

Quality of Care After Early Childhood Trauma and Well-Being in Later Life: Child Holocaust Survivors Reaching Old Age

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The link between deprivation and trauma during earliest childhood and psychosocial functioning and health in later life was investigated in a group of child Holocaust survivors. In a nonconvenience sample 203 survivors, born between 1935 and 1944, completed questionnaires on Holocaust survival experience and several inventories on current health, depression, posttraumatic stress, loneliness, and attachment style. Quality of postwar care arrangements and current physical health independently predicted lack of well-being in old age. Loss of parents during the persecution, year of birth of the survivors (being born before or during the war), and memories of the Holocaust did not significantly affect present well-being. Lack of adequate care after the end of World War II is associated with lower well-being of the youngest Holocaust child survivors, even after an intervening period of 60 years. Our study validates Keilson's (1992) concept of "sequential traumatization," and points to the importance of aftertrauma care in decreasing the impact of early childhood trauma.

Keywords: Holocaust survivors, child survivors, trauma, after trauma care, sequential traumatization

The long-term effects of persecution on the child survivors of the Holocaust, now living in Israel, are reported in numerous studies (for a review, see (Dasberg, 2001). The current study is, however, the first to focus exclusively on the youngest of these child survivors. Born some years before or during the Second World War, they survived the horrors of persecution, losses, separations, neglect, and starvation during their first and most formative years (Kestenberg & Brenner, 1996). They were confronted from the earliest age with their parents' struggle to escape annihilation, and had to endure their helplessness in providing basic protection and safety. Many of these children survived only by being separated from their parents, and entrusted to the care of strangers (Flim, 2004; Fogelman, 1994; Meijer, 2001). After the war they faced further separations as they were reclaimed by their estranged parents from the caretakers who had provided them with safety (Evers-Emden, & Flim, 1995). Many parents were too weak and mentally exhausted after the war to be able to take proper care of their children. Orphaned child survivors had to deal with numerous separations and adjustments. All were confronted with the havoc the Holocaust had wrought on family, social, and cultural structures (Kestenberg & Gampel, 1983). Furthermore, they had to readjust to more separations and ever changing circumstances as they moved from country to country, and immigrated to Israel (Lev-Wiesel & Amir, 2000).

Now in their early sixties to early seventies, many of these youngest Holocaust survivors have shown remarkable ability to

live successful lives, building families and doing well beyond expectation in professional careers (Suedfeld, 2002; Suedfeld, Paterson, & Krell, 2005). Yet, some authors have suggested that for those survivors who suffered extreme traumatic stress, apparently normal functioning can be fragile (Tauber, 1996; Van der Hart, Nijenhuis, & Steele, 2006). The younger child survivors are now reaching the age at which older survivors before them started to become more vulnerable to difficulties in dealing with the stresses of daily life (Aarts & Op den Velde, 1996; Joffe, Brodaty, Luscombe, & Ehrlich, 2003; Dasberg, 2001; Harel, Kahana, & Kahana, 1993), although they often continued to display great strength in social functioning (Kahana, Kahana, Harel, & Rosner, 1988).

Obviously there is a wide diversity in the ways adults as well as children survived the Holocaust persecution, in the severity of their exposure to trauma and deprivation, and in the quality of care they received after the war. The various, often impressive ways in which survivors of all ages after the war rebuilt their lives and adapted to post war demands have been stressed by several authors (see for a review: Suedfeld, Soriano, McMurty, Paterson, Weiszbeck, et al., 2005).

Studies of older child survivors assessed specific Holocaust experiences which could have adversely influenced well-being later in life (Krell, 1985). Some researchers focused on different settings in which child survivors had endured hardship: concentration camps, ghettos, hiding with Christian families, or hiding in the open in woods and mountains (Lev-Wiesel & Amir, 2000; Robinson, Rapaport-Bar-Sever, & Rapaport, 1994b; Yehuda, Schmeidler, Siever, Binder-Brynes, & Elkin, 1997). Others studied the influence of the hardship of loss of parents, and ensuing unstable foster care (Keilson, 1992; Robinson, Rapaport-Bar-Sever, & Rapaport, 1997). Several studies examined how developmental age at the time of persecution affected later functioning

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(Durst, 2003; Gampel, 1988; Kestenberg, 1988; Kestenberg & Brenner, 1996; Tauber, 1996). Two studies found older child survivors to be more vulnerable to symptom patterns in later life (Cohen, Dekel, Solomon & Lavie, 2003; Yehuda et al., 1997). A number of Israeli studies compared present psychological functioning of child survivors with that of matched peers who had not endured the Holocaust (Amir & Lev-Wiesel, 2003; Brom, Durst & Aghassy, 2002; Cohen, et al., 2003; Cohen, Brom, & Dasberg, 2001; Cohen, Dekel, & Salomon, 2002). These studies found a wider prevalence of posttraumatic stress disorders in child Holocaust survivors than in their non-Holocaust-exposed peers, and even higher levels of posttraumatic distress in those child survivors who applied for treatment. In a Canadian study however, which compared 45 survivors with 21 Jewish peers who had not experienced Holocaust persecution, survivors showed a higher posttraumatic stress incidence than the comparison group, but they also scored consistently higher on salutogenic (health-enhancing) assessment measurements (Cassel & Suedfeld, 2006).

In a demographic profile study among 1,036 Dutch Jews (born 1904–1981) living in the Netherlands, Dutch child survivors (born 1925–1944) showed exceptionally high scores on a loneliness assessment scale. The scores were found to be significantly related to their reports of how seriously they and their parents had suffered during the Holocaust (Van Solinge & Van Imhoff, 2001). Recently, several controlled studies have been undertaken to assess current attachment representations and styles of child Holocaust survivors. These studies attempt to explain the nature of long-term effects of Holocaust survival experience in terms of Bowlby's theory of secure and insecure attachments, which originate from relationships with primary caregivers, and form the basis for the child's future approach to social interactions (Bowlby, 1973). According to his theory, insecure attachments stemming from an infant's experiences of separation and loss compromise the sense of a "secure base" (Bowlby, 1988). While specific insecure attachment styles have been identified as risk factors for adverse psychological development, secure attachment may contribute to the enhancement of emotional resilience (Greenberg, 1999; Schuenkel, Bakermans-Kranenburg, & Van IJzendoorn, 1999). A study that assessed attachment styles by comparing psychotherapeutically treated Holocaust child survivors with nontreated survivors and a control group of non-Holocaust-exposed peers, Cohen et al., (2002) found that subjects with an insecure-avoidant attachment style showed more posttraumatic symptoms than secure and insecure-anxious-ambivalent subjects. Survivors receiving treatment showed fewer characteristics of secure attachment, suggesting that the treatment-seeking survivors suffer not only from emotional distress but also from basic personality issues.

Two other studies investigated attachment experiences related to unresolved loss. In one study a nonconvenience sample of child survivors (that is, the recruitment of the sample was not based on convenience groups such as mental health clinics, Holocaust related organizations, or advertisements [see Sagi-Schwartz et al., 2003]) was compared with matched non-Holocaust-exposed peers (Sagi, Van IJzendoorn, Joels & Scharf, 2002), while in the second study, the offspring of both groups were included (Sagi-Schwartz, Van IJzendoorn, Grossmann, Joels, Grossmann, et al., 2003). While the results showed no differences in attachment classifications between the groups, more disorganized reasoning indicative of unresolved loss (Main & Hesse, 1990; Main & Goldwyn,

1984/1998) was assessed in the Holocaust survivors group. However, this did not appear to be transmitted to later generations. Disorganized reasoning in the child survivor group, as for instance evident from statements implying a belief that the deceased remained alive in the physical sense (Hesse, 1999), was suggested to constitute a risk factor for elevated stress levels during acute crises.

Child survivors with well-documented postwar personal histories have been subject to follow-up studies after reaching adulthood. One of these studies followed up the later adjustment process of child Holocaust survivors whose initial adaptation to post-Holocaust life had been laid down by Anna Freud and Sophie Dann (Freud & Dann, 1951). They described how a group of six toddlers, as orphans liberated from the Theresien concentration camp and brought to England, adjusted relatively rapidly and favorably to a group upbringing, while making use of their strong attachments to each other, before they could trust and relate to adult caregivers. They were observed to succeed to some degree in overcoming anxieties and developing coping strategies, despite the fact that at the earliest age they had been "deprived of mother love, oral satisfactions, stability in their relationships and their surroundings" (p. 168). In a follow-up study, Sarah Moskovitz interviewed these survivors, who were then in their mid to late thirties (Moskovitz, 1983). She was impressed by the way they had been able to cope by holding on to social skills that had apparently served them since their early ordeals. She also noticed "a persistent burden of the loss of parents never known, and of a hunger for some link with the past, for traces of themselves buried in childhoods they dare not to remember" (p. 226).

A second, longitudinal, study concerns a randomly selected survey of 204 out of the 2,041 orphaned child survivors, born between 1929 and 1944, who were persecuted in the Netherlands (Keilson, 1992). This study was aimed at assessing the child survivors' psychosocial adjustment 25–30 years after the war; some of them were living and interviewed in the Netherlands ($n = 151$), and some in Israel ($n = 53$). Immediately after the war, they had been placed in the care of Jewish or Gentile foster families. Their previous history/life stories and postwar situation had been evaluated by childcare workers. The author was permitted to make use of the kept records. By means of clinical-descriptive as well as quantitative-statistical methods, the study documented a relation between the child's age at traumatization, the severity of the traumatization, and the nature of personality disorders observed in adult life. Personality problems with impaired interpersonal relationships were found in the younger age groups. For assessing severity of traumatization, Keilson subdivided the period of Nazi persecution into three sequential phases: the pre- and early war phase, the war-persecution phase, and the postwar phase. The impact of the third, postwar, traumatic sequence turned out to be more predictive of psychosocial impairments in child survivors as adults than the second sequence, which included wartime and persecution. It was on the basis of this finding that Keilson (1992) coined the term 'sequential traumatization.'

In the current study, we investigated how exposure to deprivation and trauma during earliest childhood affects present well-being of a group of Holocaust survivors reaching old age. Our sample consisted of survivors who were born several years before or during the war. The oldest group, born some years before the war, was developmentally capable of holding on to autobiographic memories of their ordeals, whereas the two younger groups, born

just before and during the war, were in general too young to do so (Siegel, 2001). Our interest particularly concerned differences between the groups in terms of physical health and various aspects of psychosocial functioning related to present well-being, for example, social belonging, attachment styles, and posttraumatic stress symptomatology, including depressive complaints.

Based on our analysis of the literature, we expected the older child survivors, born before the war, to show more (age-related) physical health complaints, as well as psychosocial problems. We also tested for differences in present functioning between the survivors who had lost one or both of their parents during the war and those who survived with their parents. Lastly, we investigated whether postwar circumstances, in particular the care arrangement in which the child survivors found themselves immediately after the end of the war, were important in mitigating or exacerbating the traumatic consequences of the Holocaust experiences.

Methods

Participants

Participants were 203 Holocaust child survivors, born between 1935 and 1944 in countries occupied by the Nazi regime, and having immigrated to Israel after 1945. A nonconvenience sample was created by recruiting through demographic information provided by the Israel Ministry of Interior Affairs, including name, year and country of birth, and date of immigration into Israel. Israeli laws concerning protection of privacy were followed. Invitations to participate in the study were sent by mail to 410 addresses. In a follow-up telephone call 293 survivors who met our criteria could be reached. Forty-nine survivors refused to participate, while 41 candidates were not available for participation during the time frame of the study. Participation consisted of completing self-report questionnaires, with questions about Holocaust survival-related experiences, and several standard psychological assessment questionnaires. The procedure took one and a half hours on average. Following the regulations of the Israeli Ministry of Health, all participants signed forms of informed consent after they had received an explanation of the purpose of the study.

The survivors were on average 65 years old, and 63% were female. For the purpose of analysis, the sample was divided into three age groups: born 1935–1937 ($n = 60$), 1938–1940 ($n = 70$), and 1941–1944 ($n = 73$). Twenty-seven child survivors (13%) had lost both their parents during the Holocaust, 46 had lost one parent (23%), and in the remaining group (64%), both parents survived.

Instruments

Holocaust survival exposure questionnaire. In this questionnaire participants answered demographic and specific Holocaust survival-related questions. In the current study we focused on questions pertaining to having recollections of the Holocaust, and to the quality of care arrangements immediately after the war. Both questions yielded scores on a 5-point scale (1 = *no memories*, 5 = *very clear memories*, and 1 = *very bad care*, 5 = *very good care*).

Physical health status. Physical health status was assessed by a self-report questionnaire developed by the Herczeg Institute on Aging (Tel-Aviv University), listing 18 chronic physical illnesses.

Respondents were asked to indicate which, if any, illness they had suffered during the last month, and if they had taken medications for this illness. This questionnaire is widely used in Israel for sociodemographic research on the aged.

Beck depression inventory (BDI). This instrument (Beck, Guth, Steer, & Ball, 1997), a 7-item self-report questionnaire, is widely used for fast screening for depression in adults. The items pertain to feelings of sadness, discouragement about the future, perceived decreases in self-confidence, a sense of being overly self-critical, and having suicidal ideation. Each question is answered on a scale of 0–3 (0 = *least*, 3 = *most*). Sensitivity and specificity rates of the 7-item questionnaire are 82%, slightly lower than the longer version. The internal consistency of the short form showed adequate internal consistency ($\alpha = .83$), and scores were not related to gender, age, ethnicity, or type of medical diagnosis. In our sample the internal consistency of the BDI was adequate as well ($\alpha = .75$, $n = 198$).

Posttraumatic stress diagnostic scale. Posttraumatic stress disorder (PTSD) functional impairment was assessed by means of the PDS (Foa, Riggs, Dancu, & Rothbaum, 1993). The 49-item self-report scale assesses DMS-IV symptoms of PTSD. It provides a categorical diagnosis of PTSD, as well as an overall measurement of symptom severity. The instrument showed good internal consistency and test–retest reliability (.91 and .74, respectively, Foa et al., 1993). The test items correspond to Diagnostic and Statistical Manual of the American Psychiatric Association–IV (American Psychiatric Association, 1994) diagnostic criteria for PTSD indicating satisfactory convergent validity and concurrent validity assessed by self-report measures of depression and anxiety (Foa, Cashman, Jaycox & Perry, 1997). Moreover, the PDS correctly classified PTSD-positive patients with a sensitivity rate of 89%, a specificity rate of 65% and an overall correct classification rate of 74% (Foa et al., 1993). In the current study we used the PTSD F-criterion for functional impairment as a stringent index of PTSD with implications for daily functioning of the participant. The F-criterion, part 4 of the PDS, ascertains the level of impairment in social, occupational, interrelational, and other important areas of personal functioning. It consists of nine questions, requiring a yes-no answer, on perceived disturbances in daily functioning during the last month, as a result of a traumatic experience. The questionnaire showed adequate internal consistency in our sample, $\alpha = .82$, ($n = 108$).

Experiences in close relationships revised (ECR-R). The ECR-R is a 36-item self-report attachment measure with scores on a 7-point Likert-type scale developed by Fraley, Waller and Brennan (2000). The instrument is based on Hazan and Shafer's (1987) findings showing parallels between the emotional attachment of human infants to their caregivers and adult romantic and marital attachment relationships. Two major dimensions were distinguished, attachment-related anxiety, and attachment-related avoidance of intimacy (Brennan, Clark, & Shaver, 1998). The ECR-R provided highly stable indicators of attachment during a 3-week period (85% shared variance). Moreover, scores explained between 30% to 40% of the between-person variation in attachment-related emotions experienced during interactions with a romantic partner and only 5% to 15% of that in interactions with family and friends (Sibley, Fischer, & Liu, 2005). We used participants' scores on the two dimensions, Avoidance (or discomfort with closeness and discomfort with depending on others, $\alpha = .91$, $n =$

167) and Anxiety (or fear of rejection and abandonment, $\alpha = .85$, $n = 145$).

The loneliness scale. This scale consists of 11 items; five are formulated positively, six negatively. The questionnaire is based on the cognitive approach to loneliness with an emphasis on the felt discrepancy between what one wants and what one has in terms of interpersonal affection and intimacy. Characteristics of the social network, number and frequency of contacts, and expectations of support are considered important loneliness-provoking factors (De Jong Gierveld, 1987; De Jong Gierveld & Van Tilburg, 1987, 1999 electronic update 2006). Typically, reliabilities in the 0.80 to 0.90 range are observed (König-Zahn, Furer, & Tax, 1994). In our sample the internal consistency was $\alpha = .87$ ($n = 193$).

Results

Bivariate Analyses

Participants in the three birth cohorts did not differ in the number of parents they lost during the war, or in quality of care after the war (see Table 1). The older survivors had more clear memories of their Holocaust experiences (see also Table 4). Furthermore, the older participants were less positive about their health condition, although the birth cohorts did not significantly differ on number of physical illnesses, or use of medication. The cohorts did not significantly differ on the avoidance, anxiety, and depression scales. However, younger survivors suffered more from feelings of loneliness (see Table 1). The three groups included similar proportions of females.

From Table 2 it can be derived that the group of survivors who did not relate to any traumatic experience as currently disturbing them and the group of survivors who reported no PTSD functional impairments did not significantly differ on any of the variables. Therefore, the two groups were collapsed in the analyses.

Comparing the Holocaust survivors without PTSD to those with functional PTSD impairment, we found that the latter group reported significantly lower quality of care after the war, suffered more from physical illnesses, and were significantly less positive about their health status. They did not, however,

differ in their use of medication. Furthermore, survivors with functional PTSD impairments were significantly more avoidant, more anxious, more depressed, and lonelier, as compared with the survivors without posttraumatic stress-related functional impairments (see Table 3). The groups of survivors with and without functional PTSD impairments included similar proportions of females.

Better quality of care after the war was associated with fewer physical illnesses, less depression, less loneliness, and lower scores on the avoidance and anxiety scales (see Table 4). Survivors with more clear memories of the Holocaust also reported more physical illnesses. More physical illnesses were related to more feelings of depression, more loneliness, and higher scores on the anxiety scale. More physical illnesses were of course associated with a less positive evaluation of the own health condition (see Table 4).

Perceived health, depression, loneliness, avoidance, and anxiety were all significantly correlated in the expected direction. In a principal components analysis they loaded on one component, explaining 49% of the variance. Therefore, a composite scale for *Lack of well-being* was computed, as the sum of the standardized scale scores for perceived health, depression, loneliness, avoidance, and anxiety ($\alpha = .73$, $n = 167$).

Multivariate Analysis

In a hierarchical multiple regression analysis predicting current lack of well-being from age, physical illnesses (first step), loss of parents during the war, and quality of care after the war (second step), only the number of physical illnesses ($\beta = .37$, $p < .01$) and quality of care after the war ($\beta = -.18$, $p < .05$) contributed significantly to the prediction. More physical illnesses and a lower quality of care after the war independently predicted less well-being (see Table 5). Loss of parents during the war and age of the survivors were not significantly associated with lack of well-being.

Discussion

Young child survivors of Nazi persecution who experienced unsatisfactory quality of care immediately after the Holocaust

Table 1
Descriptives by Age Cohort

Year of Birth	1935–1937	1938–1940	1941–1944	Total	<i>F</i>
	<i>M (SD) N</i>	<i>M (SD) N</i>	<i>M (SD) N</i>	<i>M (SD) N</i>	
Age	68.0 (0.81) 60	64.9 (0.88) 70	61.6 (1.13) 73	64.6 (2.8) 203	74.42**
Loss of parents during war	0.58 (0.72) 60	0.54 (0.77) 70	0.38 (0.66) 73	0.50 (0.72) 203	1.49
Quality of care after war	4.1 (1.11) 38	3.9 (1.26) 52	4.1 (1.37) 51	4.0 (1.26) 141	0.28
Memories of Holocaust	30.3 (5.48) 60	26.7 (7.69) 70	16.3 (7.00) 73	24.0 (9.04) 203	75.94***
Physical illnesses	2.7 (2.55) 60	2.2 (1.78) 70	1.8 (1.73) 73	2.2 (2.04) 203	2.99
Self-reported health	3.4 (0.92) 55	3.8 (0.90) 63	3.9 (0.72) 61	3.7 (0.87) 197	5.05**
Avoidance	2.8 (1.16) 57	2.6 (1.08) 67	2.9 (1.29) 68	2.8 (1.19) 192	1.87
Anxiety	3.4 (0.99) 56	3.2 (0.90) 67	3.2 (1.16) 68	3.3 (1.02) 191	0.55
Depression	2.6 (3.03) 60	2.4 (2.61) 69	2.5 (3.50) 73	2.5 (3.07) 202	0.03
Loneliness	16.7 (4.68) 58	15.9 (4.75) 70	18.1 (5.71) 73	16.9 (5.16) 201	3.34*
Gender (Female)	34 (57%)	40 (57%)	53 (73%)	127 (63%)	$\chi^2 = 4.91$
Medication	51 (85%)	48 (72%)	49 (80%)	148 (79%)	$\chi^2 = 3.51$

* $p < .05$

** $p < .01$

*** $p < .001$

Table 2

Means and Standard Deviations of Major Predictors for Three Categories of PTSD (no PTSD Symptoms; PTSD Functional Impairment; no PTSD Reported to Affect Daily Life)

PTSD	PTSD			Total	F
	No PTSD	Functional Impairment	PTSD Not Reported		
	M (SD) N	M (SD) N	M (SD) N	M (SD) N	
Age	65.1 (2.73) 44	64.7 (2.71) 75	64.3 (2.84) 84	64.6 (2.77) 203	1.21
Loss of parents during war	0.55 (0.76) 44	0.61 (0.80) 75	0.37 (0.60) 84	0.50 (0.72) 203	2.44
Quality of care after war	4.35 (1.16) 26	3.64 (1.32) 59	4.23 (1.14) 56	4.01 (1.26) 141	4.53*
Memories of Holocaust	25.0 (9.09) 44	25.2 (8.35) 75	22.5 (9.47) 84	24.0 (9.04) 203	2.17
Physical illnesses	1.95 (1.33) 44	2.95 (2.63) 75	1.67 (1.50) 84	2.20 (2.04) 203	8.83**
Self-reported health	4.00 (0.70) 38	3.50 (1.03) 66	3.81 (0.75) 75	3.74 (0.87) 179	4.66*
Avoidance	2.38 (1.16) 42	3.12 (1.29) 71	2.68 (1.03) 79	2.78 (1.19) 192	5.98**
Anxiety	3.08 (0.92) 41	3.58 (1.03) 71	3.10 (1.01) 79	3.27 (1.02) 191	5.21**
Depression	1.41 (2.39) 44	3.97 (3.69) 75	1.72 (2.13) 83	2.49 (3.07) 202	16.24**
Loneliness	14.45 (3.59) 44	19.04 (5.57) 74	16.33 (4.79) 83	16.92 (5.16) 201	13.28**
Gender (Female)	26 (59%)	49 (65%)	52 (62%)	127 (63%)	$\chi^2 = 0.49$
Medication	34 (87%)	59 (82%)	55 (71%)	148 (79%)	$\chi^2 = 4.56$

* $p < .05$

** $p < .01$

PTSD = Posttraumatic Stress Disorder.

show a lack of well-being in their sixties and seventies. The correlation between a lack of well-being in old age and perceived failing quality of post-Holocaust care remained robust even after controlling for present health situation, a variable which obviously highly influences the sense of well-being. The association between perceived quality in care and lack of well-being in old age controlling for all other pertinent factors ($\beta = .18$) indicates a small ($r = .10$) to medium ($r = .25$) effect size (Cohen, 1988). Loss of parents as a result of persecution, age of the survivors (being born before or during the war), and having autobiographic memories of the war period did not significantly affect survivors' present sense of well-being.

In our nonconvenience sample, 37% of the respondents (75 out of 203) reported PTSD-related functional impairment. As the study was carried out during the last phases of the al-Aqsa Intifada, the rather high percentage could be a reflection of this stressful period of suicide-bombings. Earlier research, during the Gulf War Iraqi Scud missile attacks on Israel, found higher levels of perceived danger and reported more symptoms of acute distress with elderly Holocaust survivors than comparison subjects; in addition, they displayed higher levels of both state and trait anxiety (Robinson, Hemmendinger, Netanel, Rapaport, Zilberman et al., 1994a; Solomon & Prager, 1992). A tendency to a lower threshold for accumulated stress in Holocaust survivors and their offspring has

Table 3

Means and Standard Deviations of Major Predictors for Two Categories of PTSD

PTSD	PTSD		Total	T
	No reported PTSD	Functional Impairment		
	M (SD) N	M (SD) N	M (SD) N	
Age	64.6 (2.81) 128	64.7 (2.71) 75	64.6 (2.77) 203	-0.42
Loss of parents during war	0.43 (0.66) 128	0.61 (0.80) 75	0.50 (0.72) 203	-1.68
Quality of care after war	4.27 (1.44) 82	3.64 (1.32) 59	4.01 (1.26) 141	2.92**
Memories of Holocaust	23.3 (9.38) 128	25.2 (8.35) 75	24.0 (9.04) 203	-1.42
Physical illnesses ¹	1.77 (1.44) 128	2.95 (2.63) 75	2.20 (2.04) 203	-3.59**
Self-reported health ¹	3.88 (0.73) 113	3.50 (1.03) 66	3.74 (0.87) 179	2.61*
Avoidance ¹	2.57 (1.08) 121	3.12 (1.29) 71	2.78 (1.19) 192	-3.03**
Anxiety	3.09 (0.98) 120	3.58 (1.03) 71	3.27 (1.02) 191	-3.24**
Depression ¹	1.61 (2.22) 127	3.97 (3.69) 75	2.49 (3.07) 202	-5.03**
Loneliness ¹	15.68 (4.48) 127	19.04 (5.57) 74	16.92 (5.16) 201	-4.43**
Gender (Female)	78 (61%)	49 (65%)	127 (63%)	$\chi^2 = 0.39$
Medication	89 (77%)	59 (82%)	148 (79%)	$\chi^2 = 0.72$

¹ Unequal variances

* $p < .05$

** $p < .01$

PTSD = Posttraumatic Stress Disorder.

Table 4
Associations Among Background Variables and Current Well-Being

	Age	Loss of of parents during war	Quality of care after war	Memories of Holocaust	Physical illness	Self-reported health	Depression	Loneliness	Avoidance	Anxiety
Age	—									
Loss of parents during war	.15*	—								
Quality of care after war	.00	-.12	—							
Memories of Holocaust	.66**	.12	-.08	—						
Physical illnesses	.12	.05	-.20*	.18*	—					
Self-reported health	-.16*	.05	.07	-.18*	-.53**	—				
Depression	.00	.12	-.17*	.07	.28**	-.41**	—			
Loneliness	-.13	.06	-.19*	-.06	.18*	-.30**	.46**	—		
Avoidance	-.06	-.03	-.19*	-.05	.11	-.20*	.33**	.58**	—	
Anxiety	.04	.11	-.19*	.06	.16*	-.21**	.34**	.38**	.32**	—

* $p < .05$

** $p < .01$

previously been noted by several researchers (see Van IJzendoorn, Bakermans-Kranenburg & Sagi-Schwartz, 2003).

We did not include a control group, which counts as one of its limitations. Other limitations concern the design, with assessments based on self-report questionnaires. Furthermore, unlike Keilson (1992) and Moskowitz (1985), we could not rely on documented information about our respondents' peri-Holocaust history, and had to rely on their own retrospective or reconstructive reports. It might be argued that participants with more physical illnesses would be inclined to report lower levels of well-being and at the same time tend to view the quality of care they received earlier on as poor, because they have a negative view of both the past and the current. However our multivariate approach shows that controlling for physical health the quality of care contributed significantly to the prediction of current well-being. Nevertheless, our findings need further validation from studies using observed or other-reported indices of mental and physical health.

The importance of the quality of the "postwar embrace" (Tauber & Van der Hal, 1997) the way in which the children were received, contained, understood, and respected by adults, as they reentered society after Holocaust and war trauma has been recognized as a

main factor in successful trauma recovery (Catherall, 1989; Lifton, 1968; Mazor, Gampel, Enright, & Orenstein, 1990). Our results are consistent with the results of Keilson's study (1992), which showed the substantial impact of postwar traumatic experiences. While Keilson's findings concerned war orphans rehabilitated in foster homes after the war, the current study shows for the first time that the cumulative effects of an unfavorable post-Holocaust sequence on later well-being also hold true for those child survivors who did not suffer parental loss. Some of them had not been separated from their parent(s) throughout the war, while others had returned to their care after liberation.

Bar-On, Eland, Kleber, Krell, Moore, et al., (1998), while acknowledging the postwar traumatic sequence, indicate that both the internal emotional state of the survivors and external social circumstances may attribute to the survivors' distress. They make the important point that only after liberation was the majority of survivors confronted with and shocked by the massive loss of relatives, peers, and whole communities. Inevitably, pathological mourning processes as described by Bowlby (1963) afflicted the adult as well as the child survivors, and are well-documented in numerous studies (e.g., Dasberg, 2001; Gampel, 1988; Kestenberg & Kestenberg, 1988; Mazor et

Table 5
Regression Analysis Predicting Current Lack of Well-being From Age, Physical Illnesses, Loss of Parents During War, and Quality of Care After the War

	Lack of well-being	R	R ²	R ² Change	F	df	Beta ¹	P
<i>Step 1</i>		.41	.17	.17	11.03	(2,112)		<.01
Age	.08						.03	.74
Physical illnesses	.41**						.37	<.01
<i>Step 2</i>		.44	.20	.03	6.67	(4,110)		<.01
Loss of parents during war	.06						.02	.83
Quality of care after war	-.25**						-.18	<.05

¹ The betas are derived from the regression model after step 2.

** $p < .01$.

al., 1990; Valent, 1998). The internal emotional state converged with the external societal circumstances into a situation in which the survivors were victimized for having survived. The outside world in Israel, as well as all over the world, did not always react empathically to the survivors' needs (Danieli, 1988; Segev, 1994; Tauber, 2003; Yablonka, 1999), which intensified the inhibition to adequately express grief. The ensuing "conspiracy of silence" during the post-Holocaust era ruled many survivor families' relational patterns, activating the sense of loneliness (Danieli, 1985). Moreover, in the prevailing postwar attitude, the impact and consequences of traumatic experiences for child survivors, in particular for the youngest of them, were not always acknowledged (Kestenberg, 1992).

A number of the youngest survivors in our study may have become victims of emotional deprivation during the post-war years, while they had to bear, apart from their own bereavements, the consequences of their parents' grief, which showed up in a complexity of different emotional and sometimes frightening preoccupations (Dasberg, 1992). This study underlines Bowlby's observations that infants are not spared late consequences of traumatic early bereavement (Bowlby, 1960). After liberation from Nazi persecution, some of the children had a second chance at childhood, but others forewent that option and lost their childhood forever (Kellermann, 2001).

Implications

Our study shows that, even after 60 years, lack of well-being of child Holocaust survivors is related to inadequate childcare arrangements after liberation at the end of the World War II. Unfortunately, children and their families continue to suffer from traumatization because of wars, terrorism, and interracial conflicts (Fazel & Stein, 2002). Our study underscores the urgency for optimizing aftertrauma care of present-day child survivors in order to decrease the impact of early childhood trauma (Papadopoulos, 1999; Whittaker, 2005).

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