

Research on consequences of the Holocaust

Katarzyna Prot

Summary

The paper presents a shift in the research focus concerning the Holocaust survivors – from investigating symptoms of post-traumatic stress disorder to discovering the sources of strength enabling their survival. A brief chronological overview of studies on the Holocaust survivors is presented. Moreover, a number of psychological problems most often experienced by the survivors are identified, including their non-acceptance of separation, fear of closeness, difficulty in defining personal and social identity, susceptibility to hurt feelings, and a sense of guilt.

trauma / Holocaust / survivor / PTSD

INTRODUCTION

A considerable time is needed before any community is capable of facing the subject of collective trauma and its consequences. Thus, despite relatively numerous studies on the Holocaust, it is still a taboo subject, also for the professional community of psychologists and psychiatrists [1].

The problem of psychological consequences of the Holocaust is important for therapists working with the first, second, and now even third generation of the Holocaust survivors and their children [2], but memory of the Holocaust in the collective consciousness is also of crucial importance. The presence of “the Shoah complex”, i.e. guilt feelings and the resulting difficulty in thinking and talking about the Holocaust [1] in the societal context, has been recently evidenced in Poland by the public’s response to the book by Gross [3, 4] about the role of the

Polish society in the Holocaust. Perhaps children of the Holocaust witnesses protect their parents from shame, the same as children of the survivors protect their parents from pain.

The aim of the paper is to present the research on the effect of the Holocaust experiences on the survivors’ mental health. A shift in perspective in dealing with the subject seems interesting. While the initial studies focused on the pathology, or on the post-traumatic symptoms occurring in the survivors, at present more and more attention is devoted to their strength and ability to survive. This can be seen also in the language, since the word “victim” is no longer in use, and the term “saved” has been replaced by “survivor”, in protest against thinking about passivity of the “saved”. This phenomenon is ascribed first and foremost to the change in the sample selection. The initial studies were conducted at the time when the survivors suffering from pathological symptoms sought psychiatrists’ help, or were examined for the purposes of obtaining Holocaust reparations from Germany [5, 6]. Subsequent studies investigating groups selected from the healthy general population show that the consequences of trauma may be diverse. This leads to the question about the sources of strength enabling survival.

Katarzyna Prot: Head of the Mental Health Center, Mental Health Centre, Institute of Psychiatry and Neurology, Warsaw, Poland. Correspondence address: Mental Health Centre, Institute of Psychiatry and Neurology, 9 Sobieskiego St., 02-957 Warsaw, Poland. E-mail: k.prot@wp.pl

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Another problem that should be taken under consideration is the course of recovery in persons with traumatic experiences. Immediately after the war, the survivors' mental health was different from that at present. Many authors point out that the process of the survivors' recovery should be construed not as a lack of symptoms, but rather as an ability to cope despite their symptoms, or an ability to invest their life with meaning [7, 8, 9].

Also in the area of the research on families of the Holocaust survivors the period of focusing on the second generation's pathology is followed by studies showing that the Holocaust history can be embedded in the family history and perceived in terms of a myth or an obligation for the way of leading one's life, and not only as a reminder of death [10]. The myth of the Holocaust becomes a part of the individual's identity, influences the way of perceiving life, and the philosophy of life. This is in line with observations concerning the survivors – some of them interpret their survival as a special obligation to make their life meaningful.

History of research on consequences of the Holocaust

The preliminary studies dealt with defence mechanisms used by persons with the Holocaust trauma. Namely, in the analysis of his co-prisoners' behaviour Bettelheim [11] described regression as their response to violence in the situation in which their pre-camp ways of coping could not be continued. Niederland emphasised the role of denial, isolation and somatization. In these authors' opinion such defence mechanisms utilised by the Holocaust survivors also after the war protected them from the onset of symptoms. Others believe that the post-war period was only ostensibly "symptom-free", and that in reality the survivors were "suffering in silence" [13].

In conclusion of the research on survivors the "concentration camp syndrome" or "survivor syndrome" were described [4, 12, 14, 15, 16, 17]. The syndromes include the following symptoms: chronic anxiety and depression, psychosomatic disorders, cognitive function impairment and memory disorders (such as hypermnesia and amnesia covering the traumatic experience), an-

hedonia, inadequate guilt feelings, psychomotor agitation, sleep disturbances (nightmares), and identity disorders (affecting body image, as well as a sense of time and space).

The first studies of more numerous survivor groups were conducted in the late 1970's and early 1980's [18, 19]. This long-lasting lack of interest in the problems of the Holocaust survivors is due to two phenomena. One is a "collusion of silence" [20]. The term denotes the attitude of the post-Holocaust world towards the Holocaust experiences. On the one hand, the Holocaust survivors do not wish to talk about their experiences, and the world does not wish to listen. On the other hand, over the years neither psychology, nor psychiatry were interested in the problems of trauma, and attempts were made "to squeeze the patient into the existing diagnostic categories" [21]. Since all these studies were launched so late, they investigated persons who had experienced extreme trauma in their childhood or adolescence, and now are either adults or elderly. Hans Keilson [22] in his research carried out in the 1970's [22] diagnosed the survivors with unfinished mourning, identity disturbances, a sense of insecurity, and difficulties in interpersonal relations. In some of his subjects personality disorders were diagnosed, but a majority of them were well socially adjusted.

Despite an adequate social adjustment of the Holocaust survivors [23, 24, 25, 26, 27], a large proportion of them were found to suffer from trauma-related mental health problems reported in many studies [28, 29, 30, 31, 32, 33, 34, 35]. As a result of the studies on Vietnam veterans, these psychological symptoms were included in psychiatric diagnostic classification in the 1980's under the name of post-traumatic stress disorder (PTSD).

Consequences of the Holocaust trauma and PTSD

Research findings and experiences of psychotherapy with the survivors show that persons who had experienced the Holocaust trauma display in older age chronic psychopathological symptoms exceeding the PTSD criteria. Therefore, most authors consider the diagnosis of PTSD to be insufficient to describe the survivors' mental health problems.

In addition to the PTSD criteria such dimensions are taken into account as “identity”, “sense of self-worth” [36], or “subjective well-being” [37]. Also in the research conducted on other trauma groups, the focus is on a “spectrum of symptoms” rather than on pure PTSD symptoms [38]. It is postulated that acute trauma resulting from a single event should be differentiated from chronic conditions due to long-term or repetitive trauma [39, 40, 41]. Judith Herman [21, 42] proposed the term “complex post-traumatic stress disorder” to denote symptoms being a consequence of long-term stress. The symptoms described by the author are beyond the scope of the PTSD, mainly as regards self-image – guilt feelings, stigmatisation and identity disturbances. A “simple PTSD” is considered by Herman to be a consequence of a single traumatic event, while the “complex PTSD” as related to a long-term or repetitive trauma, as is the case with victims of war or family violence.

In descriptions of the Holocaust survivors’ psychological problems some phenomena recur, namely: non-acceptance of separation, fear of closeness, identity disturbances, susceptibility to hurt feelings and a sense of guilt for being alive.

Survivor problems in relations with the loved ones

According to Hass [43], separation is one of the most common reasons why the survivors may seek help. Also Polish studies [24, 44, 45] and observations made during psychotherapy [46, 47] confirm that it is a painful subject of utmost importance [48, 49, 50]. The survivors respond to their children’s leaving home with a sense of loss, hurt and a belief that by doing so the children take their love away. This is in line with the research findings by Zilberfein [51] concerning trauma transmission – the author reports that the survivors perceive separation as a negative process interpreted in terms of rejection and one that is very difficult to endure. Separation may be considered as a symptom-activating kind of loss. In many cases the Holocaust survivors were separated from their family and friends by the war. Their children’s leaving home may be for them a re-enactment of this separation trauma, producing a particularly strong response [18].

In the explanation of traumatic consequences of separation and of other symptoms suffered by the survivors a special role is ascribed to the theory of attachment [52]. The theory assumes that a relationship of attachment formed in infancy provides the framework for subsequent social interactions and important interpersonal relations [53, 54]. Early childhood separation frequently experienced by the Holocaust survivors might lead to the development of either anxious-avoidant or anxious-ambivalent attachment, resulting in fear of closeness [55, 56]. The lifelong need for closeness is often construed as a return to the early childhood symbiosis. Refusal of such closeness by partners or children evokes a deluge of chaotic emotions, with anger and aggression first and foremost. Since any contact with one’s aggressive part is particularly difficult, the survivors are determined to control these feelings through association with a real persecutor. Thus, the problems related to separation are very complex, including both apprehension of rejection and fear of closeness.

Personal and social identity disturbances in the survivors

The personal dimension of identity includes a sense of continuity of the “self” over the lifespan [57] and acquirement of personal experience [58]. The crucial role of identity consists in integrating the individual’s experiences. It is Freud who posed the question concerning changes of identity in the situation when stimulus on the intensity is strong enough to overcome a protective barrier [59]. In accordance with the psychoformative theory by Lifton [60], trauma damages the “self” structure, which leads to the onset of PTSD symptoms such as psychological numbing, guilt feelings, splitting, dissociation. Lifton believes that the survivors face a task of reintegrating their “self” by developing new internal forms covering the traumatic event. They have a sense of their personal identity impairment – they describe a feeling that their “self” continuity has been broken, and point to their difficulty in integrating the past and the present [61].

Social identity can be defined as a sense of affiliation with a social group related to emotional experience [62]. Development of the survivors’

social identity was difficult due to their situation – they were hiding in Catholic families and in some cases learnt the truth about their Jewish family as late as in adulthood.

Extreme trauma results in a breakdown of the individual's life course and in loss of a sense of the world's meaningfulness. According to Janoff-Bulman [63] it is the loss of a sense of meaningfulness that is the major effect of trauma.

The survivors' susceptibility to hurt feelings

Niederland [64], the first author to note symptom-free periods in the Holocaust survivors, described the phenomenon as their characteristic trait, especially of those who had survived as the only in the family. He believed that hope for miraculous tracking down family members protected them from symptoms, particularly such as self-accusation and guilt feelings resulting from their survival. Some authors report a recurrence of trauma-related symptoms at an older age [65, 66]. Susceptibility to hurt feelings increasing with age noted in many studies is corroborated by clinical observations [20, 33, 67, 68, 69, 70]. Re-activation of trauma due to an experienced loss, first and foremost associated with separation trauma, has been mentioned earlier. Also other events, including life-threatening illness [71, 72], war [31, 73], or growing anti-Semitism [24, 44, 74] elicit PTSD symptoms in the survivors. It is important that the survivors' problems should be understood in the context of their past experiences. Illness may be for them a reenactment of the situation in which disability denoted a certain death [68]. Hospitalisation may be regarded as a reenactment of being imprisoned in a camp, thus leading to near-psychotic disorders [75]. Invasive medical procedures that deprive the patient of control over events may also provoke re-traumatisation [68]. Similarly, changes associated with increased dependence on others may result in a sense of loss of control over one's life, triggering PTSD symptoms [76]. Therefore, in diagnosing severe disorders such as psychoses [77] or pseudo-dementia [78] their possible relationship with early trauma should be taken into account.

Survivors' sense of guilt

Sense of guilt is recognised as one of the survivors' essential symptoms [12, 64]. The "survivor

guilt" hypothesis was initially developed on the grounds of the theory of identification with the aggressor, proposed by Anna Freud. In her opinion identification with the aggressor is one of the most powerful defence mechanisms in coping with threat [79]. Referring to the survivors, the theory [11, 12, 80] assumes that in the moment of trauma the humiliated victim unconsciously incorporates the aggressive part of his/her prosecutor. Under the circumstances of the victim's complete helplessness this aggression cannot be projected back onto the persecutor, therefore it is directed against the victim in the form of guilt feelings.

Lifton, the author of the psychoformative theory of PTSD, in his study on the Hiroshima survivors [81] proposed that the source of their guilt feelings was their identification with the dead. According to Lifton, survivor guilt should not be interpreted in terms of the theory of identification with the aggressor, but rather as resulting from their sense of participation in a total breakdown of values and meaningfulness [82]. Thus, survivors feel guilty because of their identification with the dead, and not due to their mental collusion with violence.

Likewise, Niederland [64] in his later works no longer associates the survivors' guilt with aggressive drives, but emphasises their identifying with their beloved dead. He proposes that survival is unconsciously perceived by the survivor as a betrayal of the murdered family members and friends. In this context survivor guilt is sometimes called "imagined guilt" [60, 83], stemming from wishful thinking about a possibility of acting.

Survivor guilt is interpreted as remorse for surviving, while the whole Jewish world was annihilated. The survivors' isolation was enhanced by the attitude of a society who did not want to listen about concentration camps and the Holocaust. Their guilt feelings could be increased by being suspected of immoral deeds that allegedly might enable them to survive. Despite the aggravation of PTSD symptoms mentioned at the beginning of the paper, the survivors' sense of guilt at present has decreased as compared to the post-war period [84]. This may be ascribed, among other factors, to changes in social attitudes towards the survivors.

Applicability of the current diagnostic criteria to Holocaust survivors

All the observations outlined above lead to the question whether the current diagnostic criteria are sufficient to describe mental health of elderly persons who had experienced extreme trauma in their childhood. Both the data reported in the literature and therapeutic experience suggest that the PTSD criteria are insufficient to diagnose disorders in such people. An attempt has been made in this respect by introducing a new category into the international classification of diseases (ICD-10), and namely: "Enduring personality change after catastrophic experience" (F62.0). However, such criteria of personality disorder to a large extent overlap with these for diagnosing PTSD in the DSM-III-R or DSM-IV. The description of personality changes includes symptoms of withdrawal, feelings of constant threat, and alienation. Therefore, the "post-traumatic" personality to a large degree corresponds to the description of a chronic post-traumatic stress disorder.

The history of the "guilt feelings" criterion disappearance from the diagnostic classification systems seems interesting. This symptom, recognised at a time as pivotal in the survivors, was present among the PTSD criteria in 1980, i.e. at the moment of this syndrome's introduction into the DSM-III. In the 1987 revision (DSM-III-R), the symptom of "guilt feelings" was included in the "associated" category, to eventually disappear from the PTSD criteria in DSM-IV.

As it has been already mentioned, in publications dealing with the survivors there is an evident need for describing their personality in categories wider than these for PTSD. For instance, Teuber [85] proposed the term of "complex personality" to emphasise the presence of a hurt child in the personality of an adult survivor.

Survivors' strengths

The "psychopathological" approach is criticised by some authors for focusing on the survivors' deficits. The main criticisms are that the dynamics of the symptoms is not taken into account, and that the emphasis is on the survivors' disorders, and not on their survival skills [86,

87]. Lomranz [87] proposes to supplement the notion of PTSD with the term PTSR (post-traumatic stress reaction), covering not only deficits, but also adjustment, possibilities of development, and coping mechanisms [86]. The postulate is due to the good social adjustment of the Holocaust survivors, without any problems in their social and occupational functioning, which is corroborated by many studies involving non-clinical groups. Polish studies indicate that the survivors often manifest an exceptionally good functioning, achieve a university education and a high professional position [24, 44]. Other studies concerning the survivors also emphasise their successful adjustment to life after the Holocaust [23, 25, 26, 88, 89, 90, 91,92]. The research findings show that the survivors are highly motivated to achieve success, which is sometimes interpreted as a fear of failure [93]. Other possible interpretations of the considerable social success of the survivors refer to the mechanism of coping with their sense of guilt – they strive to fulfil a testament of the deceased [94], or to invest their life with meaning - while others failed to survive [30]. The survivors as compared to other groups have unique coping abilities and are exceptionally well socially adjusted [95]. Thus, research findings show that neither "feelings of emptiness and hopelessness", constituting one of the ICD-10 criteria for personality disturbances, nor the DSM criterion of "sense of a foreshortened future" apply to the survivors. They were found [25] to believe more strongly than a comparative group that there is justice in the world, that the individual can influence and control the reality, and that happiness plays an important role in life. This may be interpreted either as a sign of the Holocaust survivors' compensating their severely impaired sense of security, or as a genuine process of their recovery.

CONCLUSIONS

Summarising, the PTSD criteria seem to be suitable for the assessment of "fresh" trauma, as evidenced e.g. by lower PTSD severity in the survivors than in patients receiving psychiatric treatment who have recently experienced trauma [25]. In cases of remote trauma, a major role can be ascribed to factors associated with the

specificity of traumatic events (e.g. problems of separation and identity that the Holocaust survivors cope with), re-traumatisation defined as a relapse of PTSD symptoms in stressful situations, and a sense of guilt. Interestingly, these characteristics of the survivors resemble the psychopathological profile of their children displaying the following traits: predisposition to PTSD, difficulty in the process of separation-individuation, and a mixture of flexibility and oversensitivity in coping with stress [96, 97, 98].

The diagnostic criteria currently in force are insufficient not only as regards the survivors. The need to extend the definition of PTSD is emphasised also by the already quoted author, Judith Herman [42], on the grounds of her therapeutic work with family violence victims. Despite successive changes of terminology and evident attempts at solving the problem e.g. by the introduction of “chronic PTSD” or “post-traumatic personality” notions into the classification, the diagnostic criteria do not tap the real “complexity” of trauma effects. This inadequacy of the current diagnostic criteria can be seen particularly vividly in adults who have experienced extreme trauma in early stages of their development.

In the discussion over trauma, two approaches are represented: biological, considering the effect of a traumatic event as a physical trace in the brain, and humanist, assuming that a possibly full social and personal context of the traumatic event is of importance [99]. Attempts at explaining psychological phenomena in persons exposed to the trauma of the Holocaust, such as e.g. the concept of “survivor guilt”, contribute to our understanding of the dynamics of emotional experience in other people burdened with trauma [100]. Research on the Holocaust survivors enables us to understand the needs of other groups persecuted for racial or political reasons. Such studies suggest the direction of appropriate interventions on behalf of the victims. Social support, access to psychiatric care and psychological help, taking gender differences into account, and particular care of the child turn out to be crucial factors in this respect. [101, 102].

Trauma affects various areas of life, therefore the intervention should be also comprehensive [76]. Psychological and psychiatric care must be provided to people with mental disorders resulting from trauma. The survivors’ identity should

be taken under consideration, including cultural and gender differences. Since trauma affects family relations, it is necessary to account for the systemic and intergenerational contexts in the assessment and intervention. In thinking about the injured it is important to emphasise their strengths. Moreover, their empowerment is important - they should be encouraged to participate in social life and to take control over their own life. There is one more lesson to be learned from the Holocaust experience – in order to avoid “the collusion of silence” it is important to make this genocide known to the public, and to give voice to the survivors.

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PSYCHIATRIA I PSYCHOTERAPIA. Tom 6, Nr 1 Spring 2010

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SOME REMARKS ON PROCESSES OF INTEGRATION OF PSYCHOTHERAPY
THEORIES (EDITORIAL)

Monika Talarowska, Antoni Florkowski, Krzysztof Zboralski, Piotr Gałeczki
COGNITIVE FUNCTIONS IMPAIRMENT DEPENDING ON CLINICAL TRAITS
OF UNIPOLAR RECURRENT DEPRESSION - PRELIMINARY RESULTS

Magdalena Chodak, Łukasz Barwiński

SELF-AGGRESSION AS A FORM OF COPING WITH STRESS – A REVIEW OF ISSUES

Magdalena Chodak (1), Łukasz Barwiński (2)

SELF-AGGRESSION AS A FORM OF COPING WITH STRESS – A RESEARCH REPORT

Katarzyna Olejniczak, Józef Kocur, Agata Orzechowska, Monika Talarowska, Antoni Florkowski
DIFFICULTIES IN THE DIAGNOSIS OF PERSONALITY DISORDERS IN THE STUDY CASE
OF A PATIENT DIAGNOSED WITH MÜNCHHAUSEN SYNDROM

Piotr Wierzbiński, Antoni Florkowski

CHOLINERGIC SYSTEM AND SCHIZOPHRENIA. A POTENTIAL THERAPEUTIC ROLE
OF CHOLINERGIC AGONISTS

The Holocaust law, which has been mainly driven by the Law and Justice Party, is an additional tool for the authorities to suppress dissenting views at a time when it is already increasingly difficult to express political dissent in Poland. Hundreds of cases against peaceful protesters are currently pending in the courts and many more are being investigated by the authorities. Those who openly challenge the crackdown on judicial independence, undue restrictions on human rights, and the rise of xenophobic far-right nationalist groups are threatened with detention, arrest and prosecution for the