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in second- and third- generation Holocaust survivors**

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Pepperdine University
Graduate School of Education and Psychology

PSYCHOLOGICAL SYMPTOMS, FAMILY FUNCTIONING, AND RELIGIOUS COPING
IN SECOND- AND THIRD-GENERATION HOLOCAUST SURVIVORS

A clinical dissertation presented in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Melissa M. Wasserman

August, 2017

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This clinical dissertation, written by

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DOCTOR OF PSYCHOLOGY

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DEDICATION

I want to thank and express sincere gratitude to my grandparents, Esthera Zelda Ajlman and Max Wasserman, who were both Holocaust survivors, and who continue to inspire me to rise above the challenges I face in my life.

This dissertation is dedicated to them, and to all of those who have been affected by the atrocities of the Holocaust. We will never forget.



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ABSTRACT

Research has examined psychological symptoms, communication patterns from parent to child, parenting style, and protective and resiliency factors in descendants of Holocaust survivors. The current study explored intergenerational trauma and resilience in second- and third-generation Holocaust survivors as compared to a matched comparison group. Four groups were studied based on the participants' Holocaust background and demographics: second generation (2GH; $n=47$) and third generation survivors (3GH; $n=45$) who self-identified as having at least one parent or grandparent, respectively, who is/was a Holocaust survivor interned during the war, and a matched comparison group (2GM; $n=22$, 3GM; $n=13$) for each generation consisting of non-Jewish descent who had one parent or grandparent who emigrated from the same European countries between 1945-1952. Ten 2GH and 3GH participants opted to complete the additional qualitative interview in which they were asked questions about their experiences as a descendant of a Holocaust survivor. Results showed that third-generation survivors endorsed more symptomatology than the matched comparison group; however, second generation survivors did not endorse more symptomatology than second generation match comparisons. Additionally, when descendants reported less adaptive family communication, affect responsiveness, and family cohesion, they reported higher levels of symptomatology. Lastly, we found that descendants who reported turning toward religion during times of stress (positive religious coping) endorsed higher levels of obsessive-compulsive and anxiety symptoms and those who endorsed turning away from religion in times of stress (negative religious coping) reported more depressive symptoms. A conceptual model is presented that includes vulnerability and resilience factors related to the intergenerational effects of Holocaust exposure.

Introduction

Research shows that adverse consequences of traumatic experiences are not limited to the individuals directly exposed to the event; these effects can impact others in their environment such as family, friends, and caregivers (Dekel & Goldblatt, 2008; Figley 1995). Often, this vicarious consequence of exposure to traumatic experience is referred to as secondary traumatization, intergenerational trauma, or cultural, collective, or historical trauma. Figley (1995) refers to secondary traumatization as the consequences experienced by people who have been traumatized indirectly or secondarily. *Vicarious traumatization* suggests that previously non-traumatized persons acquire trauma like responses similar to the individual who has endured highly stressful events. As a subtype of secondary traumatization and vicarious trauma, intergenerational trauma transmission has been defined as “the impact of trauma experienced by one family member on another family member of a younger generation, regardless of whether the younger family member was directly exposed to the traumatic event” (Kaitz, Levy, Ebstein, Faraone & Mankuta, 2009, p. 160). This trauma can also emerge out of the remembrance of atrocities committed on a specific group or subgroup of people (i.e. historical trauma). The remembrance of the group experienced traumatic event can often represent a *debt paid* (Lev-Wiesel, 2007) for the sufferings of previous generations.

Sotero (2006) explains a theory of historical trauma that integrates psychosocial, political/economic theory, and social/ecological perspectives. The psychosocial aspects of historical trauma note that stressors increase the susceptibility to disease and have dramatic influences on human biology. Another aspect of historical trauma includes the political, economic, and structural inequalities (e.g., unjust power relations, class inequality) that are placed upon and constrict the individual. Lastly, the social-ecological systems perspective

includes the intertwined systems and themes that can contribute to and exacerbate the presence of disease. Additionally, Sotero (2006) states that there are four basic assumptions that contribute to historical trauma:

1. The trauma was intentionally inflicted on a marginalized population by a dominant group.
2. The trauma is continuous and prolonged rather than a single isolated event.
3. There is a shared traumatic experience in which the traumatic events remain constantly present throughout the traumatized population.
4. This traumatic exposure permanently shifts and alters the path of the population.

Arguments can be made that intergenerational trauma in Holocaust survivors meet Sotero's assumptions of historical trauma. First, the Holocaust was an intentional and deliberate act to annihilate the Jewish race. Landau (2006), while speaking of the Jewish Diaspora perfectly states how the Jewish people have often felt throughout history. He speaks of, "the changing relationship – between Jew and non-Jew; between an 'alien' social, cultural, and religious minority and the 'host' societies at whose mercy they found themselves" (Landau, 2006, p. 36). Second, anti-Semitism has been widely documented throughout history (Carroll, 2001; Landau, 2006), but for the purpose of this paper, we will only consider the shared historical trauma as deemed by the Holocaust and events leading up to the Holocaust in 20th century Eastern Europe. A crucial event in the marginalization and eventual extermination of Jews began in 1935, with the enactment of the Nuremberg Laws. These laws excluded Jews from German citizenship, prohibited them from having relationships with a person of German blood, and stripped German Jews from their political and human rights (Landau, 2006; USHMM, 2016). Legally, Jewish people in Germany, and later on in other European countries, were forced to carry separate

identity cards that indicated that they were of Jewish descent. These laws and regulations, marked the beginning of prolonged and continuous trauma for European Jews in the 20th century. Previous studies of intergenerational trauma in Holocaust survivors and their descendants have aimed to evaluate whether the shared traumatic experiences remain constantly present throughout the traumatized population. The notion of *never forget*, which is often explained in relationship to the Holocaust and that the Jewish people must never forget and never let similar atrocities occur again, seems to relate to Sotero's (2006) third basic assumption that the traumatic event reverberates through the traumatized population.

The final assumption that Sotero makes explains that the traumatic exposure alters the course of the population. The Holocaust altered the course of the Jewish population as more than one third of the all the Jews in the world were murdered (Landau, 2006). Additionally, the Holocaust was followed by an influx of Jewish immigrants to England and America, and the founding of a Jewish state. The founding of Israel was incredibly impactful for the Jewish people, as they had a homeland and a place of refuge following the Holocaust. In regards to the trauma of the Holocaust altering the course of the population, this is illustrated by Landau (2006) as he speaks of the aftermath and consequences of the Holocaust, "...after so long a period of mourning and self-reckoning, the Holocaust experience is now so deeply etched on Jewish minds and hearts that the Jewish world is, to an extent, fixated on the event" (p. 246). A recent and unique study found an epigenetic mechanism of intergenerational transmission, particularly of stress effects of Holocaust exposure. Yehuda et al. (2016) found that both Holocaust survivors and their offspring have methylation changes on the same site in a functional intronic region of the FKBP5 gene, a gene that has been identified as having a role in PTSD, depression, and anxiety. This study suggests that Holocaust trauma may shift the biology of descendants of

survivors and may support Sotero's criteria of an altered path of the population. Additionally, the social-political and socio-cultural climates of the Jewish people shifted as a result of the Holocaust, particularly in light of the influx of immigrants in the post-war era and the founding of the Jewish state of Israel.

The impactful effects of trauma on the family and subsequent generations have been examined in several populations including military and veteran populations and survivors of atrocities of war, enslavement, genocide, and colonization. More specifically, the intergenerational effects of trauma have been reported in generations of American Indians (Brave Heart & DeBruyn, 1998; Ehlers, Gizer, Gilder, Ellingston & Yehuda, 2013; Evans-Campbell, 2008; Gray, Shafer, Limb & Busby, 2013; Myhra, 2011; Wiechelt, Gryczynski, Johnson & Caldwell, 2012), African Americans (Eyerman, 2001) veteran families (Ahmadzadeh & Malekian, 2004; Davidson & Mellor, 2000; Harkness, 1993; Rosenheck & Fontana, 1998b) and Holocaust families (Danieli, 1998; Lev-Wiesel, 2007; Steinberg, 1989; Wiseman, Metzler, & Barber, 2006).

Several studies have evaluated the effects of intergenerational trauma in Holocaust survivors. Some studies have examined communication patterns from parent to child (Braga, Mello, & Fiks, 2012; Danieli, 1998; Lichtman, 1984; Wiseman et al., 2002); intrusive thoughts, anxious behavior, avoidance behavior (Lev-Wiesel, 2007); parenting style, the transmission of fear and mistrust (Rowland-Klein & Dunlop, 1997); and emotional experiences of anger and guilt (Wiseman et al., 2006) in second and third generation Holocaust survivors. Many studies have taken a qualitative approach and examined themes and meanings of second-generation Holocaust survivors' narratives (Braga et al., 2012; Lev-Wiesel, 2007; Wiseman et al., 2006). Additionally, various studies have evaluated protective and resiliency factors in first, second, and

third generation Holocaust survivors (Barel, Van Ijzendoorn, Sagi-Schwartz & Bakersman-Kranenburg, 2010; Giladi & Bell, 2013; Shmotkin, Shriria, Goldberg & Palgi, 2011). In contrast, some studies have failed to find effects of transmission of secondary trauma in the children and grandchildren of Holocaust survivors (Fridman, Bakermans-Kranenburg, Sagi-Schwartz, & Van Ijzendoorn, 2011; Leon, Butcher, Kleinman, Goldberg & Almagor, 1981).

Psychological Responses to Intergenerational Trauma

The symptoms endorsed by those with second generational trauma can cause distress and dysfunction in their lives (Danieli, 1998). Furthermore, Lev-Wiesel (2007) explains that both the children and grandchildren of individuals who have experienced significant life traumas appear to be adversely affected by the traumatic event. Some of the identified symptoms experienced by those with intergenerational trauma have spanned across psychological and familial/interpersonal domains. The knowledge of the traumatic event as it occurred in a family member is associated with specific behaviors and emotions that surround the secondary traumatic stress experience. These behaviors and emotions can present as nearly identical to those presented in individuals with posttraumatic stress disorder (Figley, 1995). Additionally, the Diagnostic and Statistical Manual- 5th Edition (DSM-5) has included “learning that the traumatic event(s) occurred to a close family member or close friend” (American Psychiatric Association, 2013, p. 271) to the exposure diagnostic criterion of posttraumatic stress disorder (PTSD).

The psychological effects of secondary traumatization can include various posttraumatic responses including intrusive imagery, heightened sense of vulnerability, emotional numbing, and difficulty building trust in relationships (Dekel & Goldblatt, 2008). Research has shown that there is a higher rate of anxiety and aggression in adolescent children of veterans with PTSD compared to children of non-veterans (Ahmadzadeh & Malekian, 2004). High rates of

depression, behavior disturbance (Harkness, 1993; Lev-Wiesel, 2007; Rosenheck & Fontana, 1998a) and emotional problems (Parsons, Kehle, & Owen, 1990) are also symptoms that have been linked to children whose fathers have been exposed to traumatic events. Children of combat veterans from the Vietnam war endorsed more posttraumatic symptoms, higher levels of suicidality, more guilt, and less social support than children of non-combat veterans. Furthermore, veterans with PTSD who had combat veteran fathers were more likely to meet criteria for panic disorder and substance abuse than those with PTSD whose fathers were noncombat veterans (Rosenheck & Fontana, 1998b).

In a qualitative study conducted with urban American Indians and Alaska Natives, participants reported a common theme of fear about the possibility of experiencing further oppression (Myhra, 2011). Study participants also emphasized the importance of engaging in cultural activities and reported a desire to end inherited historical trauma shame and viewed their elders as survivors. In Lumbee and Cherokee descendants, historical loss was associated with symptoms of sadness and nervousness and those who reported historical loss associated symptoms were more likely to have recent and lifetime substance use (Brave Heart et al., 1998; Wiechelt et al., 2012). Ehlers et al. (2013) found a correlation between anxiety disorders, affective disorders, and substance dependence with historical loss symptoms. Typical PTSD symptoms have been reported by American Indians (Brave Heart et al., 1998, Evans-Campbell, 2008). For example, Evans-Campbell (2008) found that intergenerational trauma in American Indians may emerge as feeling numb in response to traumatic events, anger, depression, intrusive dreams and thoughts, rumination over past events and loss of ancestors, survivor guilt, and unresolved mourning.

Harkness (1993) found that family violence as a result of the father's PTSD, predicted

greater distress in the children, suggesting that the consequences of the diagnosis itself are likely to have a greater effect on intergenerational transmission. This is consistent with the literature on trauma among veterans and highlights the difficulty with coping and managing the effects of PTSD. Earlier studies by Rosenheck and Fontana (1998b) found that some children tend to manifest the same adjustment problems related to their father's traumatic experience, as do their fathers. This highlights the role of abusive violence or atrocities as a factor adversely affecting parent-child relationships. Rosenheck and Fontana (1998b) concluded that veterans who have participated in a combat environment have difficulty establishing meaningful emotional connections with their children.

Several empirical studies have reported lower self-esteem, poorer family functioning and emotional and psychiatric disturbances in both wives and children of Vietnam veterans with PTSD (Davidson & Mellor, 2000). Another study of children of Vietnam veterans found that almost half had used illegal drugs, more than a third reported behavioral problems and almost half reported significant PTSD (Beckham et al., 1997). Harkness (1993) found that children of combat veterans were more likely to have behavior problems, poorer school performance and less social competence than children of noncombat veterans.

Additionally, children of Holocaust survivors have presented with symptoms that resemble their parents', to include depression, anxiety, and guilt (Steinberg, 1989). Studies have examined intrusive thoughts, anxious behavior, avoidance behavior (Lev-Wiesel, 2007), and emotional experiences of anger and guilt (Wiseman et al., 2006) in second (and third) generation Holocaust survivors. Specifically, Lev-Wiesel (2007) found that second generation Holocaust survivors could experience painful memories of parental Holocaust experience; avoidance of new places and new people and avoiding heavily crowded areas. Felsen (1998) explains that

psychological functioning in second generation survivors displays a greater propensity for anxiety, depressive experiences and psychosomatic complaints. Cumulatively, these findings suggest that traumatic exposure can have lasting psychological effects on subsequent generations.

Parenting and Parent-Child Relationship

Several studies have examined the effects of parental traumatic exposure on the parent-child relationship (Banyard, Williams & Siegel, 2003; Berz, Taft, Watkins & Monson, 2008; Dekel & Goldblatt, 2008; Kaitz et al., 2009; Lichtman, 1984). In parents who have experienced a trauma, their pathology may influence the way that they relate to their child. Parents who have been exposed to trauma may feel too overwhelmed by their own distress to be cognizant of their child's emotion dysregulation or emotional turmoil/needs (Kaitz et al., 2009). Another factor that has been shown to affect the parent-child relationship is the way that trauma is communicated within the familial context.

The communication of trauma between parent and child may be meaningful in the intergenerational transmission of distress (Dekel & Goldblatt, 2008). An absence of communication about the traumatic experience may result in consequences for the child. Kaitz et al. (2009) contend that the nonverbal and verbal communication about the traumatic event helps the child understand the parent's emotional experience. However, Danieli (1998) explained that the trauma will be transmitted to further generations regardless of whether or not the survivor discussed the traumatic event with his/her child.

Studies regarding communication of traumatic exposure in families of Holocaust survivors are divided as to whether communication has an impact on the second generation's psychological well-being. Lichtman (1984) found that communication of the trauma to the

second generation was significantly related to personality characteristics of anxiety, paranoia, hypochondriasis, and low ego strength. However, Wiseman et al. (2002) explain that the survivor's ability and willingness to talk openly about traumatic experiences is related to lower levels of psychological distress in second generation.

There is a growing body of literature that examines parental trauma history and its effects on parenting. Banyard (1997) found that parents' own abuse histories are risk factors for consequences in the parenting role, including the use of more punitive, aggressive and physical discipline. In their study of mothers with a variety of interpersonal trauma in both childhood and adulthood, Banyard et al. (2003) found that overall higher levels of trauma exposure were linked with decreased levels of parental satisfaction, reports of child neglect, use of physical punishment. Similarly, emerging literature on the impact of post combat PTSD symptoms on veterans' family life indicates that both male and female veterans' PTSD symptoms are associated with decreased levels of parenting satisfaction, which is defined as a parent's feeling of efficacy and enjoyment related to parenting, as well as a perception of the quality of the parent-child relationship (Berz et al., 2008). Male Vietnam veteran's PTSD symptoms were associated with decreased parental satisfaction and poorer attachment levels with their children, possibly resulting in secondary trauma and increased risk for mental health problems (Palmer, 2008) as compared to civilian children. In summary, clinical evidence indicates that PTSD symptoms can impact a parent's functioning and ability to parent, resulting in far reaching consequences for their children (Cohen, Hien & Batchelder, 2008).

Resiliency and Coping

The Centers for Disease Control and Prevention (2015) define protective factors, as individual or environmental characteristics, conditions, or behaviors that reduce the effects of stressful life events. These factors also increase an individual's ability to avoid risks or hazards, and promote social and emotional competence to thrive in all aspects of life, now and in the future. Garmezy (1991) viewed protective factors as the ability to moderate emotions, cope with stressors, and manifest adaptive responsiveness to stressors. A well-researched protective factor, resilience, is viewed as an adaptive behavior in response to the vulnerability of risk, in this case trauma and the development of psychopathology (Agaibi & Wilson, 2005). Resilience has been defined as the process of adapting well in the face of adversity, trauma, tragedy, threats of harm, or even significant sources of stress (Yehuda & Flory, 2007).

Despite the similarities in defining resilience as a protective factor, some researchers suggest that resilience has not taken into account an individual's cultural and contextual differences (Ungar, 2011). Researchers identify resilience as a quality that reflects an individual's capacity to engage in processes that make it likely they will overcome adversity and achieve normal or exceptional levels of psychosocial development (Ungar & Liebenberg, 2011). However, few studies take into account the effect of cultural immersion into the dominant culture and the heterogeneity of ethno-racial minorities themselves, suggesting that there are many cultural differences regarding one's ability to overcome stressful events and what this means for each (Ungar & Liebenberg, 2011). Ungar (2008), provides a socio ecological definition of resilience:

In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and

physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided and experienced in culturally meaningful ways. (p. 225)

Although there appear to be several psychological, relational, biological and physiological effects of intergenerational or secondary traumatization, it is important to note that every individual exists within his/her own dynamic contextual framework. Mediators and moderators of secondary trauma may change one's susceptibility to secondary traumatization. It is important to investigate strength-based factors that could mediate the effects of intergenerational trauma like coping and resiliency.

Successful adaptation to stress includes the way individuals manage their emotions, think constructively, regulate and direct their behavior, control their autonomic arousal, and act on social and nonsocial environments to alter or decrease sources of stress. Coping is viewed as an ongoing dynamic process that changes in response to the varying demands of a stressful encounter and the regulatory processes involved in coping draw on and are constrained by the biological, cognitive, social, and emotional development of the individual (Compas, Connor, Saltzman, Harding & Wadsworth, 2001). Coping reflects distinct aspects of successful development and adaptation to intergenerational trauma. The distinction being that coping refers to the processes of adaptation and resilience is reflected in outcomes for which coping has been effectively put into action in response to stress and adversity. Furthermore, coping includes the behaviors and thoughts implemented by individuals when faced with stress, and resilience refers to the individuals coping responses who have been faced with stress and have coped in an adaptive and effective manner (Compas et al., 2001).

A two-dimensional model of coping has received the most attention in the empirical

research and is often used as a conceptual framework for categorizing numerous other strategies (Goldenberg & Matheson, 2005). Lazarus and Folkman's (1984) dimensions of problem focused and emotion focused coping, reflect the function of coping responses to either act on the source of stress in the environment or palliate distressing emotions that arise from a stressful encounter or event. Problem-focused coping refers to a response to a problem or stressful situation by formulating a plan or approach, changing the environment to make it more bearable, or managing or escaping from the problem. Emotion-focused coping involves attempts to reframe, deny or distance oneself from the problem or stressful situation (Morano, 2010). Some studies suggest that the coping style an individual adopts is a result of one's age, situational factors, inner representation (Gaylord-Harden, Gipson, Mance & Grant, 2008; Goldenberg & Matheson, 2005; Morano, 2010). For example, Irion and Blanchard-Fields (1987) found that older adults are more likely to engage in problem focused coping when they believe a stressful situation is controllable and emotion focused coping when they perceive they have no control over the situation. Similarly, Compas et al. (2001) noted that in infants, early coping efforts may be oriented towards palliating distressing emotions through primary behavioral means, including seeking support and soothing from others, behavioral withdrawal from threat and use of tangible objects for soothing and security. Individuals who perceive or appraise a situation and their ability to view that situation as manageable will ultimately fare better than those who view the situation as unmanageable (Morano, 2010). In terms of inner representation, individuals who view the world as meaningful, predictable and controllable are more likely to use problem solving strategies in comparison to those who view the world as random and uncontrollable. Additionally, individuals who have maladaptive views or schemas about the world are more likely to use maladaptive coping strategies (Goldenberg & Matheson, 2005).

Problem-focused coping, as well as seeking social support, which is arguably an emotion focused approach to coping, generally predict better recovery from stressful events (Goldenberg & Matheson, 2005). Agaibi and Wilson (2005), found that problem focused coping is more effective than emotion focused coping when dealing with traumatic stress. Furthermore, Lalonde and Nadeau (2012) viewed social support and problem focused coping as protective factors and reduce the development of PTSD following a traumatic event.

Studies that examine coping in Holocaust survivors conclude that the level of stress experienced by the survivor directly relates to the second generation's inability to cope with stressful life events. This may be directly linked to findings that adult children of Holocaust survivors display a higher level of distress when presented with non-life threatening events (Yehuda, Schmeidler, Wainberg Binder-Brynes & Duvdevani, 1998), which may highlight a limited ability to cope with adverse experiences. In research conducted by Fridman et al. (2011), as survivors reported higher levels of stressful life events, their daughters also reported higher levels of stressful life events. Lev-Wiesel (2007) explain that children of Holocaust survivors exhibit posttraumatic-stress symptoms including the presence of intrusive thoughts, socially-anxious behavior, and avoidant behavior. Additionally, second generation survivors reported higher levels of childhood trauma as compared to their controls (Yehuda, Halligan & Grossman, 2001). Researchers also recognize the epigenetic component of secondary trauma, which considers both genetic predisposition and an environmental stressor in the susceptibility of secondary traumatization (Kaitz et al., 2009).

Studies have evaluated protective and resiliency factors in both first and second-generation Holocaust survivors. Giladi and Bell (2013) concluded that self-differentiation and open family communication are correlated with lower levels of traumatic stress in second-

generation survivors. Van IJzendoorn, Bakermans-Kranenburg & Sagi-Schwartz (2003) note that the survivors' prewar experiences (i.e. strong social support) may serve as a protective factor in first generation survivors, and that adaptive and supportive pre-war interpersonal relationships also help to create post-trauma resiliency. These experiences and relationships may have allowed for improved psychological adjustment, post war. Similarly, the building of post-war social support may also have created a buffer to psychological maladjustment after combat experiences (Van IJzendoorn et al., 2003), which may have led to more adaptive coping skills. Religious coping has been found to promote resilience and psychological adjustment following a traumatic experience (Bonanno, 2004).

Religious coping has been found to correlate with adjustment and resilience following traumatic exposure (Bonanno, 2004). In positive religious coping, one turns to religion in times of stress, particularly appraising life events to benevolence, seeking out religious or spiritual support and fostering a spiritual connection with G-d. Positive religious coping has been shown to be beneficial for those who are experiencing stress (Rosmarin, Pargamet, Krumei, & Flannelly 2009). In contrast, in negative religious coping, one passively defers religious and possesses discontent for religion. In prior studies, negative religious coping has been correlated with higher levels of anxiety and depressive symptomatology (McConnell, Pargament, Ellison, & Flannelly, 2006). Additionally, research has shown that positive religious coping is a protective factor to long-term effects of extreme trauma (Palgi, Shrira, & Ben-Ezra, 2011) such as the Holocaust or prolonged exposure to combat. There is scarce research conducted in the area of religious coping as it relates to second- and third- generation offspring, however research has been conducted examining the effects of religious coping in Holocaust survivors. Positive religious coping seems to mediate the effects of psychological symptoms and maladjustment and buffers the long-term

traumatic effect on the psychological functioning of Holocaust survivors (Palgi et al., 2011). A study conducted by Palgi et al. (2011) showed that European-origin Israeli secular survivors reported lower psychological functioning as compared to ultraorthodox survivors. In addition, Holocaust survivors who had high levels of psychological distress reported less synagogue attendance than their less distressed counterparts who attend synagogue frequently (Brodaty, Joffe, Luscombe, & Thompson, 2004).

Critique and Further Need for Study

There appears to be a lack of consensus among researchers about the effects of intergenerational trauma in Holocaust survivors. To understand these diverse views, it is important to consider the limitations of previous studies. Inconsistent findings of secondary traumatization in Holocaust survivors may be attributed to unobserved mediating and moderating factors that may affect second generational trauma transmission (Sorscher & Cohen, 1997). Many studies that have examined the intergenerational effects of trauma have relied solely on qualitative methods. In addition, the use of measures with questionable psychometrics might contribute to inconsistent findings in the field (Baranowsky, Young, Johnson-Douglas, Williams-Keeler & McCarrey, 1998). Most research evaluating intergenerational trauma in Holocaust survivors have employed case example methodologies or studies with small sample sizes. Additionally, much of the research has used qualitative approaches. Only few studies have used a mixed methods approach. There is a need to use complementary quantitative methods in evaluating inter-generational Holocaust trauma, including measures that are both valid and reliable to help substantiate qualitative findings.

There is also a lack of specificity regarding the survivors' unique Holocaust experience (e.g. hiding, concentration-camp, death camp, number of camps transported to, etc.) in

examining the inter-generational effects of Holocaust trauma. Another rarely studied aspect of second-generation Holocaust survivors is the impact of culture on this population. For example, a factor that has not been sufficiently studied is the effect of religious coping on second or third generation Holocaust survivors' ability to manage secondary traumatization. Cultural factors should be considered in future studies, which may specifically relate to the way second- and third-generation survivors cope with their secondary trauma symptoms and may also illuminate protective factors, which might mediate symptomatology. Clinically, the psychological impact on descendants needs to be appropriately assessed and addressed in treatment. Additionally, it is important to help paint a more holistic and contextual portrait of the impact on psychological and familial functioning in second and third generation survivors.

Methods

Participants

After receiving full Institutional Review Board approval (Appendix A), participants were recruited for the study. There are two multi-generational groups that were included in the study and are depicted

in Figure 1.

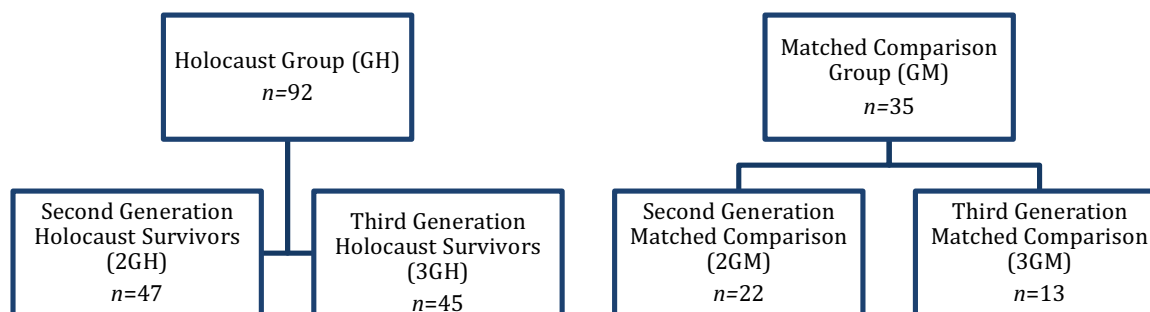


Figure 1. Study participants by group.

The Holocaust group included second (2GH, $n=47$) and third (3GH, $n=45$) generation descendants of Holocaust survivors and the matched comparison group which included second (2GM, $n=22$) and third (3GM, $n=13$) generation descendants of non-survivor European immigrants. Specific demographic information can be found in Table 1. The groups are each defined below.

Holocaust groups. Second generation survivors (2GH) were defined as having one parent (living or deceased) who survived the Nazi Holocaust. Third generation survivors (3GH) were defined as having at least one grandparent (living or deceased) who survived the Nazi Holocaust. For the purpose of this study, *Holocaust survivor* has been defined as having been

imprisoned in a Nazi concentration camp, work camp, or death camp. Survivors who were in hiding or fought with partisans were also included in this study.

Inclusion criteria for the Holocaust group included: (a) over 18 years of age; (b) be 2G or 3G of a Holocaust survivor who was interned in a concentration camp; (c) parents or grandparents must have immigrated to America from the following European countries between 1945-1952:

Germany, Poland, Czech Republic and Slovakia (formerly known as Czechoslovakia), Austria, Hungary, or Romania; (d) Holocaust survivors must not have been placed in a formal leadership position within the concentration camps (i.e. Kapo).

Exclusion criteria included high-risk individuals including those who have suicidal ideation and/or a history of psychiatric hospitalizations. Exclusion criteria were assessed during the initial screening phone call (Appendix B).

Matched comparison groups. There were two matched comparison groups in this study. The second-generation matched comparison group (2GM) matched 2GH group in age, generation, and parental immigration status. The third-generation matched comparison group (3GM) matched 3GH in age, generation, and grandparent's immigration status. Inclusion criteria for the matched comparison groups included: (a) over 18 years of age; (b) parents or grandparents must have immigrated to America from the following European countries: Germany, Poland, Czech Republic and Slovakia (formerly known as Czechoslovakia), Austria, Hungary, or Romania; (c) they must identify as non-Jewish. Exclusion criteria include high-risk individuals including those who have suicidal ideation or a recent hospitalization for mental health concerns.

Table 1

Demographic Information

	<u>3G</u>		<u>3G</u>		<u>2G</u>		<u>2G</u>	
	<u>Holocaust</u>		<u>Matched</u>		<u>Holocaust</u>		<u>Matched</u>	
	M	SD	M	SD	M	SD	M	SD
Age	34.02	8.65	8	8.13	60.96	6.11	7	6
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Gender								
Female	35	77.8	8	4	28	60.4	13	66.7
Male	10	22.2	5	6	19	39.6	9	33.3
Marital Status								
Single, never married	20	44.4	6	5	2	4.2	3	1
Domestic partnership	2	4.4	1	7.69	0	0	1	3.7
Widowed	1	2.2	0	0	1	2.1	1	3.7
Married	19	42.2	6	5	39	81.25	17	6
Divorced	2	4.4	0	0	6	12.5	4	1
Separated	1	2.2	0	0	0	0	1	3.7
Education								
Less than HS	0	0	0	0	0	0	0	0
High School/ GED	1	2.2	0	0	0	0	1	3.7
Some college	0	0	4	7	4	8.4	3	1
Associates degree	18	40	1	7.69	0	0	2	7.41
Bachelor's degree	26	57.8	4	7	17	35.4	9	3
Graduate degree	0	0	4	7	27	56.3	12	4

(continued)

Employment Status								
				84.6				66.6
Employed	37	82.2	11	2	30	62.5	18	7
Unemployed	5	11.1	1	7.69	3	6.3	0	0
Homemaker	3	6.7	1	7.69	1	2.1	2	7.41
								25.9
Retired	0	0	0	14	29.2	25.93	7	3
Jewish Sect								
Reform	18	40	-	-	15	31.3	-	-
Conservative	13	28.89	-	-	17	35.4	-	-
Orthodox	4	8.89	-	-	2	4.2	-	-
Other	9	20	-	-	14	29.2	-	-
Income								
Less than 20,000	0	0	0	0	0	0	1	3.7
				15.3				11.1
20,000-40,000	1	2.22	2	8	2	4.2	3	1
				38.4				14.8
40,000-70,000	14	31.11	5	6	3	6.3	4	1
								14.8
70,000-100,000	8	17.78	1	7.69	9	18.8	4	1
				30.7				25.9
100,000-150,000	8	17.78	4	7	6	12.5	7	3
								14.8
More than 150,000	13	28.89	1	7.69	21	43.8	4	1

Recruitment

Holocaust groups. The first step in the recruitment process for the Holocaust group included contacting Jewish organizations in the Greater Los Angeles area. Jewish organizations in the Los Angeles area (e.g. Jewish Federation, Los Angeles Museum of the Holocaust, Aish HaTorah, Simon Wiesenthal Center, Skirball Cultural Center, and Jewish Genealogical Society of Los Angeles) were asked to send out information about the study in their newsletter (Appendix C). Another sampling method included recruitment through advertisements (Appendix D) posted through local Jewish organization's social media pages. The advertisements and flyers informed the potential participant about the nature of the study and stating that the study is both voluntary and confidential. The advertisements also included

information regarding compensation for participation in the study and the contact information of the lead investigator.

Matched comparison groups. Participants were recruited through posted flyers at local universities (e.g. Pepperdine University, Cal State University Northridge, University of Southern California, University of California Los Angeles) and local businesses (i.e. coffee shops, grocery stores; Appendix D). Another sampling method included recruitment through advertisements on social media websites of European immigrant organizations (Appendix C). The recruitment flyers and advertisements informed the participants to the nature of the study, confidentiality, and compensation information.

Measures

Demographic form. All participants were given a self-report demographic form (Appendix E) which asked them to specify age, gender, education level, marital status, current employment, socioeconomic status, ethnicity, race and religious identification.

Trauma History Screen. To assess for previous traumatic exposure that is independent from parental traumatic exposure, the Trauma History Screen (THS; Carlson et al., 2011; Appendix F) was administered. The THS is a very brief self-report measure of exposure to traumatic stressors. It assesses the frequency of stressors and traumatic distress and asks for specific information regarding these events. The first part of the measure includes 14 items that assesses the occurrence of traumatic exposure using a “yes or no” response format. The second part allows the respondent to give detailed descriptions of the event to which they answered “yes”. The psychometric properties of the THS are adequate with temporal stability ranging from .85 to .96, median kappa coefficients ranging from .61 to .77 and convergent validity of .73-.77 (Carlson et al., 2011; Hooper, Stockton, Krupnick, & Green, 2011).

Symptoms Checklist-90-R. In order to assess symptom distress, the *Symptom Checklist-90-Revised* (SCL- 90-R; Derogatis, 1983; Appendix G) was administered, which is a 90-item, self-report measure that evaluates psychiatric symptoms. The SCL-90-R is divided into nine subscales: Somatization (SOM), Obsessive-Compulsive (O-C), Interpersonal Sensitivity (I-S), Depression (DEP), Anxiety (ANX), Hostility (HOS), Phobic Anxiety (PHOB), Paranoid Ideation (PAR), and Psychoticism (PSY). In addition, there is a Global Severity Index to help measure overall psychological distress. The SCL-90-R has demonstrated adequate reliability and validity with the internal consistency reliabilities ranging from 0.77 to 0.90. Additionally, test-retest reliability for the SCL-90-R with a one-week interval ranged between 0.80 and 0.90 (Derogatis, 1983).

The McMaster Family Assessment Device. Family communication patterns were assessed using the Communication, Affective Responsiveness, and General Functioning subscales of the *McMaster Family Assessment Device* (FAD; Epstein, Baldwin, & Bishop, 1983; Appendix H). Due to the length of the measure, only three subscales were given out of respect for participants' time. This should not pose a problem to the reliability and validity of the data because each subscale has been independently validated. The measure was created as a screener to evaluate variables of family functioning. Participants report their level of agreement with specific items and rate their responses on a Likert scale (1- Strongly Agree to 4- Strongly Disagree). The Communication subscale evaluated how family members communicate and includes items such as “you can't tell how a person is feeling from what they are saying” and “when someone is upset the others know why.” The Affective Responsiveness subscale assessed how individual family members experience and display affect within the family unit. Items include, “some of us just don't respond emotionally” and “we cry openly.” The General

Functioning Subscale measured overall family functioning and consists of 12 items. Items include, “we feel accepted for what we are” and “we confide in each other.” Together, the Communication, Affective Responsiveness, and General Functioning subscales include 24 items. The *FAD* subscales were validated individually and each demonstrates adequate reliability and validity. The Communication subscale has reliability of .75, Affective responsiveness subscale of .83 and General Functioning subscale of .92 (Epstein et al., 1983).

Jewish Religious Coping Scale. To measure religious coping factors, the Jewish Religious Coping Scale (*JCOPE*, Rosmarin et al., 2009; Appendix I) was administered. The *JCOPE* is a 16-item measure that assesses an individual’s religious coping with life stressors and distinguishes the coping as either “positive” or “negative.” Positive religious coping includes a sense of spiritual connectedness following a traumatic event. Items include, “I look for a stronger connection with G-d” and “I sought G-d’s love and care.” Negative religious coping includes a spiritual struggle following a significant life event. Items include, “I feel punished by G-d for my lack of devotion” and “I wonder what I did for G-d to punish me.” Preliminary studies have established incremental validity of the *JCOPE* positive and negative subscales. Reliability for the positive subscale was high ($\alpha=.92$) and reliability for negative religious coping subscale was adequate ($\alpha=.71$) with demonstrated concurrent and incremental validity (Rosmarin et al., 2009).

Interview protocol. The semi-structured interview (Appendix J) was adapted from Hass (1990) and included questions regarding the participant’s perception of his/her parent or grandparent’s Holocaust experience and how it has affected his/her life. Hass (1990), a second-generation survivor and psychologist, explains how he developed the interview questions:

Although my queries were specific, they encompassed concerns of my own that I

believed were central issues in the life of a child of survivors. I hope that my questions about parents would provide both information about the interaction between survivors and their children and a view of the survivors other than the one we have received from the survivors themselves or from mental-health professionals. In addition, I addressed a number of issues on which earlier research had not reported. (p. 4)

Participants were informed that they were not required to answer any questions and could opt out of or skip any question.

Procedures

The current study used a mixed methods approach to examine the effects of intergenerational trauma in 2G and 3G Holocaust survivors. Those expressing interest were given a summary of the study via telephone and asked screening questions to determine eligibility for the study (Appendix B). Those who did not meet eligibility requirements were thanked for their time and informed that they did not meet criteria for the current study. During the initial phone screen, Holocaust group participants were asked if they would be willing to participate in the qualitative interview. The Holocaust group participants who were willing to participate in the semi-structured interview were informed that they would receive additional compensation for their time.

Once eligibility was determined through the phone screening, participants were given a five digit randomly assigned number that would act as their identifier for the online survey. This was done in order to protect and ensure participant confidentiality as they completed surveys online and all measures and information were de-identified to protect participant privacy. Participants in both the Holocaust groups and matched comparison groups completed the demographic form and quantitative measures online. Each participant was given a copy of the

informed consent agreement (Appendix K). On the homepage of the survey, A brief introduction to the study was given, followed by (a) orientation to the nature of the study, (b) information of any potential harm or risks involved in participating in the study, (c) a reminder that participation in the study is both voluntary and confidential. The final page of the survey directed participants to a how to guide to find a mental health provider in their area in addition to a page on how to cope with distressing feelings and thoughts (Appendix L). Finally, participants were also provided with recommendations about self-care mobile applications (e.g. breathing exercise and relaxation applications) and a list of self-care activities that they can engage in (Appendix M). Following the completion of the measures, the matched comparison group participants were given \$10.00 compensation. The Holocaust-survivor participants who only completed quantitative measures were given \$10.00 compensation.

The Holocaust participants who opted to complete the additional qualitative interview were scheduled to meet the primary investigator at a university clinic in the Greater Los Angeles area. Informed consent was reviewed and obtained. Each qualitative participant was given a referral list to mental health providers in the area should they experience any distressing thoughts or feelings following participation in the study (Appendix L). The Holocaust-survivor group participants who participated in the qualitative interview were given an additional \$10.00 for their participation.

During the qualitative interview, if the participant experienced distress, the principal investigator engaged in grounding techniques and/or breathing exercises; additionally, the participants were reminded that there was no penalty if they chose to end the interview or skip any questions. Coping activities were recommended when the participant showed signs of distress from discussing interview content. Steps 1 and 2 of the Distress Protocol (Appendix N)

were utilized with three participants total with only one participant requiring completion of a breathing exercise. All three participants were offered to skip the question, take a break, or discontinue but all chose to proceed with the interview. Recommendations were provided to all participants, including emergency numbers and therapist locator resources (Appendix L), resources about self-care mobile applications (e.g. breathing exercise and relaxation applications) and a list of self-care activities that the participant can engage in following their participation in the study (Appendix M). Additionally, participants were informed of the potential risks during the consent process and were told that they could discontinue participation in the study at any time.

Data Analysis

A mixed methods approach was used to better explain and interpret intergenerational trauma and add to the scarce body of research of 2G and 3G Holocaust survivors. Analysis of this data triangulated findings from the other measures and interviews. Specifically, the analyses examined correlations between self-reported symptoms, family communication styles, family affective responsiveness, general family functioning, and religious coping. Additionally, the quantitative measures were triangulated with qualitative themes. Outcomes from quantitative measures were cross-referenced with content from qualitative interviews for thematic consistency and richness. Parts 1 and 2 of this study only include quantitative analyses and Part 3 includes the qualitative interpretation.

Quantitative analysis. Quantitative measures assessed symptomatology, communication patterns, affective responsiveness, family functioning, and religious coping. There are two separate parts to the quantitative data analysis. Part 1 is inferential and examined the means of 2GH/3GH and 2GM/3GM in reported symptomatology (2G Holocaust group and 2G matched

comparison group; 3G Holocaust group and 3G matched comparison group). Part 2 of the quantitative data analysis examined the relationship between different variables within 2GH and 3GH in reported family communication, affective responsiveness, family functioning, and religious coping. Descriptive statistical analyses are derived from Pearson correlations from the means and standard deviations from quantitative measures and were calculated and compared using SPSS. Demographic variables that are significantly related to any of the study variables were controlled for in the analyses. To explore correlations, cross-tabulations between demographic items and study variables were made and are discussed below. The study's hypotheses are depicted in Figure 2.

Part 1 (comparing 2GH/3GH to 2GM/3GM). T-test analyses were conducted to compare between group symptoms. Inferential statistical analysis was obtained from a *t*-value and was used to compare means of the two groups' symptom scores (symptomatology). Two *t*-test values were calculated: one comparing the symptoms of 2GH to 2GM and the other examining symptoms of the 3GH to 3GM. Research question includes: What is the effect of Holocaust trauma in the intergenerational transmission of trauma in 2GH and 3GH as compared to 2GM and 3GM?

Hypothesis 1. The 2GH will produce higher SCL-90-R scores than 2GM. The analytic approach for hypothesis 1 included a *t*-test comparison between 2GH and 2GM to examine the differences in the SCL-90-R Global Severity Index scores. SCL-90-R subscales were also examined to evaluate differences in specific symptom presentations.

Hypothesis 2. 3GH will demonstrate significantly greater SCL-90-R scores as compared to the 3GM's symptoms. The analytic approach for hypothesis 2 also included a *t*-test comparison between 3GH and 3GM to evaluate the differences in SCL-90-R Global Severity

Index scores and subscale scores.

Part 2 (comparing 2GH to 3GH). These quantitative measures' means and standard deviations aided in examining the qualitative theme analysis. The measures provided additional information to provide insight into the results of the qualitative interviews regarding intergenerational Holocaust experience. Research questions included:

1. Are 3G Holocaust survivors less likely to be experiencing psychological symptoms than 2G Holocaust survivors?
2. What is the relationship between Holocaust trauma and 2G and 3G psychological symptoms, religious coping, and family functioning?
3. What is the relationship between parental/grandparental Holocaust trauma and psychological symptoms in 2G and 3G Holocaust survivors?
4. What is the relationship between parental/grandparental Holocaust trauma and overall family functioning, specifically family communication and affect responsiveness?

Hypothesis 3. 3G will produce lower scores on the SCL-90-R than 2G. This hypothesis was grounded in previous research that 3Gs display higher levels of psychological well-being compared to 2G. The analytic approach for hypothesis 1 included an analysis of variance (ANOVA) to examine differences in SCL-90-R Global Severity Index scores as a function of generation. SCL-90-R subscales were also examined and compared between 2G and 3G.

Hypothesis 4a. 2G participants who report fewer psychological symptoms will also report higher levels of religious coping. To test whether the relationship between psychological symptoms and religious coping, a series of linear regression analyses were performed. Psychological symptoms reported in the SCL-90-R were independently regressed to religious coping (as measured by the JCOPE).

Hypothesis 4b. It is hypothesized that participants who report more psychological symptoms will report lower levels of familial communication. This hypothesis was analyzed through regression analysis in which, psychological symptoms as measured by the SCL-90-R were independently regressed to levels of communication and affect as measured by the McMaster Family Assessment Device.

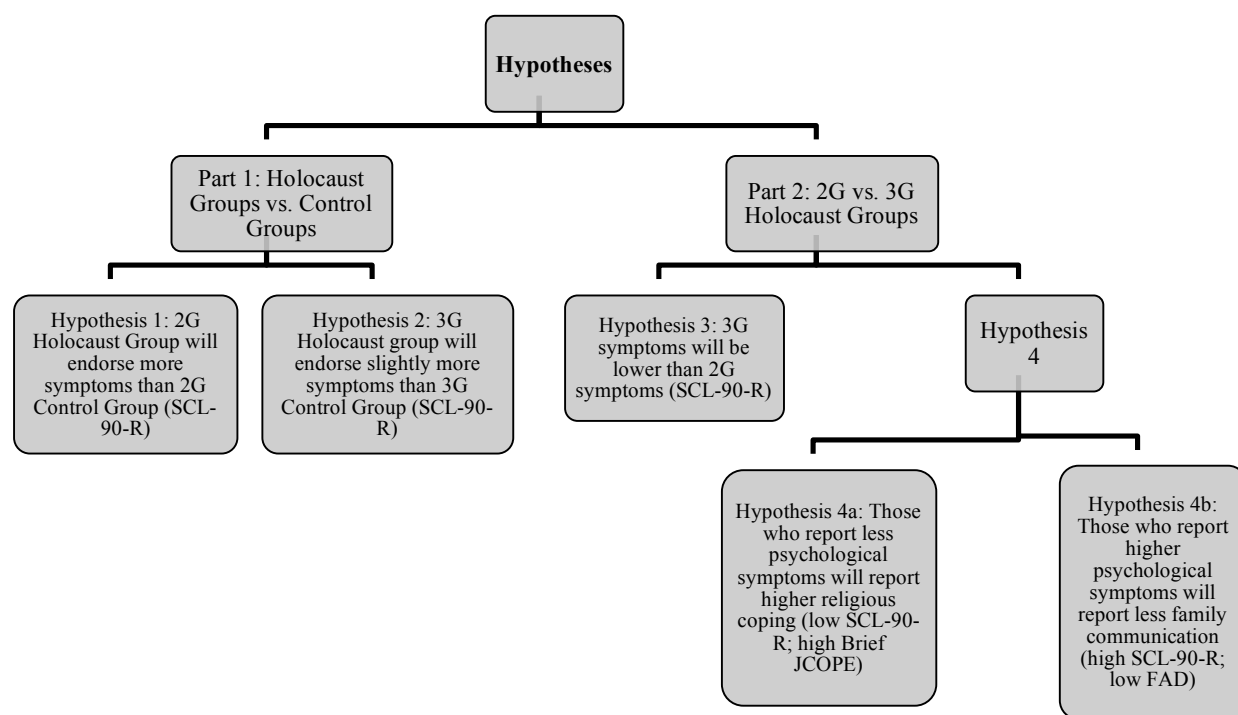


Figure 2. Study hypotheses.

Qualitative analysis

Qualitative methods provide in depth understanding of a particular construct and help provide a meaningful understanding of said construct. The qualitative findings in this study aimed to enhance the quantitative data and provide a deeper understanding of second and third

generations' experiences. Part 3 of this study included the qualitative component of this study. The Holocaust-survivor group participants who agreed to participate in the qualitative interview were included in the Part 3 analysis. Research question: What is the second and third generation's perception of the Holocaust, their parents/grandparents, and the Holocaust's effect on their lives? It was expected that the qualitative findings would support the quantitative data and provide for a more robust interpretation of results.

This study used a Grounded Theory research approach (Glaser & Strauss, 1967) to focus on the process, actions and interactions experienced by the participants and the hypotheses will emerge out of specific themes generated by the qualitative data and triangulated with quantitative data. Each interview was audio-recorded and transcribed verbatim. Grounded Theory (GT) has been utilized in other Holocaust studies (Braga et al., 2012). GT includes a systematic analysis procedure that includes several phases to deduce themes and meanings from qualitative data. The first phase is the pre-analysis stage where the coders initially review the transcriptions without making thematic assumptions. The second phase consists of thematic analysis within each individual interview and analyzing themes within the context of all interviews. The final stage consists of a categorical codification of themes, which are inductively derived from interview content. In order for a theme to be considered a category, it must be present in two or more of the interviews (Corbin & Strauss, 1990). The content analysis was conducted from the interview transcriptions by multiple coders to ensure inter-rater reliability. Additionally, there was also an auditor who reviewed the reliability of the independent coders.

Results

Quantitative

Group differences. With regard to differences in SCL overall averages and SCL subscale averages across matched group and Holocaust groups, t-test results indicated there were significant differences. Among the 2G Holocaust and 2G Matched groups, there was a significant difference in the average scores on the SCL psychoticism subscale, with the 2G matched group reporting higher scores ($M=.20$, $SD=.28$) than the 2G Holocaust participants ($M=.33$, $SD=.51$, $t=-1.48$, $p<.01$).

Table 2

T test Results of Mean Differences between 2GH and 2GM SCL Scales

<u>SCL Scale</u>	<u>2G Holocaust (n=48)</u>	<u>2G Matched (n=26)</u>
Somatization	0.31	0.39
Psychoticism	0.20*	0.33*
Obsessive Compulsive	0.63	0.51
Depression	0.58	0.57
Interpersonal Sensitivity	0.52	0.56
Anxiety	0.37	0.41
Hostile	0.33	0.34
Phobia	0.18	0.16
Paranoid	0.36	0.49
SCL Total	0.41	0.45

Note. *= $p<.05$

Between the 3G Holocaust and 3G Matched groups there were significant differences on the SCL anxiety, phobia, and paranoia subscales as well as differences in the total average SCL

scores. The 3G Holocaust group reported higher scores than the 3G Matched participants in anxiety ($M=.33$, $SD=.23$ vs. $M=.42$, $SD=.36$, $t=-1.06$, $p=.01$), phobia ($M=.17$, $SD=.25$ vs. $M=.07$, $SD=.11$, $t=-1.46$, $p=.04$), paranoia ($M=.38$, $SD=.43$ vs. $M=.21$, $SD=.21$, $t=-1.46$, $p=.02$), and total SCL average ($M=.49$, $SD=.30$ vs. $M=.31$, $SD=.16$, $t=-2.16$, $p=.04$).

Table 3

T test Results of Mean Differences between 3GH and 3GM SCL Scales

<u>SCL Scale</u>	<u>3G Holocaust</u> <u>(n=45)</u>	<u>3G Matched</u> <u>(n=13)</u>
Somatization	0.39	0.24
Psychoticism	0.24	0.15
Obsessive Compulsive	0.22	0.50
Depression	0.15	0.40
Interpersonal Sensitivity	0.67	0.36
Anxiety	0.50*	0.34*
Hostile	0.72	0.37
Phobia	0.40*	0.07*
Paranoid	0.56*	0.21*
SCL Total	0.36*	0.31*

Note. *= $p<.05$

Of note, there were no significant differences on the SCL average subscale scores or total score between the 3G Holocaust group and 2G Holocaust groups.

Univariate results. Univariate analyses revealed that among the 2G Holocaust group, the SCL somatization subscale scores were significantly associated with communication scores ($B=.606$, $t=3.10$, $p<.01$). SCL depression scores ($B=.242$, $t=2.04$, $p=.04$) and anxiety scores

($B=.337$, $t=2.17$, $p=.04$) were also significantly associated with communication, as was psychoticism scores ($B=.739$, $t=3.01$, $p<.01$). Regarding FAD Affect subscale scores, psychoticism was the sole significant association in univariable models ($B=.833$, $t=2.50$, $p=.02$). Among the 3G Holocaust participants, SCL obsessive compulsive scores were significantly associated with positive religious coping scores ($B=.383$, $t=2.72$, $p<.01$), as was anxiety scores ($B=.278$, $t=1.89$, $p=.03$) while depression scores were significantly associated with negative religious coping ($B=.750$, $t=1.41$, $p=.02$). The SCL psychoticism scores were also a significant predictor of FAD General Functioning subscale scores for the 3G Holocaust group ($B=.401$, $t=2.27$, $p=.03$).

Table 4

Regression Analyses for 3GH Predicting Symptomatology

<u>SCL</u> <u>Subscale</u>	Positive Religious Coping	Negative Religious Coping	FAD General Subscale
	<i>r</i>	<i>r</i>	<i>r</i>
Obsessive Compulsive	0.36*	0.25	0.28
Interpersonal Sensitivity	0.05	0.19	0.27
Depression	0.20	0.34*	0.01
Anxiety	0.32*	-0.11	0.16
Hostile	-0.03	-0.14	-0.24
Phobia	0.12	-0.06	0.15
Paranoid	0.09	0.10	0.15
Psychoticism	0.00	0.09	0.33*

(continued)

Somatization	0.15	-0.12	-0.06
SCL Total	0.18	0.13	0.19

Note. *= $p < .05$

Among the combined Holocaust participants (2G and 3G), SCL average psychoticism scores ($B=.435$, $t=2.45$, $p=.02$), phobia scores ($B=.342$, $t=2.33$, $p=.02$), anxiety scores ($B=.311$, $t=2.61$, $p=.01$), and total SCL scores ($B=.409$, $t=2.51$, $p=.01$) were significantly associated with FAD Communication subscale scores. Psychoticism scores ($B=.748$, $t=3.14$, $p<.01$) also significantly predicted affect scores when all holocaust group participants were assessed together. At the univariate level, psychoticism scores ($B=.558$, $t=3.15$, $p<.01$) and anxiety scores ($B=.244$, $t=2.01$, $p=.04$) were associated with FAD General Functioning subscale scores among the combined group.

Table 5

Regression Analyses for Combined 2GH and 3GH Predicting Symptomatology

SCL Subscale	Communication	Affect	FAD General Functioning
	<i>r</i>	<i>r</i>	<i>r</i>
Obsessive Compulsive	0.19	0.11	0.19
Interpersonal Sensitivity	0.17	0.19	0.17
Depression	0.19	0.16	0.19
Anxiety	0.27**	0.06	0.27**
Hostile	0.07	0.04	0.07
Phobia	0.24*	0.13	0.24*
Paranoid	0.03	0.16	0.03
Psychoticism	0.25*	0.32**	0.25*

(continued)

Somatization	0.16	0.10	0.16
SCL Total	0.27**	0.18	0.27**

Note. *= $p < .05$; **= $p < .01$

Multivariate results. Among the 2G Holocaust participants, multivariate analyses revealed that somatization subscale scores remained significantly associated with communication scores ($B=.562$, $t=2.32$, $p=.03$), when controlling for demographic and trauma measures. Among 3G Holocaust participants, average SCL obsessive compulsive scores remained a significant predictor of positive religious coping while controlling for demographic measures ($B=7.02$, $t=2.38$, $p=.02$) as did average anxiety scores ($B=7.21$, $t=2.08$, $p=.04$). Among the 3G group, psychoticism scores were significantly associated with FAD General Functioning subscale scores in the final multivariate model ($B=.408$, $t=2.53$, $p=.02$). Among the combined Holocaust groups multivariate results revealed that psychoticism significantly predicted communication scores ($B=.396$, $t=2.04$, $p=.04$), as did average phobia scores ($B=.361$, $t=2.18$, $p=.03$), anxiety ($B=.320$, $t=2.53$, $p=.01$) and total SCL scores ($B=.449$, $t=2.54$, $p=.01$). Psychoticism remained a significant predictor of affect scores in the final model ($B=.659$, $t=2.64$, $p=.01$). Last, psychoticism also remained a significant predictor of FAD General Functioning subscale scores in multivariable models ($B=.520$, $t=3.06$, $p<.01$).

Qualitative

The major qualitative themes that emerged in this study include: psychological symptoms, parent's PTSD symptoms, communication, feeling different, loss, Jewish identity, attribution for survival, and self-efficacy.

Psychological symptoms. This theme captured the descendant's report of experiencing

distress. Subthemes included unspecified distress, self-criticism or negative self-talk, withdrawal/isolation, somatization, sadness/tearfulness, irritability and anger, guilt, fear of loss/abandonment, and anxiety. Sadness/tearfulness was the most endorsed symptoms, and was coded when the descendant reported being tearful or experiencing depressed mood or helplessness. The second most endorsed subtheme included general psychological symptoms, which was coded when the descendant reported feeling distressed but was unable to identify the specific distressing affect or emotion that emerged. Anxiety was the third most endorsed and was coded when the descendent explained experiencing a painful or apprehensive uneasiness of mind.

One participant explained himself as anxious and stated, “I would say I’m anxious, or more anxious than the average person.” Another participant explained his feeling of withdrawal and his profound sense of feeling as if he was different from others:

You know when, when a bunch of friends are going out for a drink it would not occur to them to invite me or not occur to them that I might be interested. And I’m not sure that I would be interested, even though they’re friends of mine. So I feel, I feel like I walk in the same circles, but like, like walking through one of those tubes that goes through an aquarium, you know where you’re surrounded by the sharks.

Parent’s PTSD symptoms. This theme encapsulates the descendants directly witnessing their parent’s trauma symptomatology, including nightmares and intrusive memories. For example, “when I was a kid I and would ask questions, she would have screaming nightmares the following night.” Another participant explained, “I remember there were all the steel mills lined up around Indiana and they reminded my mother of the crematoriums and she would just burst

out into tears from that.”

Participants also endorsed that their parents had enhanced sensitivity, exaggerated intensity of behaviors when detecting threats, mistrust of others, and fear of abandonment/loss. One participant mentioned that her parents “were very strict... They always wanted to know where we were, they always wanted to keep tabs on us all the time.” Another participant explained, “I think...I don’t think there was anything about the Holocaust that galvanized her into anything more positive. It galvanized her into things more negative or distrustful. Lastly, another participant report.

I think because they lost so many people they loved, there maybe a part of them, that their own consciousness wouldn’t allow them to get too close. As much as they loved their own children, they tried to keep us close, but there was still this part of them, the fear of loss.

Communication. Themes related to communication that emerged included: sharing of experiences, concealing of experiences by survivor, descendant non-inquisitiveness, and social engagement with other survivors. Sharing of experiences was the most common theme that emerged and was coded when the descendant explained that Holocaust experiences were shared in any type of setting or to anyone. For example, “They were pretty open about talking about stuff and they used to get together with their survivor friends when I was growing up. And I would sit around and listen to their stories.” Concealing of experiences by survivor was coded when the descendant expressed their parent or grandparent concealing their Holocaust experiences from others in some way. One participant explained, “She would tell me stories but I think I was aware pretty early on that they were abridged.” Descendant non-inquisitiveness refers to the descendant’s inclination to actively choose to not inquire about the survivor’s experiences.

Many descendants expressed a hesitancy to ask about their parent or grandparent's experiences for fear of upsetting them or because they believed that they were "not supposed" to inquire about Holocaust experiences. One participant explained, "the children actually got the message that this wasn't okay to ask about." Lastly, social engagement with other survivors was coded when the descendant explained that a survivor developed a post-war support network.

Feeling different. Feeling different was a theme that was coded when descendants report experiencing self as "other" in some way different due to parent/grandparent's Holocaust experiences. One participant explained, "I think my mother's Holocaust experiences have directly led to my feeling that I just don't fit in this world. That I'm constantly fighting that, constantly trying to channel my friends who, who glide smoothly through these waters."

Loss. Loss of family was coded when the descendant mentioned lack of family or awareness and mention of the death of family members during the Holocaust. One participant discussed the palpable loss that her parents experienced on Jewish holidays and explained, "Every single year on Yom Kippur, on the anniversaries of their parent's deaths or when they knew they were taken and killed, it was an open raw wound and they suffered tremendously for the losses they experienced, tremendously."

Loss of opportunity was coded when a descendant referred to opportunities that the survivor did not have as a direct result of the Holocaust. One participant explained, "I think that her life was derailed by Hitler and therefore I had to be everything and more that she was denied being."

Jewish identity. Jewish identity encapsulates the descendant's identification with Judaism. Jewish identity was sub-coded into different themes. Religiosity was coded when a participant mentioned religious practices, or connectedness to religious aspects of Judaism and

was commonly mentioned by both second- and third-generation survivors. Cultural was coded when an individual related their Jewish identity as related to cultural or traditional values of Judaism and was the most common identity subtheme noted by both second- and third-generation participants. One participant explained:

I'm not religious, I mean like I grew up to like Hebrew school, had a Bat Mitzvah and being Jewish is very, has always been very important to me but definitely consider myself a more cultural Jew, more holidays, it's about going to Temple, it's about family dinner or traditions.

Rejection or *Concealing* was coded when the descendant described themselves as blatantly rejecting their Jewish identity or attempting to conceal it. One participant stated, "there is nothing that, that draws me into a sense of being Jewish." *Spiritual* was coded when a participant specifically stated that their Jewish identity manifests as a connection to a spiritual sense of the world which they explained as distinctly different than a religious identity. For example, "I am not demonstratively Jewish in my religious beliefs, I guess I'm more spiritual."

Attribution for survival. Participants explained how they believed their parent or grandparent survived the Holocaust. Instinct/Resourcefulness was the most endorsed and was coded when the descendant described survivorship as related to the survivor's ability to adapt to situation and independently devise ways and means of survival. One participant explained:

Whatever they needed, she became. And that's what saved her. And also what saved her life was she would watch when they had a selection where the weak people went to the right and the strong people went to the left, she'd sneak into the left.

Other reasons for survival included *help from others* which was coded if the descendant described a situation in which survival related to the receipt of help or aid from another. Another

reason for survival included *luck* which was coded when the descendant explained the reason for survival that was based on chance rather than through one's own actions. Lastly, only one participant reported survival as related to a *high power's doing*, more specifically that participant explained an "angel on [survivor]'s shoulder" which helped the survivor through challenges faced during the Holocaust.

Self-efficacy. Self-efficacy includes the descendant identifying as being strong, resourceful and self-efficacious. One participant explained how her parent's experience allowed her to feel better equipped to face her own challenges in life:

I don't even want to imagine. But I do feel that their experience has transferred onto me strength and the will, the will to survive. Just trials and tribulations of regular life. And I went through a divorce, I got through it fine. I raised my kids alone, I got through it fine. I started a business that I created out of nothing and then I started in a different direction and I wasn't afraid to try it. And I think all of that comes from them.

Discussion

This study explored the relationship between psychological symptoms, family functioning, and religious coping in second- and third-generation Holocaust survivors. Our analyses included both a quantitative and qualitative examination of intergenerational trauma in second and third generation Holocaust survivors.

Symptomatology

First, we hypothesized that 2GH would produce higher SCL-90-R scores than 2GM. Surprisingly, we did not find that 2GH endorsed higher levels of symptomatology as compared to their matched counterparts. In fact, 2GM endorsed more psychotic symptoms. Fridman et al. (2011) suggest that although Holocaust survivors display post-traumatic symptoms, their resilience is evident in that lack of symptomatology endorsed by second generation survivors. The findings in this study may suggest that the war and post-war immigration histories of the parents of 2GM may have been also traumatic and may have also had lasting impact. Additionally, these may be a reflection to the overall chaos of the World War II era and the impact that it had on the Eastern European population as a whole. Interestingly, the only significant difference in symptoms was on the psychoticism subscale, in which 2GM endorsed more feelings of withdrawal and isolation. Within the psychoticism subscale of the SCL-90-R, the construct of psychoticism is represented as a continuous dimension of human experience. The scale includes interpersonal alienation, withdrawal, and isolation. Notable items include: feeling lonely when you are with other people; the idea that something serious is wrong with your body; never feeling close to another person, and; the idea that something is wrong with your mind (Derogatis, 1983). This may also be indicative the 2GM's reluctance to identify as a post-Holocaust immigrant from that era. Other symptom variables showed no significant different

between 2GH and 2GM. Studies have found that psychological functioning in second generation survivors was within the normative ranges, however, second generation showed greater proneness to psychological symptoms as well as difficulty expressing emotion and in the parent-child relationship, particularly with separation-individuation (Felsen, 1998; Rowland-Klein & Dunlop, 1997; Van IJzendoorn et al., 2003), which was evident in qualitative data that will be discussed. In a meta-analysis of intergenerational Holocaust trauma, Barel et al. (2010) explained that some offspring showed secondary traumatization while others manifested latent or no posttraumatic stress symptoms. Prior studies also indicate that it is important to consider immigration status as a potential moderating factor to deeper feelings of being different, symptoms expression or distress, and Jewish cultural emphasis within the family (Barel et al., 2010; Rowland-Klein & Dunlop, 1997).

We also hypothesized that 3GH would produce higher symptoms scores than 3GM but lower symptoms scores than 2GH. Although there was no significant difference between 3GH and 2GH symptom endorsement, notably, 3GH endorsed significantly greater symptomatology as compared to 3GM. First, 3GH endorse more global symptoms than 3GM. They endorsed more symptoms of nervousness and tension, including feelings of panic. Additionally, 3GH also endorsed disordered thinking including suspiciousness and fear of loss of autonomy. Lastly, 3GH also endorsed more persistent fear responses to people and situations disproportionate to the stimulus, which may relate to avoidance or escape behavior. It is an interesting finding that 3GH's symptoms were significantly greater than 3GM but that we did not see the same results when comparing 2GH and 2GM. While Lev-Wiesel (2007) found that both second- and third-generation survivors express strong identification with their parent or grandparent's suffering, Sigal & Weinfeld (1989) found that third generation had a higher level of identification with the

survivor. Key themes reported were sadness, duty to remember, and overprotection of the survivor's emotional experience. Other studies have found that third generation survivors feel an intensely strong connection to the Holocaust and a duty to "never forget" and to teach subsequent generations about the Holocaust (Bender, 2004; Lazar, Litvak-Hirsch, & Chaitin, 2008), while also expressing difficulty coping with the emotional repercussions of the Holocaust (Chaitin, 2002). This relates to Sotero's (2006) assumptions of a shared traumatic experience in which the traumatic events remain constantly present throughout the traumatized population and that the traumatic exposure shifts the path of the population. Additionally, Landau (2006) explains how the Holocaust is "deeply etched on Jewish minds and hearts" (p. 275) to a point of almost being engrossed or absorbed by the event. This difficulty coping, or this fixation on the Holocaust, may be further evidenced by the results of this study in which 3GH reported significantly more psychological symptoms than 3GM while 2GH did not report significantly higher symptoms as compared to 2GM, which may also relate to how the Holocaust was communicated from 1G-2G and 2G-3G.

Qualitatively, there was mixed data in regards to the descendants themselves endorsing psychological symptoms. Several second-generation participants endorsed feeling anxious, isolated or withdrawn. This may be related to the internalization or holding onto externalized symptoms including aggression or hostility. While on the surface, this may be a resilient factor in the externalization of maladaptive or impairing symptomatology, it may represent the cultural value of maintaining peace, or shalom in the home. Bobker (2009) explains this idea of maintaining shalom within the home: "Shalom bayis is one of the main spiritual tasks the Torah sets for us in life. When the opposite occurs, 'the Altar in the Holy Temple sheds tears'" (p. 156).

Communication

We hypothesized that descendants, who reported more psychological symptoms, would also report lower levels of family communication. First, we found that descendants (both 2GH and 3GH combined) who reported maladaptive family communication endorsed more global symptomatology. Studies (Danieli, 1998; Felsen, 1998; Kaitz et al., 2009) suggest that both verbal and nonverbal communication of trauma between subsequent generations may have a significant impact on both family functioning and the descendant's well-being. These findings might also indicate that first generation survivors lacked adequate emotional resources that allowed for open communication with their children. However, their grandchildren may have been far enough removed to have the survivor feel comfortable conversing with them about their experiences. This may also relate to the duration of time that has passed since the atrocities of the trauma or that the context has changed sufficiently enough that the grandchildren no longer feel as threatened. However, these communication patterns may continue to reverberate through direct generations (e.g., 1G-2G and 2G-3G), while manifesting differently within the grandparent-grandchild relationship. This may be because 2GH directly witnessed their parent's post-traumatic stress responses and also relates to how the descendant views her/his own psychological functioning. An additional factor, may include the mediating influence of raised or heightened status (e.g., socioeconomic status) and the presence of a Jewish homeland which may impact the descendant's ongoing perception of threat within the sociopolitical and sociocultural contexts of the United States. This greater sense of control and perceived safety may minimize the sense of threat and thus relate to a decrease in stress for both the survivor and descendants. Research shows that socioeconomic status and increase on the socioeconomic hierarchy is correlated with psychological and physical health benefits (Cohen, Janicki-Deverts, Chen &

Matthews, 2010).

Furthermore, Wiseman et al. (2002) found that first generation survivor's ability to discuss their Holocaust experiences with their children was correlated with lower levels of psychological distress in the second generation. Additionally, Giladi and Bell (2013) found that better family communication in families of Holocaust survivors were associated with lower levels of secondary traumatic stress in subsequent generations. Interestingly, they also found that lack of communication was also associated with greater feelings of reported loneliness by second generation survivors. This is consistent with our results in which both second- and third-generation survivors who reported less adaptive family communication also reported higher levels of withdrawal and isolation. Additionally, we found that both second- and third-generation survivors who reported less family communication, reported higher levels of phobic anxiety including persistent fear responses to people, places, of situations which are characterized as being irrational or disproportionate to the stimulus. These fears are often associated with avoidance or escape behavior. This may directly relate to feelings of mistrust of the world. Additionally, we also found that descendants who reported less adaptive family communication reported higher levels of nervousness, tension, and feelings of panic.

Almost all participants reported that they at some point felt that their parent or grandparent deliberately withheld their Holocaust experiences from them. Additionally, second generation survivors endorsed more hesitancy in inquiring about their parent's Holocaust experiences in an attempt to protect or shield them from intrusive memories and in an attempt to not upset them further. Third generation survivors did not indicate a hesitance to inquire about their grandparent's experiences and in fact expressed just the opposite; that they felt a duty to inquire and to tell their grandparents story. There are many factors that may relate to the

survivor's willingness to discuss experiences and the third generation's tendency to initiate conversations and communication about Holocaust experiences. One includes the duration of time from the trauma, in which through the passage of time, the survivor becomes more open to discussing Holocaust experiences with descendants. Another includes the increase in sense of status, or socioeconomic status, which may lessen the sense of perceived environmental threat. These two factors may render the trauma more tolerable or controllable for the survivor as a result of an increase in sense of safety around discussion of the trauma. Sotero (2006) speaks of the political, economical, and structural inequalities (e.g., unjust power relations, class inequality) that constrict an individual and relate to the manifestation of historical trauma. It is possible that the lessening of said economic and structural inequalities relate to survivor's willingness to eventually discuss their Holocaust experiences with their grandchildren later in life. An added factor may include the reflective and existential themes that emerge in later life, in which the survivor feels or felt an innate need to pass on life experiences to future generations, particularly to the third-generation. However, due to this fervent effort to learn about their grandparent's experiences, third generation may be experiencing vicarious traumatization merely by their increased involvement, exposure, and inquiry to their grandparent's experience.

Danieli (1998) explained that a key aspect of the intergenerational transmission of trauma is the quality of family communication about the traumatic experiences. He explains the *conspiracy of silence* which includes a nonverbal agreement to withhold family discussion about the trauma. Themes related to this "conspiracy of silence" emerged qualitatively in the second-generation survivors reporting that they wanted to protect their parent's emotional experience by not engaging in a discussion about Holocaust trauma. Many stated that they did not ask questions about their parent's Holocaust experience for fear of upsetting them. This theme displays a

hesitance of inquiry as initiated by the second generation. Bar-On et al. (1998) explain that the “conspiracy of silence” relates to the survivors need to forget about traumatic experiences. They also propose that withholding communication about Holocaust experiences was critical to their children’s normative development. This led second-generation survivors to not ask about their parent’s experiences, and therefore the silence became mutually upheld. Danieli (1998) explained that some Holocaust survivor families coped by living in silence, withholding their Holocaust experiences and the emotions associated with their trauma. He explains this cycle of both the parents protecting one another and the children’s’ attempt to protect their parents. This conspiracy of silence is displayed when one participant stated, “well, I would say that, in respect to me I was always very concerned with not upsetting my parents. We didn’t want to upset them, we didn’t want to anger them.” Another participant explained, “I think that I, it was really always kind of like cautious around them in terms of what I would ask.”

Third-generation survivors often explained that their grandparent openly shared their experiences with them. They often reported that they would do their class projects on their grandparent’s experiences, in which the survivor would openly discuss experiences and sometimes even come to classrooms to discuss their experiences within a larger group. One third generation participant explained:

Well I don’t know, I don’t actually think they really started talking about it until my dad was much older. I think the really common with 2G’s, they couldn’t really talk to their parents the way that the grandchildren could, they felt uncomfortable asking them.

Qualitatively, third generation survivors reportedly feel incredibly connected to their grandparent’s Holocaust experiences. Participants emphasized the importance of “never forgetting” and engaging in Holocaust outreach activities to ensure that their grandparent’s

legacy lives on. These outreach activities include being involved in Holocaust museums or writing or documenting their family's Holocaust experiences. The relationship between survivor's Holocaust experiences and descendant's expressed connection to the survivor's experiences may manifest differently in second- and third generation survivors.

Descendants often referred to their parent or grandparent openly sharing experiences with other survivors as a way of coping. One participant explained, "...part of their coping mechanism was to talk about it. They certainly talked about it when they came among their friends and their circle of friends were all Holocaust survivors." Others described a surrogate family of other survivors in which their parents were close with and in which they all "shared their thoughts" about the Holocaust as a means of coping with the memories.

Affect Responsiveness and Family Functioning

We also found that descendants who reported less adaptive emotional expressivity within their family endorsed higher levels of withdrawal and isolation. Additionally, we found that descendants who reported less family cohesion and poorer overall family functioning, also reported significantly more symptoms of anxiety and withdrawal and isolation. Previous studies conclude that survivors may be pre-occupied with their trauma, having not effectively dealt with it and therefore less sensitive to their child's emotional needs (Ancharoff, Munroe, & Fisher, 1998; Bar-On, 1995). Previous studies show that survivors have their own difficulty coping with their trauma, and may have difficulty managing their own internal processes in light of attending to their child's affect and emotion regulation needs. Survivors may even minimize their child's distress when they compare them to their own past trauma. Holocaust survivors might even respond to their child with anxiety or stress, and their children may function as a loss reminder of the experiences they have lost or the family members that they have lost. Particularly, this also

relates to the second-generation's avoidance of distressing emotions, such as anger and guilt, in an attempt to modulate and regulate their parent's affect (Wiseman et al., 2006). These processes may be buffered in the survivor's relationships with their grandchildren, as they see their grandchild as farther removed and an indication of the procreation of the Jewish faith.

Religious Coping, Religiosity, and Jewish Identity

With regards to religious coping, we had some interesting and surprising findings. We found that those who engaged in positive religious coping, reported higher levels of anxiety and the experience of unwanted thoughts. There is little research conducted in the area of religious coping in second- and third-generation Holocaust survivors. However, in other populations, positive religious coping seems to mediate the effects of psychological symptoms and maladjustment following traumatic exposure (Bonanno, 2004; Palgi et al., 2011). This finding may relate to anxious individuals feeling more inclined to pray or seek religious support in order to cope with symptomatology. However, we also hypothesize that the correlation between symptoms and positive religious coping may be affected by the descendant's motivation behind engaging in religious activity.

Jewish identity was discussed in all of the interviews as a participant's connection to Judaism was asked. Our findings indicate that descendants of Holocaust survivors connect to different aspects of their Jewish identity. Many participants report "feeling Jewish," while not engaging in religious practices. Hass (1990) explained the ambivalence toward strictly religious Jewish identity as he suggested that post-war, survivors were left with skepticism about their faith, nevertheless, urged their children to continue the Jewish tradition. They simultaneously lost their "religious conviction", although continued to force Jewish identity upon their descendants. Many participants explained feelings of guilt when they do not engage in religious

activities. Participants often explained “feeling Jewish” but not having a strong desire to engage in traditional Jewish activities. They often equated this to feelings guilty that they do not feel more Jewish. Additionally, descendants often described their Jewish identity related to honoring or paying tribute to their parent's or grandparent's Holocaust experience or family members who died as a direct result of Jewish affiliation. One participant stated that he “maintain[s] [his Jewish] identity for [his] parents.” Unexpectedly, only one participant attributed parent's Holocaust survival to a higher power's doing while all other participants explained that their parent or grandparent survived due to their adaptability and resourcefulness.

Bowen (1978) explains the concept of differentiation, which refers to one's ability to balance the need for connectedness and the need for individuation. Participants reported feeling different which they relate to their parent's Holocaust experiences. Second generation descendants explained that there was always an unspoken, unknown feeling of being “different.” This equated to knowing, even if not overtly discussed, that their family members were killed. One participant described, “I think it's in our, it's in my DNA. It has to be. And there's just a lot of death running through my DNA.” There were times that participants reported feeling different as a result of not only their family's Holocaust background but also because of their Jewish background. Some stated that they attempted to conceal their Jewish identity as an attempt to “fit into” America and acculturate fully to American values. One participant explained, “They just became very Americanized... and they wanted to be like everybody else.” This desire to Americanize in conjunction with engaging in religious practices out of guilt and grappling with a G-d who “allowed” the Holocaust to happen may greatly impact descendants' Jewish identities. By engaging in religious practices, they may be filled with anxiety and unwanted cognitions about an unjust G-d or an unjust world.

Loss

Loss was a concept that was frequently discussed in the narratives including discussion of loss of family members or opportunities lost by the survivor as a result of the Holocaust. These themes are loss illustrate Sotero's (2006) assumptions of historical trauma that the trauma remains constantly present throughout the traumatized population as descendants reported having reminders related to family loss. One particular reminder included that they come from a small family. These loss reminders relate to the awareness of the lack of family or lack of extended family due to the Holocaust. One participant explained, "we just always knew that we have no family on this side they were all dead, so that was very unusual to not have any family on one whole side of your family."

Another participant reported that she would be reminded of this when her mother experienced her own loss reminders. He stated, "I remember many times my mother would cry, she would sometimes say things like, she wished she could be with her brothers and sisters who were all gone...my mother was the only survivor of her family."

These loss reminders also related to the loss of opportunities that were taken from their parents or grandparents. Many participants directly related loss of opportunity to their own academic and occupational achievement. One participant explained, "They valued education, they valued the opportunity to get an education because it was very clear that they were denied that." Danieli (1998) explained that some survivor families often coped by having an intense drive for achievement, which relates to an attempt to control their emotional experience by redirecting toward achievement or drive based activities. This type of coping may manifest as the survivor being overinvolved in the descendant's life. Chaitin (2003) explained this phenomenon related to second generation survivors dreaming of living up to the image that they have as their

parent as “hero.” One participant explained:

Education was first and foremost. They were very involved in our schooling, they were involved in our extracurricular activities to the extent of making sure that we were on the right track. I think it was very important to them that I made the most of my life and my career potential.

Resilience

Descendants qualitatively reported adaptive coping resources to deal with their parent or grandparent’s Holocaust experience. Particularly, it seems that both second- and third-generation survivors attempt to reconcile the survivors’ experiences by engaging in Holocaust outreach and through documenting the survivors’ experiences. Many participants explained that they have a “duty to remember” their parent’s or grandparent’s experiences. This presented as feeling empowered by engaging in remembrance. For descendants, engaging in outreach and remembrance activities might represent meaning making out of traumatic adversity. Participants were asked how they would qualify their parent’s or grandparent’s reason for survival. Most participants indicated that their parent’s or grandparent’s survival was due to instinct or resourcefulness.

Both second- and third-generation survivors also attributed that their parent’s or grandparent’s Holocaust experiences allowed them to feel more efficacious in dealing with their own problems and challenges. One participant described her grandparent’s “Holocaust strength” as a significant factor in her own ability to be resilient in the face of adversity, “I like to say sometimes I feel Holocaust strength, cause I can be weak in so many ways but at my core I’m really strong and resilient and...it just makes me think of my grandma.”

One of the historical trauma assumptions discussed by Sotero (2006), relates to traumatic

exposure permanently shifting or altering the path of a population. This learned or transmitted self-efficacy from survivor to descendant may have in fact shifted or altered the path of the population, particularly through a resiliency lens.

In conclusion, while there appears to be difficulties that come along with being the child or grandchild of a Holocaust survivor, there are also resiliencies that emerge. Kellerman (2009) explains the concept of paradoxical integration and how it relates to Holocaust trauma, particularly that we are constantly attempting to include vulnerability and resilience as we evaluate the intergenerational effects of the Holocaust. While we acknowledge the adverse impact and psychological consequences of Holocaust trauma, we must always balance and appreciate the extraordinary growth that accompanies the atrocities and acknowledge that the human spirit's ability to adapt and heal is remarkable.

Clinical Implications

This study has clinical implications and can be applicable to clinicians who are treating children and grandchildren of Holocaust survivors and other individuals who have experienced historical trauma. It is crucial that clinicians understand the impact of secondary traumatization and its role in symptomatology, religiosity and posttraumatic growth. However, it is important to note that it cannot be assumed that just because someone has parent or grandparent who is a Holocaust survivor, that they suffer from intergenerational trauma symptomatology. More so, it is crucial to consider the contextual and cultural factors associated with being the descendant of a Holocaust survivor. This study has implications related to the specific variables studied. It provides a deeper understanding of the effects of intergenerational trauma on symptomatology both between groups (second- and third-generation Holocaust survivors and non-Holocaust survivors) and within group (second- and third-generation Holocaust survivors). It also

underscores and explains the religious experience of a population that until this point has been under-researched. Additionally, this study provides clarification within an area that has been inconclusive, specifically, the effects of family communication of trauma and its impact on second- and third- generation survivors. This study may also highlight the impact of protective strategies that people can use to enhance family cohesion and communication to potentially decrease the impact of intergenerational trauma within families. This study also provides insight into the impact of religious coping and Jewish identity in relation to secondary trauma. Additionally, this study may be generalizable to other areas of historical trauma and its effects on future generations. Further studies need to consider individual Holocaust experience including specificity of survivorship, (e.g. concentration camp, partisan, and labor camp) in addition to other cultural implications of each survivor (e.g. country of origin and location during the war).

This study creates a more holistic picture of those who have been impacted by intergenerational Holocaust trauma by considering the cultural (e.g. religious coping), environmental (e.g. family factors), and protective factors (e.g. resiliency, coping) that affect secondary and tertiary trauma transmission. The emergence of the additional criteria for Posttraumatic Stress Disorder in the DSM-5 (American Psychiatric Association, 2013), which now includes indirect traumatic exposure, further emphasizes the importance of this research. The results are applicable to other collectively traumatized populations as it emphasizes the need for effective family communication in the face of traumatic adversity. Communication presents as a resilience factor and may buffer the impact of psychological symptoms on subsequent generations. Clinical interventions to promote family communication following a stressor should be utilized to promote psychological well-being in families. Integrating these skills into therapeutic treatment may have a lasting impact within the family unit and in the life of the

descendant. It is also notable that descendants appear to engage in Holocaust outreach as a way of making meaning out of their parent or grandparent's Holocaust experience. It may be beneficial to integrate outreach activities as a means to facilitate meaning making processes in patients who are struggling with intergenerational trauma symptomatology.

Limitations

It is important to consider the limitations within this study. First, quantitative data can often be limited, based on the participant's interpretation of the interview questions, however, qualitative interviews allowed for the opportunity to fully explain participant's meaning making. Additionally, the qualitative sample consisted only participants residing in the Los Angeles area, which may call into question the generalizability to other areas where survivors may reside. Another limitation is that since Holocaust survivors themselves were not interviewed or evaluated for this study, there is no way of knowing whether child/grandchild's account was merely a perception of survivor behavior. Another limitation includes the small sample size of this study, therefore wide generalizations cannot be derived from these findings. It is important to note that immigration and acculturation can independently be stressful overall, however for the purpose of this study we examine the uniqueness of the impact of immigration post-Holocaust. It was quite difficult to recruit individuals for the matched comparison group due to the very specific criteria that were included. Therefore, the matched comparison sample size was significantly smaller than the Holocaust group sample. However, given the limited financial resources within this study in addition to all exhausted recruitment measures for the matched comparison group, we chose to proceed to data analysis with the small sample size. This is considered a limitation and future studies should incorporate a more robust sample. Finally, with any study, there is the potential for researcher bias in the evaluation of core themes. However,

these risks were minimized by the use of two independent coders and one auditor to ensure reliability of core themes.

Conclusion

In conclusion, our findings show that Holocaust trauma reverberates through generations. A particularly interesting finding was that third-generation survivors endorsed more symptomatology than their matched counterparts while second generation survivors did not endorse more symptomatology than their matched counterparts. Third generation participants also reported feeling incredibly connected to their grandparent's Holocaust narrative and even reported feeling a need to re-experience their grandparent's experiences via Holocaust outreach and trips to concentration camps. This higher level of exposure to Holocaust related stories and memories may relate to the increase in symptomatology. Interestingly, the most significant variable that correlated with family communication, affect responsiveness, and general family functioning in both second and third survivors was withdrawal and isolation. This may further be evidence that Holocaust descendants greatly attempt to maintain *shalom bayis* by internalizing negative feelings about self or family. These findings suggest that clinicians treating descendants of Holocaust should consider the impact that their survivor parent or grandparent's experiences have on their symptoms expression and/or distress and impairment within the individual or family contexts.

Our study also demonstrates the remarkable resilience that reverberates through generations, particularly related to family closeness, communication, and affect expression. Those who reported more adaptive levels of family closeness, communication, and affect expression appear to endorse less symptomatology. In family level clinical work, these strengths should be continuously drawn from and discussed so families can utilize them when other

challenges arise in family life. Finally, this study provides an intergenerational framework that suggests that Holocaust families demonstrate remarkable resilience and adaptability, and that descendants feel more self-efficacious in dealing with their own challenges. Not only does trauma reverberate through generations, but *Holocaust strength* reverberates through generations as well and strengths and resilience factors should continue to be evaluated and maximized in treatment.

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APPENDIX A

Institutional Review Board Approval Letter

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

May 5, 2016

Protocol #: P0215D07-AM3 Project Title: Psychological symptoms, religious coping, and family communication in second- and third- generation Holocaust survivors

Dear Ms. Wasserman:

Thank you for submitting your amended exempt application, *Psychological symptoms, religious coping, and family communication in second- and third-generation Holocaust survivors*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Bryant-Davis, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - <http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html>) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(2) states:

(b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

Category (2) of 45 CFR 46.101, research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence

related to this approval. Should you have additional questions, please contact Kevin Collins, Manager of the Institutional Review Board (IRB) at gpsirb@pepperdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

A handwritten signature in cursive script, appearing to read "Judy Ho".

Dr. Judy Ho, Ph.D.
Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leach, Compliance Attorney
Dr. Thema Bryant-Davis, Faculty Advisor

APPENDIX B

Phone Screening Script

My name is _____ and I'm calling from Pepperdine University's Intergenerational Trauma Study. How are you today?

Thank you for your interest in our study.

I need to ask you a few questions in order to determine whether you may be eligible for the research. Before I begin, I would like to tell you a little about the research.

This research study is looking at the effects of intergenerational trauma in Holocaust survivor's children and grandchildren. If you are eligible, your participation in this research will consist of a 1-hour session, which will consist of several questionnaires to fill out. At the conclusion of that session you will be given up to \$20.00 for your time and participation in the study.

The screening will take about 10 minutes. You may feel uncomfortable answering questions about your personal life. You do not have to answer any questions you do not wish to answer and you may stop at any time. Your participation in this screening is voluntary. A decision whether or not to participate in the screening will not affect your relationship with Pepperdine University. Would you like to continue with the screening to find out if you can take part in the study?

If yes, continue with the screening. If no, thank them for their time and hang up.

Your answers will be confidential. No one will know the answers except for the research team. If you do not qualify for the study, your information will be destroyed. If you do qualify, your answers will be de-identified and your name will not be used on any published documents. Anything with your name on it will be kept in a locked cabinet and/or a secured server to ensure your privacy.

Would you like to continue with the screening to find out if you qualify for the study?

If yes, continue with the screening. If no, thank them for their time and hang up.

Screening Questions:

Section A

Are you 18 years old or older? *If yes, continue with the screening. If no, thank them for their time and hang up.*

Section B

Are you the child or grandchild of a Holocaust survivor? *If yes continue to questions to Section D. If no continue to Section C below:*

How many of your parents/grandparents were survivors (one? Both?) : _____

Section C

Did your parent or grandparent immigrate from Europe between 1945-1952? *If yes, continue with screening. If no, thank them for their time and hang up.*

What year did he/she/they immigrate? _____

What country did your parent or grandparent immigrate from? *If one of the following countries, continue: Germany, Poland, Czech Republic and Slovakia (formerly known as Czechoslovakia), Austria, or Hungary. If not, thank them for their time and hang up.*

What country did they immigrate from: _____

Was your parent/grandparent interned or imprisoned during the war? *If yes, continue, If no, thank them for their time and hang up. (NOTE: this includes ANY type of internment.)*

Was your parent or grandparent interned in a concentration camp, work camp, or death camp? *If yes, continue. If no, thank them for their time and hang up. (Children or grandchildren of survivors who fought as a partisan or were in hiding during the war will not be included in this study).*

Section D

Was your parent or grandparent placed in a formal leadership position within the camp? (An example of a formal leadership position would be a Kapo.) *If no, continue. If yes, thank them for their time and hang up.*

Do you identify either religiously or culturally as Jewish? *If yes continue. If no, thank them for their time and hang up.*

Section E (For Los Angeles participants only)

Where do you currently live? _____

Do you live in the Los Angeles area? *If yes proceed below. If no, proceed to Section F.*

Would you be willing to partake in an interview for this study, which includes about an additional hour and a half in which you would be asked a few questions about yourself? You would be compensated with an additional \$10.00 for your time. *Note whether or not they agree to participate in interview.*

Section F

Are you currently having thoughts of harming yourself or others? *If no, continue with the screening. If yes, thank them for their time, give them a list of referrals over the phone.*

Referrals include Pepperdine Community Counseling Center in Encino, West LA, and Irvine. Pepperdine West LA (310) 568-5752; Pepperdine Encino (818) 501-1678 Pepperdine Irvine (949)223-2570. If person does not live in the Los Angeles area, proceed with Distress Protocol,

and National Referral List.

Have you recently been hospitalized for mental health concerns? *If no, continue with the screening. If yes, thank them for their time and hang up.*

Thank you for answering the screening questions. *Indicate whether the person is eligible, or ineligible and explain why.* Also discuss compensation (Control group- \$10.00; Holocaust group [only quantitative]= \$10.00; Holocaust group agree to qualitative interview= \$20.00)

Do you have any questions about the screening or the study?

If eligible, explain to them the next step:

Online Participants: give them 5 digit random number.

<https://www.random.org/integers/>

Input 5 under Generate _____ random integers.

Enter values between 1 and 9.

Format in 5 columns.

The number generated will be their survey number.

Random Integer Generator

This form allows you to generate random integers. The randomness comes from atmospheric noise, which for many purposes is better than the pseudo-random number algorithms typically used in computer programs.

Part 1: The Integers

Generate random integers (maximum 10,000).

Each integer should have a value between and (both inclusive; limits $\pm 1,000,000,000$).

Format in column(s).

Part 2: Go!

Be patient! It may take a little while to generate your numbers...

Give them the 5 digit random number over the phone.

The Survey Link will be e-mailed to them within 24 hours. They will use their 5 digit random number as a signature for consent and for the research team to be able to identify their responses. We use the 5 digit random number to ensure privacy-so they will not put their names on the surveys.

Participants willing to come in for qualitative interview:

Set up time to come in for interview. Offer them Encino or WLA Clinic.

Last Step

I am going to give you a couple of telephone numbers to call if you have questions later. If you have questions about how the investigators decide whether you can take part in the study, you may call me, Melissa Wasserman, and I will answer any other questions that you may have.

If you would like to talk to someone other than the principal investigator about the study, please call Dr. Thema Bryant-Davis, the IRB Chairperson.

Thank you so much for your time.

APPENDIX C

Advertisement/Newsblast

IS YOUR PARENT OR GRANDPARENT A HOLOCAUST SURVIVOR?

We are recruiting families to participate in a research study to examine the effects of intergenerational trauma in children and grandchildren of Holocaust survivors. This study will create a better understanding of the long term effects and resiliencies of Holocaust trauma. Participation is voluntary and confidential.

You may be eligible if:

- You 18 years of age or older
- You are the child or grandchild of a Holocaust concentration camp survivor
- If your parent or grandparent emigrated from Germany, Poland, Czech Republic and Slovakia (formerly known as Czechoslovakia), Austria, or Hungary after World War II

Participation involves:

- A brief telephone screening
- A 1-hour visit where you will fill out a questionnaire
- An optional interview where you will be asked questions about yourself

Participants receive:

- Up to \$20.00 at the conclusion of the visit

To find out if you are eligible or to make a referral, please contact:
Melissa Wasserman, M.A.

IS YOUR PARENT OR GRANDPARENT A EUROPEAN IMMIGRANT?

We are recruiting families to participate in a research study to examine the effects of intergenerational trauma in children and grandchildren of Holocaust survivors as compared to European immigrants who emigrated post World War II. This study will create a more robust understanding of the long term effects and resiliencies of Holocaust trauma. Participation is voluntary and confidential.

You may be eligible if:

- You are 18 years of age or older
- If your parent or grandparent emigrated from Germany, Poland, Czech Republic and Slovakia (formerly known as Czechoslovakia), Austria, or Hungary after World War II
- You are not Jewish

Participation involves:

- A brief telephone screening
- A 1-hour visit where you will fill out a questionnaire

Participants receive:

- \$10.00 at the conclusion of the visit

To find out if you are eligible or to make a referral, please contact:
Melissa Wasserman, M.A.

APPENDIX D
Recruitment Flyers

IS YOUR PARENT OR GRANDPARENT A HOLOCAUST SURVIVOR?

Receive up to \$20.00 for participation

We are seeking participants for a research study that examines the effects of intergenerational trauma in children and grandchildren of Holocaust survivors. This study will create a more robust understanding of the long term effects and resiliencies of Holocaust trauma. Participation is voluntary and confidential.

You may be eligible if:

- You 18 years of age or older
- You are the child or grandchild of a Holocaust concentration camp survivor
- If your parent or grandparent emigrated from Germany, Poland, Czech Republic and Slovakia (formerly known as Czechoslovakia), Austria, Hungary, or Romania after World War II

Participation involves:

- A brief telephone screening
- A 1-hour visit where you will fill out a questionnaire OR **optional online survey**
- An optional interview where you will be asked questions about yourself

IS YOUR PARENT OR GRANDPARENT A EUROPEAN IMMIGRANT?

Receive a \$10.00 gift card for completing online survey!

We are seeking participants for a research study that examines the effects of intergenerational trauma in children and grandchildren of Holocaust survivors as compared to European immigrants who emigrated post World War II. This study will create a more robust understanding of the long term effects and resiliencies of Holocaust trauma. Participation is voluntary and confidential.

You may be eligible if:

- You are 18 years of age or older
- If your parent or grandparent emigrated from Germany, Poland, Czech Republic and Slovakia (formerly known as Czechoslovakia), Austria, or Hungary after World War II
- You are not Jewish

Participation involves:

- A brief telephone screening
- Completion of an online survey OR if residing in the Los Angeles area you may attend an in person 1-hour visit in which you will complete the questionnaire

APPENDIX E

Demographic Questionnaire

1. Gender: Female Male Other: _____

2. Age: _____

3. Ethnic/Racial Identification (“X” ONLY one with which you MOST CLOSELY identify):
 - American Indian or Alaska Native More than one race
 - Asian Hispanic
 - Black or African American Middle Eastern
 - Native Hawaiian or Other Pacific Islander Other: _____
 - White

4. Marital Status
 - Single, never married Married
 - Domestic Partnership Divorced
 - Widowed Separated

5. Education (Highest grade Completed)
 - Less than high school Associates Degree
 - High School Diploma or equivalent (GED) Bachelor’s Degree
 - Some college but no degree Graduate Degree

6. Employment Status
 - Employed, *please indicate occupation:* _____
 - Unemployed
 - Homemaker

Retired

7. Religion

Please indicate religious affiliation: _____

If indicated Judaism, please indicate level of religious affiliation that best fits you:

Reform

Conservative

Orthodox

Other: please specify: _____

8. Please report an estimate of your family's combined annual income:

Under \$20,000

Between \$20,000-\$40,000

Between \$40,000-\$70,000

Between \$70,000-\$100,000

Between \$100,000- \$150,000

More than \$150,000

APPENDIX F

Trauma History Screen

The events below may or may not have happened to you. Circle "YES" if that kind of thing has happened to you or circle "NO" if that kind of thing has not happened to you. If you circle "YES" for any events: put a number in the blank next to it to show how many times something like that happened.

PART 1

			Number of times something like this happened
A. A really bad car, boat, train, or airplane accident.....	NO	YES	_____
B. A really bad accident at work or home	NO	YES	_____
C. A hurricane, flood, earthquake, tornado, or fire	NO	YES	_____
D. Hit or kicked hard enough to injure - as a child	NO	YES	_____
E. Hit or kicked hard enough to injure - as an adult	NO	YES	_____
F. Forced or made to have sexual contact - as a child	NO	YES	_____
G. Forced or made to have sexual contact - as an adult	NO	YES	_____
H. Attack with a gun, knife, or weapon.....	NO	YES	_____
I. During military service - seeing something horrible or being badly scared	NO	YES	_____
J. Sudden death of close family or friend	NO	YES	_____
K. Seeing someone die suddenly or get badly hurt or killed	NO	YES	_____
L. Some other sudden event that made you feel very scared, helpless or horrified.....	NO	YES	_____
M. Sudden move or loss of home and possessions.....	NO	YES	_____
N. Suddenly abandoned by spouse, partner, parent, or family.....	NO	YES	_____
Did any of these things really bother you emotionally?	NO	YES	

If you answered "YES", fill out questions below in Part2 to tell about EVERY event that really bothered you.

Part 2

Letter from above for the type of event: _____ Your age when this happened:

Describe what happened:

When this happened, did anyone get hurt or killed? NO YES

When this happened, were you afraid that you or someone else might get hurt or killed? NO

YES When this happened, did you feel very afraid, helpless or horrified? NO YES

After this happened, how long were you bothered by it? not at all / 1 week / 2-3 weeks / a month or more

How much did it bother you emotionally? not at all / a little / somewhat / much / very much

APPENDIX G

Symptom Checklist-90-Revised

Symptom Checklist-90-Revised

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, select one of the numbered descriptors that best describes HOW MUCH THAT PROBLEM HAS BOTHERED OR DISTRESSED YOU DURING THE PAST WEEK, INCLUDING TODAY. Circle the number in the space to the right of the problem and do not skip any items. Use the following key to guide how you respond:

Circle 0 if your answer is NOT AT ALL

Circle 1 if A LITTLE BIT

Circle 2 if MODERATELY

Circle 3 if QUITE A BIT

Circle 4 if EXTREMELY

Please read the following example before beginning:

Example: In the previous week, how much were you bothered by:

Backaches	0	1	2
3	4		

In this case, the respondent experienced backaches a little bit (1).

Please proceed with the questionnaire.

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1.	Headaches	0	1	2	3	4
2.	Nervousness or shakiness inside	0	1	2	3	4
3.	Unwanted thoughts, words, or ideas that won't leave your mind	0	1	2	3	4
4.	Faintness or dizziness	0	1	2	3	4
5.	Loss of sexual interest or pleasure	0	1	2	3	4
6.	Feeling critical of others	0	1	2	3	4
7.	The idea that someone else can control your thoughts	0	1	2	3	4
8.	Feeling others are to blame for most of your troubles	0	1	2	3	4
9.	Trouble remembering things	0	1	2	3	4
10.	Worried about sloppiness or carelessness	0	1	2	3	4
11.	Feeling easily annoyed or irritated	0	1	2	3	4
12.	Pains in heart or chest	0	1	2	3	4
13.	Feeling afraid in open spaces or on the streets	0	1	2	3	4
14.	Feeling low in energy or slowed down	0	1	2	3	4
15.	Thoughts of ending your life	0	1	2	3	4
16.	Hearing voices that other people do not hear	0	1	2	3	4
17.	Trembling	0	1	2	3	4
18.	Feeling that most people cannot be trusted	0	1	2	3	4
19.	Poor appetite	0	1	2	3	4

HOW MUCH WERE YOU BOTHERED BY:

		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
20.	Crying easily	0	1	2	3	4
21.	Feeling shy or uneasy with the opposite sex	0	1	2	3	4
22.	Feeling of being trapped or caught	0	1	2	3	4
23.	Suddenly scared for no reason	0	1	2	3	4
24.	Temper outbursts that you could not control	0	1	2	3	4
25.	Feeling afraid to go out of your house alone	0	1	2	3	4
26.	Blaming yourself for things	0	1	2	3	4
27.	Pains in lower back	0	1	2	3	4
28.	Feeling blocked in getting things done	0	1	2	3	4
29.	Feeling lonely	0	1	2	3	4
30.	Feeling blue	0	1	2	3	4
31.	Worrying too much about things	0	1	2	3	4
32.	Feeling no interest in things	0	1	2	3	4
33.	Feeling fearful	0	1	2	3	4
34.	Your feelings being easily hurt	0	1	2	3	4
35.	Other people being aware of your private thoughts	0	1	2	3	4
36.	Feeling others do not understand you or are unsympathetic	0	1	2	3	4
37.	Feeling that people are unfriendly or dislike you	0	1	2	3	4
38.	Having to do things very slowly to insure correctness	0	1	2	3	4
39.	Heart pounding or racing	0	1	2	3	4
40.	Nausea or upset stomach	0	1	2	3	4
41.	Feeling inferior to others	0	1	2	3	4
42.	Soreness of your muscles	0	1	2	3	4
43.	Feeling that you are watched or talked about by others	0	1	2	3	4
44.	Trouble falling asleep	0	1	2	3	4
45.	Having to check and double-check what you do	0	1	2	3	4
46.	Difficulty making decisions	0	1	2	3	4
47.	Feeling afraid to travel on buses, subways, trains	0	1	2	3	4
48.	Trouble getting your breath	0	1	2	3	4
49.	Hot or cold spells	0	1	2	3	4
50.	Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
51.	Your mind going blank	0	1	2	3	4
52.	Numbness or tingling in parts of your body	0	1	2	3	4
53.	A lump in your throat	0	1	2	3	4
54.	Feeling hopeless about the future	0	1	2	3	4
55.	Trouble concentrating	0	1	2	3	4

HOW MUCH WERE YOU BOTHERED BY:

		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
56.	Feeling weak in parts of your body	0	1	2	3	4
57.	Feeling tense or keyed up	0	1	2	3	4
58.	Heavy feelings in your arms or legs	0	1	2	3	4
59.	Thoughts of death or dying	0	1	2	3	4
60.	Overeating	0	1	2	3	4
61.	Feeling uneasy when people are watching or talking about you	0	1	2	3	4
62.	Having thoughts that are not your own	0	1	2	3	4
63.	Having urges to beat, injure, or harm someone	0	1	2	3	4
64.	Awakening in the early morning	0	1	2	3	4
65.	Having to repeat the same actions such as touching, counting, washing	0	1	2	3	4
66.	Sleep that is restless or disturbed	0	1	2	3	4
67.	Having urges to break or smash things	0	1	2	3	4
68.	Having ideas or beliefs that others do not share	0	1	2	3	4
69.	Feeling very self-conscious with others	0	1	2	3	4
70.	Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
71.	Feeling everything is an effort	0	1	2	3	4
72.	Spells of terror or panic	0	1	2	3	4
73.	Feeling uncomfortable about eating or drinking in public	0	1	2	3	4
74.	Getting into frequent arguments	0	1	2	3	4
75.	Feeling nervous when you are left alone	0	1	2	3	4
76.	Others not giving you proper credit for your achievements	0	1	2	3	4
77.	Feeling lonely even when you are with people	0	1	2	3	4
78.	Feeling so restless you couldn't sit still	0	1	2	3	4
79.	Feelings of worthlessness	0	1	2	3	4
80.	Feeling that familiar things are strange or unreal	0	1	2	3	4
81.	Shouting or throwing things	0	1	2	3	4
82.	Feeling afraid you will faint in public	0	1	2	3	4
83.	Feeling that people will take advantage of you if you let them	0	1	2	3	4
84.	Having thoughts about sex that bother you a lot	0	1	2	3	4
85.	The idea that you should be punished for your sins	0	1	2	3	4
86.	Feeling pushed to get things done	0	1	2	3	4
87.	The idea that something serious is wrong with your body	0	1	2	3	4
88.	Never feeling close to another person	0	1	2	3	4
89.	Feelings of guilt	0	1	2	3	4
90.	The idea that something is wrong with your mind	0	1	2	3	4

Reference: Derogatis, L.R., Lipman, R.S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale—Preliminary Report. *Psychopharmacol. Bull.* 9, 13–28

APPENDIX H

McMaster Family Assessment Device

McMaster Family Assessment Device

Response categories:

Strongly agree

Agree

Disagree

Strongly disagree

Communication

1. When someone is upset the others know why.
2. You can't tell how a person is feeling from what they are saying.
3. People come right out and say things instead of hinting at them.
4. We are frank with each other.
5. We don't talk to each other when we are angry.
6. When we don't like what someone has done, we tell them.

Affective Responsiveness

1. We are reluctant to show our affection for each other.
2. Some of us just don't respond emotionally.
3. We don't show our love for each other.
4. Tenderness takes second place to other things in our family.
5. We express tenderness.
6. We cry openly.

General Functioning

1. Planning family activities is difficult because we misunderstand each other.
2. In time of crisis we can turn to each other for support.
3. We cannot talk to each other about sadness we feel.
4. Individuals are accepted for what they are.
5. We avoid discussing our fears and concerns.
6. We can express feelings to each other.
7. There are lots of bad feelings in the family.
8. We feel accepted for what we are.
9. Making decisions is a problem for our family.
10. We are able to make decisions about how to solve problems.
11. We don't get along well together.
12. We confide in each other.

APPENDIX I

Jewish Religious Coping Scale

Jewish Religious Coping Scale

Jewish RCOPE (16-items)

Dealing with Stress: This questionnaire asks about different ways in which you might rely on religion to deal with stress. Choose the answer that best describes how often you do the following things when you have a stressful problem.

1 – Never 2 – Hardly 3 – Sometimes 4 – Most of the Time 5 – Always

WHEN I HAVE STRESSFUL PROBLEMS:

1) I ask G-d to forgive me for things I did wrong.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

2) I get mad at G-d.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

3) I try to be an inspiration to others.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

4)) I try to see how G-d may be trying to teach me something.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

5) I think about what Judaism has to say about how to handle the problem.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

6) I do the best I can and know the rest is G-d's will.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

7) I look forward to Shabbat.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

8) I talk to my rabbi.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

9) I look for a stronger connection with G-d.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

10) I question whether G-d can really do anything.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

11) I pray for the well-being of others.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

12) I pray for G-d's love and care.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

13) I wonder if G-d cares about me

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

14) I try to do Mitzvot (good deeds).

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

15) I try to remember that my life is part of a larger spiritual force.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

16) I question my religious beliefs, faith and practices.

Never	Hardly	Sometimes	Most of the Time	Always
-------	--------	-----------	------------------	--------

Positive Subscale Items: 1, 3, 4, 5, 6, 7, 8, 9, 11, 12, 14, 15

Negative Subscale Items: 2, 10, 13, 16

APPENDIX J

Interview Protocol

Interview Protocol

Several questions adapted from Hass (1990)

Are one or both of your parents/grandparents Holocaust survivors? (If one, which one?)

Under what circumstance were they during the war? (e.g. concentration camp, death camp, labor camp, partisan, in hiding, etc.)

How much do you know about your parents'/grandparents' experiences during the Holocaust?

How did you find out?

How old were you when you learned of them?

How do you believe your parents'/grandparents' experiences during the Holocaust affected the way they raised you as a child?

How did it affect your relationship with them?

In what ways (if any) do you perceive your survivor parent(s)/grandparent(s) to be affected by their experience?

How did your parent/grandparent cope with their Holocaust experience?

How have your parents'/grandparents' experiences affected your feelings about being Jewish?

Can you tell me a little bit about the role that religion and/or spirituality play in your life, if any?

How does your parent/grandparent identify their survivorship?

How do/did they explain that they survived?

How do/did they discuss survivorship?

Has the Holocaust affected your outlook on life?

Have you ever had any psychological problems, which you would partially attribute to your family's Holocaust background?

Have you any particular strengths which you would partially attribute to your family's Holocaust background?

Is there anything else about you and the Holocaust, which you believe is important that I have failed to touch upon?

APPENDIX K

Informed Consent

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Participant: _____

Principal Investigator: Melissa Wasserman, M.A.

Title of Project: Intergenerational Holocaust Study

1. I, _____, agree to participate in the research study being conducted by Melissa Wasserman, M.A. under the direction of Thema Bryant-Davis, Ph.D. I understand that while the study will be under the supervision of Dr. Thema Bryant-Davis, other personnel who work with them may be designated to assist or act on their behalf.
2. The purpose of this study is to investigate the impact of intergenerational trauma in Holocaust survivor families. The overarching goal of the study is to gain a better understanding of the several factors involved in secondary traumatization and examine the relationships between said factors. I understand that I have been asked to participate in a research study that is designed to study intergenerational trauma in Holocaust survivors. I understand that the study intends to identify the effects and factors related to intergenerational trauma.
3. My participation will involve providing 1) basic demographic information such as age, ethnic/racial identification, marital status, education, religious affiliation, employment, and combined family income; and 2) questionnaires where I will answer personal questions about myself. I also understand that I may choose not to answer any of the questions asked.
4. My participation in the study will last for approximately one hour and a half and shall be conducted in a private room located either in the Pepperdine West Los Angeles or Encino campuses.
5. I understand that the possible benefits to myself and/or society from this research are to gain a greater understanding of the long term effects of Holocaust exposure. Some participants may feel good about being given a chance to contribute to a better understanding of intergenerational trauma in Holocaust families. Your valuable contribution will potentially help others by developing a greater understanding of the challenges that descendants of Holocaust survivors face.
6. I understand that there are no major anticipated risks or discomforts in this study. However, some participants might become upset by some of the questions that we ask. If there is a question that makes you feel uncomfortable, you do not have to answer any question that you do not want to. Additionally, during the study I understand that I may

take a break and/or discontinue participation at any time. I also understand that I am not obligated to complete any of the questions and have the option of skipping questions that are asked of me. If I become bored or fatigued from completing the questionnaire, I understand that I may discontinue participation at any time or take a break from the questionnaire. Distressed feelings may include any negative reactions that I have in response to the questions asked of me.

7. I understand that my estimated expected recovery time after the experiment will be minimal because the study has minimal risk. The potential minimal risk of this study includes being exposed to emotional charged material and you may be emotionally triggered when you respond to the questionnaires. To help prepare for this potential risk, you will be provided with a referral list to mental health providers in the area if further counseling is necessary or desired.
8. I understand that I may choose not to participate in this research.
9. I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the project or activity at any time without penalty or loss of benefits to which I am otherwise entitled.
10. I understand that the investigator(s) will take all reasonable measures to protect the confidentiality of my records and my identity will not be revealed in any publication that may result from this project. The confidentiality of my records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others. I understand there is a possibility that my record, including identifying information, may be inspected and/or photocopied by officials of the Food and Drug Administration or other federal or state government agencies during the ordinary course of carrying out their functions. If I participate in a sponsored research project, a representative of the sponsor may inspect my research records.
11. I will be informed of any significant new findings developed during the course of my participation in this research, which may have a bearing on my willingness to continue in the study.
12. I understand that in the event of physical injury resulting from the research procedures in which I am to participate, no form of compensation is available. Medical treatment may be provided at my own expense or at the expense of my health care insurer which may or may not provide coverage. If I have questions, I should contact my insurer.
13. I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form which I have read and understand. I hereby consent to participate in the research described above.

14. I understand that Melissa Wasserman, M.A. is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact her by e-mail if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I can contact Dr. Thema Bryant-Davis, Chairperson of the Graduate School of Psychology IRB of Pepperdine University.

Participant's Signature

Date

I have explained and defined in detail the research procedure in which the subject has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person's consent.

Melissa Wasserman, M.A.
Principal Investigator

Date

APPENDIX L

Referrals and Coping with Distressing Thoughts

Referrals to mental health providers

Crisis Hotlines

National Suicide Prevention Lifeline

Call: (800) 273-8255

www.suicidepreventionlifeline.org

Didi Hirsch Suicide Prevention Center

Call: (877) 727- 4747

<http://www.didihirsch.org/spc>

Find a therapist in your area: Good Therapy.Org Call: 888-563-2112

<http://www.goodtherapy.org/>

Therapist Locator

<http://www.therapistlocator.net/>

Psychology Today Find a Therapist

<https://therapists.psychologytoday.com>

Los Angeles Referrals

Pepperdine Community Counseling Center

West Los Angeles

6100 Center Drive

Los Angeles, CA 90045

(310) 568-5752

Encino

16830 Ventura Blvd, Suite 216

Encino, CA 91436

(818) 501-1678

Irvine

18111 Von Karman Avenue, Suite 401

Irvine, CA 92612

(949) 223-2570

Hollywood Sunset Free Clinic

3324 Sunset Blvd,

Los Angeles, CA 90026

(323) 660-2400

Edelman Westside Mental Health

11080 W Olympic Blvd,

Los Angeles, CA 90064

(310) 966-6500

Center for Individual and Family Counseling
5445 Laurel Canyon Blvd,
North Hollywood, CA 91607
(818) 761-2227
<http://www.cifc1.org>

Neighborhood Counseling Center
5535 Balboa Blvd, Suite 221
Encino, CA 91316
(818) 788-2738
<http://www.nccencino.org/>

APPENDIX M

Recommendations for Coping with Distressing Emotions

Recommendations for Coping with Distressing Emotions

Recommended Mobile Applications

Free Available on Apple and Android devices

Headspace

By Headspace meditation limited

Free Available on Apple and Android devices

Silva Relaxation

Universal Breathing- Pranayama Free Pranayama

By, Saagara Free Available on Apple and Android devices

Breathe2Relax

By The National Center for Telehealth and Technology

Breathe2Relax is a portable stress management tool which provides detailed information on the effects of stress on the body and instructions and practice exercises to help users learn the stress management skill called diaphragmatic breathing. Breathing exercises have been documented to decrease the body's 'fight-or-flight' (stress) response, and help with mood stabilization, anger control, and anxiety management. Breathe2Relax can be used as a stand-alone stress reduction tool, or can be used in tandem with clinical care directed by a healthcare worker.

Headspace is meditation made simple, a way of treating your head right. Using proven meditation and mindfulness techniques we'll show you how to train your mind for a

healthier, happier, more enjoyable life.

By Mindvalley Creations Inc. Available on Apple devices only

Free

Description: This app teaches the Silva Method of Relaxation, which involves "centering" yourself through meditation. Choose the 30-minute deep relaxation track or the 20-minute quick relaxation.

Description: Stressed? Balance your life and experience a relaxed meditative state to relieve your daily stresses and tensions. Health through Breath is a simple and intuitive guide to deep breathing that features a progressive course based on the principles of yoga to help you find balance and stress relief.

List of potential self-care/coping activities

- Write in a journal
- Garden
- Read
- Talk to someone you trust
- Write a note to someone you care about
- Use humor
- Spend time with friends and/or family

- Serve someone in need
- Make a gratitude list
- Find an inspirational quote
- Exercise or play sports (e.g. yoga, walking, jogging)
- Deep/slow breathing
- Pray or meditate
- Reach out to a spiritual leader
- Watch a funny movie
- Go to a bookstore and read
- Go to your favorite café for coffee or tea
- Do a puzzle

APPENDIX N

Distress Protocol

Distress Protocol

Some signs of distress:

Tearful and/or crying

Glancing at the door

Fidgeting

Shaky voice

Defensiveness in responding

Participant states that they are uncomfortable or distressed

If the participant displays signs of distress, the following steps should be taken:

1. Check in
 - a. Acknowledge distress
 - i. "I see that this is causing difficulty for you and that feelings are coming up around this topic." Continue to Step 2.
2. Ask about continuation
 - a. "Would you like to skip the question?"
 - i. *Yes*: Continue to 2b.
 - ii. *No*: Continue to 2b, then continue the interview/measures. Remind the participant that they can skip any question, take a break, and/or discontinue their participation at any time. Then resume interview/measures. Continue to monitor participant's distress. When participant displays distress at any point of the interview, at the conclusion of the interview proceed to Steps 5-6.
 - b. "Would you like to take a break?"
 - i. *Yes*: Take a break. Check back in with participant after 15 minutes. Remind the participant that they can skip any question, take a break, and/or discontinue their participation at any time. Then resume interview/measures. Continue to monitor participant's distress. When participant displays distress at any point of the interview, at the conclusion of the interview proceed to Steps 5-6.
 - ii. *No*: Continue to Step 2c.
 - c. Are they comfortable continuing?
 - i. *Yes*: Remind the participant that they can skip any questions take a break, and/or discontinue their participation at any time. Continue with the interview and continue to monitor participant's distress. At the conclusion of the interview, check in with participant's distress and complete Steps 3-4 when necessary. When participant displays distress at any point of the interview, at the conclusion of the interview proceed to Steps 5-6.
 - ii. *No*: Discontinue interview and proceed to Steps 3-6.
3. Breathing exercise
 - a. Engage Client in the following breathing exercise script:

Close your eyes or focus on one spot in the room. Relax your muscles. Observe your breathing. Notice how your breath flows in and out. Make no effort to

change your breathing in any way, simply notice how your body breathes. When your attention wanders, as it will, just focus back again on your breathing. Notice any stray thoughts, but don't dwell on them. Simply let the thoughts pass. Feel the air entering through your nose...picture the breath flowing through your nose and then down to your lungs... As thoughts intrude, allow them to pass, and return your attention to your breathing. Feel your chest and stomach gently rise and fall with each breath. As you inhale, count...one...two...three...four. And as you exhale count...one...two...three...four...five. Continue to count as you inhale and exhale. As you inhale, count...one...two...three...four. And as you exhale count...one...two...three...four...five. Notice now how your body feels.

Keeping your eyes closed, notice the sounds around you. Feel the floor beneath you. Wiggle your fingers and toes. Open your eyes, and remain sitting for a few moments longer.

Straighten out your legs, and stretch your arms and legs gently. Shrug your shoulders.

- b. After breathing exercise check in with the participant. Remind the participant that they can skip any questions take a break, and/or discontinue their participation at any time.
 - c. If participant still displays or endorses distress, proceed to Step 4.
 - d. If participant appears to respond positively to breathing exercise, check in with his/her distress levels.
 - i. If participant is still visibly distressed, conclude the interview and proceed to Steps 4-6.
 - ii. If participants is not longer visibly distressed, ask participants if they would like to continue the interview.
 1. *Yes*: Continue with the interview and continue to monitor participant's distress. At the conclusion of the interview, check in with participant's distress and engage in Steps 3-4 when necessary. When participant displays distress at any point of the interview, at the conclusion of the interview proceed to Steps 5-6. Remind the participant that they can skip any question, take a break, and/or discontinue their participation at any time.
 2. *No*: Proceed to Step 5.
4. Grounding Activity
- a. Let the participant know that "Sometimes when we talk about the past, it can be helpful to remind ourselves that we are not in that situation anymore."
 - b. Ask the participant:
 - i. "Look around the room and tell 3 things that you see."
 - ii. What do you hear?
 - iii. Feel your back against the chair and your feet on the ground.
 - iv. "What are you looking forward to within the next week?"
 - c. If participant is still visibly distressed, conclude the interview and proceed to Steps 5 & 6.
 - d. If participant is no longer visibly distressed, ask participant if they would like to continue the interview.

- i. *Yes*: Continue with the interview and continue to monitor participant's distress. At the conclusion of the interview, check in with participants distress and engage in Steps 3-4 when necessary. When participant displays distress at any point of the interview, at the conclusion of the interview proceed to Steps 5-6. Remind the participant that they can skip any question, take a break, and/or discontinue their participation at any time.
- ii. *No*: Proceed to Step 5.

5. Referral List

- a. "It can be helpful to work through memories and emotions that arise around relationships with our parents/grandparents."
 - b. Offer them list of referrals and recommendations for coping with distressing emotions.
6. Follow up before ending interview
- a. Check in:
 - i. Now that we have concluded the interview, how are you feeling?
 - ii. Check in with safety planning
 1. Are you currently having feelings of harming yourself or others?
 - a. Safety planning when necessary.