specific trauma transmission, or as a form of distress that is unrelated to parental trauma. Different conceptualisations will of course lead to different clinical implications. This will vary according to the theoretical orientation informing the practitioner, but may for example have some bearing on whether or not some reconstruction of what actually happened to the parent is
recommended or not, and also on whether a lot of work needs to be
done on separating what happened to the parent from what the child
had internalised but did not actually happened to her in person.
The aim of this research is to find out how psychologists and therapists
conceptualise a form of distress conveyed by some daughters of
mothers who are Holocaust survivors.
The following hypotheses were formulated:

1. When presented with a scenario in which a woman reports
distress, the responses of the group of professionals informed
about the Holocaust survivor status of the woman’s mother,
will be significantly different from those given by the group
informed about the mother’s traumatic childhood more
generally and also from the ones given by the group that was
not informed about the mother’s past.

2. Gender will be a significantly predictive factor in the
responses provided by participants, due to issues of
identification with the gender of the individuals under scrutiny
(both females)

3. Profession (psychologists versus therapists) will be significantly
predictive factor in the responses provided by participants
(because of their slightly different training).

4. Experience will be a significantly predictive factor in the
responses provided by participants (due to the impact of
more experience on the skills needed to formulate patients’
difficulties).

5 Theoretical orientation will be a significantly predictive factor in the responses provided by participants. (The exposure of practitioners of different orientations to the mostly psychoanalytic literature on this topic might not be similar)

METHOD

Design
The present study adopted a cross-sectional quasi-experimental design: (three groups were treated as levels of an Independent Variable (IV) and the responses participants gave were measured on a single variable (the score obtained on the answers to a questionnaire). Data were elicited by using vignettes and questionnaires (see p. 210 for further information about the vignettes and questionnaire). The three groups created, received one of three vignettes, that were similar between them, but varied in relation to the information provided by the manipulated IV (Sara’s mother was depicted as Holocaust survivor, having had traumatic childhood or no information about her upbringing was provided to create a matched control). The different IV made the 3 vignettes different between them. It was repeated towards the end of the vignette in order to facilitate participants in picking up the information provided by the IV. The above manipulated IV was predicted to produce different Dependent Variables (DVs)
between the three groups (different scores on the 38 item questionnaire that all participants were asked to complete). The questions of the questionnaire were aiming to tap into professionals’ ideas about how to formulate Sara’s distress.

The above study was designed as an experiment, as participants were randomly allocated to three groups according to the vignette that they have received (see Dancey & Reidy, 2004). Together with the vignette, participants received a standard questionnaire. In designing the vignettes and questionnaire, attention was paid to producing situations and questions that looked credible, while concealing the interest in Holocaust trauma from most participants (two of the three groups). The research included also a qualitative part.

Participants

Six hundred questionnaires were sent to qualified psychologists and therapists. An inclusion criterion for the selection of volunteers was being a qualified clinical or counselling psychologist or a therapist registered with an established accrediting body. Half of the questionnaires (300) were sent to psychologists and the other half (300) to therapists. Three hundred psychologists (clinical and counselling) were identified on the register of the British Psychological Society through their online register (BPS 2005/2006), and 300 psychotherapists were identified through the registers of the United Kingdom Council for Psychotherapy (UKCP) lists, the British Association for Counselling and
Psychotherapy (BACP) lists; British Psychoanalytic Council (BPC); and the British Association for Behavioural and Cognitive Psychotherapies (BABCP). The relevant registers were accessed online (UKCP 2005/2006; BACP 2005/2006; BPC 2005/2006 & BABCP 2005/2006). One hundred individuals were selected from the UKCP register; 33 from the BACP; 67 from the BPC; and 100 from the BABCP register. These four registers were deemed to address the main theoretical orientations that dominate the psychotherapy field at present, and consist of practitioners using psychodynamic, cognitive behavioural, humanistic and integrative approaches. The specific theoretical orientation of each participant did not form part of the inclusion criteria because the research was trying to uncover what psychologists and therapists across the clinical spectrum think. Participants were not required to have any specific experience of working with daughters of Holocaust survivor mothers, nor were they expected to have had any previous experience in working in the field of trauma more generally. The rationale for this was that this research was trying to identify what psychologists and psychotherapists will make out of a hypothetical situation.

An exclusion criterion was that participants should not be employed by the National Health Service (NHS). The rationale for this choice took into account the obligation to apply for the Central Office for Research Ethics Committee (COREC)'s ethical approval which is standard practice when participants are recruited on account of their status as
NHS staff members. Unfortunately the tight academic schedules, made this lengthy process a risky undertaking. Professionals who are NHS employees were identified via the letters 'NHS' embedded in their email addresses and they were excluded from the sample. This exclusion criterion was also mentioned clearly in the Information Sheet that formed an integral part of the 'research package' sent to participants (see Appendix A). As these Registers contain several thousands of members, a random strategy was used to select the proposed numbers of participants from both professions (see Fife-Schaw, 1995).

Seventy five participants returned completed questionnaires which is 12.50% of the professionals approached. Of those 59 (78.6%) completed the qualitative part (see p. 212 for more information on the qualitative element of the research).

Research instruments

Demographic Questionnaires

Participants were greeted with an information sheet, explaining to them the purpose and content of the research. They were then asked to complete an anonymous demographic questionnaire (see Appendix B). The construction of the questionnaire was guided by the format of the 2001 UK census, as well as other questions aimed at teasing out some basic information regarding the personal and
professional profile of participants.

Vignettes

All participants received one of three vignettes (see Appendixes C, D, and E) constructed as a referral letter to a GP concerning a hypothetical woman called 'Sara'. While being a fictitious situation, the referral conveyed a typical potential daughter of a mother who is a Holocaust survivor, as gleaned from a previous literature review and qualitative research (see Abeles-Srebernik, 2004, 2005)

Vignettes are 'capsule descriptions' of people or situations. They create vivid hypothetical scenarios that encourage participants to think about a set of characteristics or circumstances. It is assumed that the choices participants are asked to make when subsequently completing the questionnaire will be guided at least to some degree by their analysis of the information conveyed to them via the vignette (Alexander & Becker, 1978). Vignettes can help to set the scene for an experimental situation, meant to test hypotheses. Their unique contribution is in conveying the same basic scenario to a large number of participants, regardless of their different personal and professional experiences. The vignettes varied in one item of information provided about Sara's mother (Holocaust survivor, had a traumatic childhood, and no mention of her childhood).
The questionnaire/ attitude scale

Participants were also asked to respond to a questionnaire (see Appendix F) once they had completed to read the vignette that was allocated to them. The questionnaire was designed to assess participants' understanding of the characteristics of a hypothetical woman (Sara) and to find out how they formulated this woman's distress. In order to develop the questionnaire, the information about women who were daughters of Holocaust survivors that was identified in previous studies (Abeles-Srebernik, 2004, 2005) was taken into account. This information was encoded in themes ('difficulty to separate', 'need to suppress anger', 'role reversal', 'being influenced by mother's Holocaust past', 'having absorbed the inner pain of the mother', 'vulnerability to post traumatic stress disorder [PTSD]', and finally 'becoming symptomatic when exposed to stress'). These themes were then used to develop questions. All questions attempted to tap into the way professionals understand the symptoms presented by Sara in the three vignettes. In creating this questionnaire the seven items included in the transmission subscale of a self-report instrument scale developed by Kellermann (2001) were adapted and made use of. Furthermore, attention was paid to ensuring that professionals from all major theoretical approaches were able to make sense of the language adopted throughout the questionnaire. The questionnaire consists of 38 items. All questions were rated on a seven point Likert scale (Oppenheim, 1998), in order to establish to what degree
participants agreed or disagreed with the statements made in each question. In creating the questionnaire, particular attention was paid to ensure that it possessed content, criterion and construct validity (McLead, 2003), by trying to match as much as possible between the underlined construct as theoretically understood and the questions in the scale (Pallant, 2005).

The vignettes and questionnaire were piloted with ten counselling and clinical psychologists in training who were encouraged to give feedback in relation to the clarity of the questions and the general layout of the research package. While the materials were not piloted with qualified professionals, the advantage was that more open and detailed feedback could be gathered. The wording of question 4 had to be changed because it was unclear to pilot-participants whether the death referred to in the question, was Sara's or her mother's. Furthermore, piloting helped to make sure that the information came across as credible to all three groups and to establish how long on average the whole procedure took. The information regarding the length of time required, was then included in the information sheet.

**Space for qualitative input**

Participants were also asked to write in a designated space, a quick formulation of Sara's distress, having read the vignette. The rationale for adding this part to the research package was to obtain some qualitative information to compare with the quantitative data.
Participants however were encouraged to complete the questionnaire even if they chose to not make use of this space.

**Procedure**

All participants were sent one of three research packages. Each of the professional groups were randomly assigned to one of these three groups so that there were an equal number of Psychologists, and Psychotherapists registered with the various professional bodies chosen, assigned to the three groups. All participants were sent a 'research package' that included the same 'Information sheet', a 'Demographic Questionnaire', one of three 'Vignettes', a space to write down some thoughts after the vignette reading, the 'Survey-Questionnaire', and information regarding 'Support Organizations'. All participants were provided with a self-addressed envelope in order to facilitate the return of their completed questionnaires. The information sheet for all three groups modified slightly the title of the study, and qualified the information regarding the topic and purpose of this study, in order to conceal the manipulated element.

Ethical approval was obtained from the University of Surrey's Ethics Committee (see Appendix G). Despite the fact that this study considers a very sensitive and potentially painful topic (transmission of trauma between generations), participants were only asked to pronounce judgements on a hypothetical situation (vignette), and so,
participation was not expected to cause any distress. It was however acknowledged that some difficult emotional responses might be triggered for some participants as a result of being exposed to the content of this study. While assuming that participants (who are all qualified professionals by definition), could be trusted to take the necessary steps to help themselves (like contacting another professional for supervision or counselling), information was provided to them regarding 'Support Organizations' (see Appendix H), in order to facilitate quick access for help if the need arose. As there was no way of identifying who had returned the questionnaire that they received, participant anonymity was ensured.

Analytic Strategy

Before analysing the questionnaire data, a codebook was prepared summarising the instructions needed to convert the information obtained from each case into a format that SPSS could interpret, and data were entered to create a data file.

The data were then analyzed, using SPSS for windows to assess professionals' conceptualization of Sara's presentation. The variable that was manipulated (IV) was the fact that participants were notified regarding the status of the mother. She was reported as a 'Holocaust survivor' (IV-1), having had a traumatic (unspecified) childhood (IV-2),
or there was no mention of her past (IV-3). After ensuring that the questionnaire was reliable for our sample by running SPSS procedure for checking the reliability of a scale (that is the items that made up the scale ‘hang together’ and are all measuring the same construct), independent one way Analysis of Variance (ANOVA) (Wright, 2002) was used in order to analyse and compare the three experimental conditions. Prior to the application of this analysis, it was confirmed that scores were drawn from a normally distributed population and that the variance were similar for the different groups (using Levene’s Test for independent ANOVA).

Once this analysis was completed, regression analysis was applied in order to find whether independent variables such as years in practice, gender, theoretical orientation, professional membership, marital status, education could predict significant difference in the dependent variable (total score obtained by participants on the questionnaire) across the three groups.

As for the qualitative data, content analysis (a highly systematic version of quantifying qualitative data, as expounded by Krippendorff, 1980) was applied in order to analyze participants’ input. The epistemological stance of this procedure is positivist empiricist and assumes that social phenomena exist in the objective world and can be gleaned from the data. It felt that this method of analysis was
suitable to be included in a quantitative study. A ‘top-down’ approach was adopted (Wilkinson, 2003). Categories were derived from prior familiarity with the literature (actually from the themes that helped to generate the questionnaire plus a further category of ‘other’ to cater for further themes that were identified in the data).

RESULTS

Sample Characteristics

Seventy five participants returned the completed questionnaire (12.5% response rate). Of the 75 respondents, 50 were female (66.7%) and 24 were male (32.0%). 1 participant did not specify her/his gender (1.3%). The age of participants ranged from 31-77 years old, with a mean age of 54.75 (SD= 9.82). Forty nine participants reported being married (65.3%); 11 had a partner (14.7%), one of whom described themselves as having had a civil partnership; 11 were divorced, separated or widowed (14.7%), and 3 described their situation as being single (4.0%). One participant did not answer the relevant question. Seventy participants (93.33%) did not have children and only 5 (6.67%) were parents.

When describing their ethnicity, 73 participants described themselves as White (93.3%). 59 described themselves as White British (78.7%); four (5.3%) as Irish and ten (13.3%) reported being ‘White other’. The only non White participant (1.3%) described themselves as ‘Mixed other’ and
reported a mixed Indian, African and European ancestry. One participant did not specify what their ethnicity was.

Participants had various degrees of education due to their mixed professional status. In terms of their highest educational qualification, 42 possessed a masters degree (56%) and, 21 had been awarded a doctorate (28%), seven (9.3%) had obtained diplomas and four (5.3%) had completed an undergraduate degree. One participant did not provide information about their education. In terms of professional membership, 46 (61.3%) were registered with the BPS and 28 (37.4 %) with a range of counselling and psychotherapy organizations. These were distributed as follows: 14 (18.7%) were members of the UKCP, five (6.7%) were registered with the BACP, six participants (8.0%) were members of the BABCP and the last three (4.0%) reported being registered with the BPC. One participant did not provide this information. Twenty two participants (29.33%) were registered with both the BPS and at least one of the counselling/ psychotherapy organizations. Participants varied in how they described their professional occupation. 42 (56.0%) described themselves as Psychologists, 25 (33.3%) as psychotherapists and five (6.7%) as counsellors. Three participants (4.0%) did not provide this information. Six participants (8.0%) described themselves as lecturers as well as practitioners. Participants' years of practice ranged from 3-45 years of practice with a mean years of 16.99 (SD= 9.95).
Participants subscribed to a wide range of theoretical orientations: twenty five (33.3%) defined their orientation as cognitive behavioural, 18 (24.0%) were practicing from an integrative perspective, 14 (18.7%) described their theoretical orientation as psychodynamic, nine (12.0%) used humanistic ideas and eight (10.7%) described their orientation as 'other'. Of those: two participants stated 'Gestalt' as their main theoretical orientation, and there were single representatives of models such as hypnotherapy, feminism, narrative, psycho synthesis and systemic therapy. One participant stated 'my own' in response to this question.

When considering the three distinct sub groups divided by the factor (vignette), the number of participants in each group were as follows: 28 (37.3%) belonged to group 1 (received the 'Holocaust survivor' vignette), 21 (28.0%) belonged to group 2 (received the 'childhood trauma' vignette), and 26 (34.7%) belonged to group 3 (received the 'control' vignette). The mean and SD of the group as a whole and the three sub groups divided by the factor vignette are presented in Table 1.
Table 1: Mean and Standard Deviation of the entire group and three sub groups on age, years of practice and total score on attitudes

<table>
<thead>
<tr>
<th></th>
<th>AGE</th>
<th>Y YEARS IN PRACTICE</th>
<th>TOTAL SCORE ATTITUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Whole group (N=75)</td>
<td>54.75</td>
<td>9.82</td>
<td>16.99</td>
</tr>
<tr>
<td>Holocaust group (N=28)</td>
<td>54.28</td>
<td>8.84</td>
<td>15.29</td>
</tr>
<tr>
<td>Childhood trauma group (N=21)</td>
<td>56.43</td>
<td>10.09</td>
<td>18.52</td>
</tr>
<tr>
<td>Control group (N=26)</td>
<td>53.88</td>
<td>10.78</td>
<td>16.27</td>
</tr>
</tbody>
</table>

Reliability of overall scale

The Cronbach's alpha coefficient for the whole scale was found to be .83. As this value is above .7, it meant that all items were measuring a similar construct and the scale could be considered reliable with the sample. No items were removed as the reliability of the scale as a whole was high and would not be improved by reducing items. No subscales were considered for statistical analysis as none were deemed reliable. Because of the small sample (N=75) and small ratio between the number of participants and number of items on the scale (38) (ratio=2 items for each participant), it was not possible to conduct
factor analysis to identify whether the items load on specific factors.

**ANOVA on total scale score**

A one-way between-groups analysis of variance was conducted to explore the impact of the information presented in three different vignettes, on the answers given by participants, as measured by the scores on a questionnaire developed by the researcher.

There was no statistically significant difference in total scores across the three vignette groups \([F (2, 72) =2.7, P=0.07]\). As there was no significant difference between groups, post hoc tests could not be performed.

**Standard multiple regression**

An examination of the capacity of independent variables (such as gender, theoretical orientation, professional membership, age, years in practice, degrees completed and marital status) to predict the dependent variable (total scores on the questionnaire) did not yield any significant results.

The Correlation matrix of the above relationship is presented in Table 2.
Table 2: Correlation matrix between independent variables (gender, theoretical orientation, professional bodies, age, yeas in practice, education, and marital status and their capacity to predict the dependent variable (total score on the attitude scale)

<table>
<thead>
<tr>
<th>Pearson Correlation</th>
<th>Total scale</th>
<th>Gender</th>
<th>Theoretical orientation</th>
<th>Professional bodies</th>
<th>Age</th>
<th>Years in practice</th>
<th>Education</th>
<th>Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total scale</td>
<td>1.00</td>
<td>-.020</td>
<td>-.239</td>
<td>.006</td>
<td>.010</td>
<td>.094</td>
<td>.050</td>
<td>-.140</td>
</tr>
<tr>
<td>Gender</td>
<td>-.020</td>
<td>1.000</td>
<td>.090</td>
<td>-.049</td>
<td>.038</td>
<td>-.228</td>
<td>-.197</td>
<td>.070</td>
</tr>
<tr>
<td>Theoretical orientation</td>
<td>-.239</td>
<td>.090</td>
<td>1.000</td>
<td>-.232</td>
<td>.163</td>
<td>.109</td>
<td>.226</td>
<td>.184</td>
</tr>
<tr>
<td>Professional bodies</td>
<td>.006</td>
<td>-.049</td>
<td>-.232</td>
<td>1.000</td>
<td>.084</td>
<td>-.107</td>
<td>-.604</td>
<td>-.135</td>
</tr>
<tr>
<td>Age</td>
<td>.010</td>
<td>-.038</td>
<td>.163</td>
<td>.084</td>
<td>1.00</td>
<td>.637</td>
<td>-.066</td>
<td>-.174</td>
</tr>
<tr>
<td>Years in practice</td>
<td>.094</td>
<td>-.228</td>
<td>.109</td>
<td>-.107</td>
<td>.637</td>
<td>1.000</td>
<td>.136</td>
<td>-.144</td>
</tr>
<tr>
<td>Education</td>
<td>.050</td>
<td>-.197</td>
<td>.226</td>
<td>-.604</td>
<td>.136</td>
<td>1.000</td>
<td>.162</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>-.140</td>
<td>.070</td>
<td>.184</td>
<td>-.135</td>
<td>-.174</td>
<td>-.144</td>
<td>.162</td>
<td>1.000</td>
</tr>
</tbody>
</table>

All correlations were lower than .3 which is suggested as the threshold for substantial correlation. None of the variables examined predicted total scores on the attitude scale.

Content analysis

This was performed on the comments that participants (professionals) made in an attempt to formulate the difficulties of Sara (the woman that was described in the vignette). (See Appendix J for an example of qualitative data from ‘Holocaust group’). These comments were
analyzed and allocated to the different categories. (For a display of all categories, illustrated with representative quotations from the data, see Appendix K). The final step was to convert qualitative data into quantitative form. This was achieved by counting the frequency that each category was used by professionals when formulating Sara's difficulties in their comments.

Table 3 illustrates the frequency with which each category was mentioned in participants' formulations divided across the 3 groups.
Table 3: Content Analysis – quantitative presentation – record of the number of instances (frequency) with which professionals used each category when formulating Sara’s difficulties

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>FREQUENCY (%)</th>
<th>Holocaust group (N=21)</th>
<th>Childhood trauma group (N=18)</th>
<th>Control group (N=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problematic attachment &amp; unresolved separation from mother</td>
<td>14 (66.6%)</td>
<td>11 (61.1%)</td>
<td>12 (60.0%)</td>
<td></td>
</tr>
<tr>
<td>Ambivalent feelings, repressed anger &amp; guilt</td>
<td>11 (52.4%)</td>
<td>8 (44.4%)</td>
<td>10 (50.0%)</td>
<td></td>
</tr>
<tr>
<td>Role reversal between Sara &amp; her mother</td>
<td>9 (42.8%)</td>
<td>14 (77.7%)</td>
<td>10 (50.0%)</td>
<td></td>
</tr>
<tr>
<td>The impact of family narrative regarding the past</td>
<td>10 (47.6%)</td>
<td>2 (11.1%)</td>
<td>3 (15.0%)</td>
<td></td>
</tr>
<tr>
<td>States of distress passed on to Sara</td>
<td>12 (57.1%)</td>
<td>9 (50.0%)</td>
<td>3 (15.0%)</td>
<td></td>
</tr>
<tr>
<td>Susceptibility to PTSD</td>
<td>15 (71.4%)</td>
<td>8 (44.4%)</td>
<td>8 (40.0%)</td>
<td></td>
</tr>
<tr>
<td>Developing symptoms in response to stress</td>
<td>9 (42.8%)</td>
<td>7 (38.8%)</td>
<td>9 (45.0%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Life span challenges</td>
<td>5 (23.8%)</td>
<td>6 (33.3%)</td>
<td>7 (35.0%)</td>
</tr>
<tr>
<td>Angst about mortality</td>
<td>3 (14.3%)</td>
<td>9 (50.0%)</td>
<td>8 (40.0%)</td>
<td></td>
</tr>
<tr>
<td>Losing control/feeling unsafe</td>
<td>2 (9.5%)</td>
<td>8 (44.4%)</td>
<td>10 (50.0%)</td>
<td></td>
</tr>
</tbody>
</table>

From Table 3, it is clear that the groups differ between them for some of the categories but not for others. The categories that register substantial difference in their 'popularity' between the groups are 'role reversal between Sara and her mother', 'the impact of family narrative regarding the past', 'states of distress passed on to Sara', 'susceptibility to PTSD' and two sub categories of the 'Other' category ('angst about...
mortality' and 'losing control/feeling unsafe'). The Holocaust group scored higher than the other two in 'the impact of family narrative' and 'susceptibility to PTSD'. The trauma group scored highest for 'role reversal' and both Holocaust and trauma groups scored higher than the control group for 'states of distress passed on to Sara'. The Holocaust group scored lower than the other two for 'Angst about mortality' and 'losing control'. There were no substantial differences between the 3 groups for the rest of the categories ('problematic attachment', 'ambivalent feelings' 'developing symptoms' and finally 'life span challenges' a sub category of the 'other' category).

The results outlined above confirm in part, the first and major hypothesis (Holocaust group will give significantly different responses from those given by the other two groups). Professionals who read the 'Holocaust' vignette, used the categories 'the impact of family narrative regarding the past' and 'susceptibility to PTSD' substantially more frequently in order to formulate 'Sara's difficulties, when compared to the other two groups (those who read the 'childhood trauma' vignette and those who read the 'control' vignette). In other words those professionals who were informed of Sara's Holocaust past felt that they could understand some of her distress in relation to the impact of having been brought up by a mother who was a Holocaust survivor. That is by formulating Sara's distress using what could fit the category 'the impact of family narrative regarding the past', professionals
conveyed their understanding of the way Sara experienced herself, others and the world. This according to these professionals, was shaped by the information, rules and beliefs that she learned and gleaned from the stories, culture and general demeanour of her mother who was functioning from the way she was coping with the scars of her Holocaust experience.

By formulating Sara's difficulties using comments that could be subsumed under the category 'susceptibility to PTSD', the professionals who read the Holocaust vignette expressed their view, that her mother's Holocaust background made Sara more likely to respond with PTSD-like symptoms. This formulation was made much less by the professionals from the other two groups.

In line with this, professionals reading the Holocaust vignette were substantially less inclined to use the category 'other' in order to account for Sara's difficulties. The logic behind this is probably that if professionals were identifying the mother's Holocaust survivor status as an important factor in the understanding of Sara's presentation they will be less likely to find factors that are unrelated to this pertinent.

All these results echo the literature that see Holocaust trauma as transmitted indirectly to the second generation (see Weiss et al. 2000, Felsen, 1998, Shafat, 1994), and children of Holocaust survivors as possessing a characteristic vulnerability to respond with PTSD to stress (see Solomon et al. 1988).
A different picture emerges when considering how professionals chose the category 'states of distress passed on to Sara'. This category was using the construct of 'Transposition' (see Kestenberg, 1982, Wardi, 1992 and Kogan, 1995) in order to formulate Sara's distress. According to this construct Holocaust trauma is directly transmitted to the offspring in a way that is unique to them and creates in the offspring an intimate knowledge of the trauma, nearly as if they had experienced it in person. This category was not identified by professionals as uniquely relevant to daughters of Holocaust survivor mothers. In fact this category was equally used by professionals of both the 'Holocaust' group and 'childhood trauma' group and was substantially higher than the 'control' group. This result support the literature that sees Holocaust trauma transmission as a single case of trauma transmission generally (Degraaf, 1998)

There was no substantial difference between the frequency in which three of the categories ('problematic attachment and unresolved separation from mother', 'ambivalent feelings, repressed anger and guilt' and 'developing symptoms in response to stress' were used by professionals across the three groups. In other words professionals did not find the background of Sara's mother important in any way in determining her distress when considering these categories in their formulation. This perspective recalls the studies that claim that children of Holocaust survivors were not affected by the experience of their
survivor parents in any specific easy to trace way, and claim that it is not possible to talk about 'trauma transmission' (see Hazan, 1987 and Aleksandrowicz, 1973).

Lastly, a slightly baffling result: professionals who read the 'childhood trauma' vignette used the category 'role reversal between Sara and her mother' substantially more than professionals from the other two groups (Holocaust and control). Could it be that describing the mother as having had a 'traumatic childhood' generated more parental feelings and thoughts about the need to 'protect' her (hence high frequency of the category 'role reversal') whereas describing her as a 'Holocaust survivor' implied horrific experiences but also some resilience (hence less need to be 'looked after')?

Overall, the results of the quantitative part are mixed, with professionals who read the 'Holocaust' vignette using substantially more some of the categories to formulate Sara's distress but not others. This might also explain why the total score of the questionnaire was not significantly different across the three groups, as some of the categories (potential sub scales) might be significantly different between the groups and others not.
DISCUSSION

Overview of the findings

None of the hypotheses generated in trying to study the way professionals conceptualise Holocaust trauma transmission, was statistically confirmed. There were no significant differences between the overall scores that participants obtained when responding to the questionnaire among the three groups. Moreover, none of the independent variables considered (gender of participants, age, years in practice, education, theoretical orientation, profession or marital status) could be proved predictive of significant differences of the dependent variable (total score achieved when completing the questionnaire) between the three groups. This means that professionals who were informed of the ‘Holocaust trauma status’ of the mother were not likely to conceptualise Sara’s difficulties differently from professionals who did not possess such knowledge (allowing for normal variability). In other words the means of the distributions traced by the responses of the three groups were not significantly different and belong to the same population.

The results gleaned from the qualitative part on the other hand, were different and revealed some differences between the groups. The Holocaust group obtained substantially higher frequency for some of the categories but not for others. When considering the results of the qualitative part (no pretence to generalise them to the entire population because of the low response rate), it is possible to assess
that some elements of the distress that daughters of Holocaust survivor mothers display, do get formulated in a differentiated way across the groups, and other elements of the same construct (Holocaust trauma transmission) do not. Thus, there is no consistency across the various elements of the construct, in the 'popularity' with which they can substantially differentiate between the groups.

Limitations and value of this study

A very low response rate (12.5%) means that it is not possible to draw any certain conclusions beyond the participants who completed the questionnaires. The reason for this is that the results obtained do not come from a sample that can truthfully represent the population they were supposed to be drawn from. Thus, the sample in this study might be biased in that the participants who did return the questionnaires might possess some specific attributes that made them more likely than the rest of the professionals approached to respond. For example, the age of the group that responded could illustrate this point: mean age of 54.75 years, is probably much higher than the mean of the population of qualified professionals. This relative bias in the age variable might correspond to practitioners who have more free time or more interest in research as a result of lifespan issues.

It is very important to understand why the response rate was so poor. Could this outcome be put down (at least partially) to the fact that many private practitioners are inundated with requests to fill in
questionnaires by students? Is it possible that a process of fatigue has set in, contributing to low response rate? Also the timing of sending off the questionnaires (just before the Easter break) might have been unfortunate (many participants might have been away and found the questionnaire on their return, together with a large pile of mail waiting for attention).

Last but not least, the labels on the envelopes provided by the University were hand-written which might have deducted from their overall professional presentation.

The quantitative part of this study yielded no significant differences between the groups, while the qualitative part yielded substantial differences for some elements of the construct of Holocaust trauma transmission. It is important to think through what could have been done differently to ensure that methodologically the study would have been designed to as high a standard as possible. As most literature on this topic came from Psychoanalytic perspective, it was not easy to convert this construct into definite variables suitable for quantitative research. As some of the categories of this construct were found to differentiate better than others in the way professionals used them in their formulation, the categories that make up the construct (potential subscales that make the total scale) were probably not as neatly defined as they should have been. Another critique that can be
expressed here is that maybe the vignette was too long and complex, containing lots of elements for professionals to consider, which might have introduced some confounding elements to the variables under consideration. For example many professionals seem to have considered the impact of the death of the father that happened five years prior to the time of referral, in their formulation. This was not anticipated by the researcher.

The value of this study stands in its attempt (first to the best of the knowledge of the researcher) to bring together the contrasting views, present in the literature, of how to conceptualise Holocaust trauma transmission, and in creating a study in which professionals' prevalent view was tested empirically. Another potential contribution of this study stands in the initiation of a process that might lead to the construction of a scale assembling all the components of 'Holocaust trauma transmission' (assuming the construct does exist).

**Practical suggestions**

Several strategies will be offered here, in order to hopefully increase response rate in future research. Firstly, as there is now a short COREC route for students, it might be helpful to not exclude NHS practitioners unless this is important for the study under consideration. Secondly, the questionnaires could have been numbered, in correspondence to the name of the practitioner. This would have meant that the study could
Methodological suggestions for future research

The scale on the whole was reliable but not able to differentiate between the groups. There is however some basis to assume that some subscales could achieve better results in differentiating professionals' responses: firstly, some of the sub scales of the questionnaire did have significant results in the ANOVA but had not sufficient reliability to be statistically viable, this potential of some categories to substantially differentiate between the groups was then reiterated in the results of the qualitative part. A suggestion for future researchers might be to further define the components of the Holocaust trauma transmission construct and related sub scales, to create a questionnaire that is reliable as a whole scale (like the one used in this study), but also contain reliable subscales that can be tested for their capacity to significantly differentiate between the groups. A larger sample will also
allow factor analysis of the whole scale to further differentiate the elements that yield significant differences from the ones that do not. Lastly, the vignette might need to be simplified, and particularly if the relationship mother daughter is scrutinized, details regarding the death of Sara's father need to be pulled out, in order to control for this confounding unintentional variable.

**Theoretical implications**

As the results of this study are not definite, it is only possible to say that the construct of 'Transposition' as described by Kestenberg, (1982, 1983, 1989, and 1990) was not identified as substantially informing professionals' formulation of Sara's distress. That is, the professionals in the sample above, were not likely to think that this construct of direct trauma transmission unique to the Holocaust, was the best way to conceptualise the distress that women like Sara demonstrate. Future research questions might try and differentiate between the elements of Holocaust trauma transmission that have validity to the ones that don't, and develop a scale that possess reliable subscales, thus refine the construct.
Implications for practice

The results of this study are not definite enough to draw conclusions. What can be said however is that professionals were mixed in the way they conceptualised Holocaust trauma transmission as seen in the qualitative results. Some elements of Holocaust trauma transmission were teased out by professionals, but other professionals preferred to subsume Holocaust trauma to trauma more generally or were just as likely to find other reasons for Sara's distress. Practitioners are therefore invited to keep an open mind about the right formulation of women that display the kind of PTSD-like distress that Sara in the vignette exhibit, and scan for the potential relevance of the history of the mothers of these women (whether they are Holocaust survivors, had a traumatic childhood elsewhere, or had no significant traumatic history).
REFERENCES


APPENDIX L: Use of self and reflections

AN INVESTIGATION INTO THE CONCEPTUALISATION OF HOLOCAUST TRAUMA TRANSMISSION BETWEEN GENERATIONS BY PSYCHOLOGISTS AND THERAPISTS

Use of self and reflections

It seems only yesterday that I took the decision to conduct my research on the topic of the offspring of Holocaust survivors. I was pulled in that direction but also very apprehensive. It did feel like opening a Pandora's Box and I could not know in advance what will pop out once the box is open. While reading the literature and processing what my participants for the qualitative part told me in the interviews, I did shed tears and experienced pain in a way unknown to me before. In some mysterious way, however, despite all that, I feel that I am emerging from this process more secure and confident than I was before I started it. I am not sure I would like to take this delving into the theme of the Holocaust any further for the time being, but I am glad I have done it.

Unlike the first two parts of the research process, this last and quantitative part produced less raw feelings. It's as if much of the pain, horror, and fear that were associated with delving into the literature and the interviewing process had now been put into a logical organised system, and that felt like a healthy closure.
Not obtaining any significant results in the quantitative part however, felt very bruising initially. It felt shameful in some way ...as if I was exposed to the rest of the world as a 'fake'. Another take on it though, is that Holocaust trauma transmission is extremely difficult to pin down and reduce into clear rational concepts, quantification etc. It's actually short of a miracle that the effects of such a regressed, cruel, humiliating and destructive process such as the Holocaust can be thought about, researched, written about and submitted for marking.

Despite the fact that I have not managed to prove empirically that 'Transposition' exists and is acknowledged by professionals in their formulations, I still feel that it is a valid construct, at least some of the time, for some of the children of Holocaust survivors. In my own life there were some incidents which made me think that this construct could have been used to make sense of otherwise baffling reactions. For example: I have often had tears streaming down my face when I attended school concerts of my children (even if what was performed was perfectly happy and trouble free); I could never stop these tears nor could I understand why it took place. I was then reminded of one of the few stories I have heard from my father about his memories of being rounded up by the Nazis. The story was that all his family was gathered with other Jews from their town into the synagogue before being sent off to Auschwitz. He remembered his father [who probably by then realised that something awful is about to happen] saying to a
relative: “I’m glad I provided my children with the best education I could have afforded (that was probably his way of reassuring himself that being educated will somehow help his children to survive). Also there was this book that I read about the Tereisenstadt ‘model’ camp where children were made to paint and put up performances in order to deceive the ‘Red Cross’ in relation to the real purpose of the camp. They all of course got killed soon after the performance...I think these two ‘memories’/narratives combined together to make school performances so emotional for me.

Thinking about the vulnerability of children of survivors to PTSD, I am aware of being more ‘on alert’ than most people. It was my sister in law who discovered this when she was thirteen, and would enjoy standing behind me, calling me, and have great fun to see me jumping. I also like many people from survivor families listen a lot to the news. These intrusive incidents and general ‘being on guard’ in some way are not highly paralysing in any way, but I think they are examples of minor episodes of ‘Transposition’ where the present is seen through a prism that is taken from the world of ‘Holocaust imagery’.

Moreover, the construct of ‘Transposition’ helped me to understand something else: I was in analysis on two occasions and in both cases there was a sort of ‘role reversal’ between me and the therapist. In both cases there was no conscious intention for this to happen on
either side, and yet, in both cases my dreams reflected a clear trend to 'look after my therapist', identify unconsciously what was 'on their mind' or 'bothering them' and in some instances 'learn' certain facts about them, that I could have not known about otherwise. The only way for me to make sense of this is to think about it in the context of me trying to unconsciously 'role reverse' with the therapist. This was of course some sort of unconscious attitude that I 'practised' as a child with my father who was a Holocaust survivor. Like many children of survivors there was some unconscious dynamic between the child and the survivor parent, in which the parent projected some of the pain and unprocessed experiences he had, and the child received this projection in some way and helped the parent to process some of his/her internal experiences for them. In both cases the therapists who were qualified Jungian psychoanalysts were not Jewish, and the fact that my father was a Holocaust survivor was never really looked at in the analysis. It was only years later, reading about 'Transposition' and the tendency to 'role reverse' that what went on in these analyses started to make sense to me.
- THE END -