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HOLOCAUST SURVIVOR STUDIES IN THE CONTEXT OF PTSD

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This article highlights the emotional problems of Holocaust survivors from a historical point of view. We focus on the experiences we have had with the survivors in the United States, our discoveries and recognition of the aftereffects of their traumatization, and, briefly, on harmonizing these observations with other contemporary studies of trauma.

Liberated survivors, finding themselves alone and feeling driven to reestablish families rapidly, sometimes made inappropriate choices. They tried to emigrate, reestablish some kind of security, and cover up or deny all their difficulties. When survivors finally found themselves in charity clinics connected with resettlement services and were informed that they could apply for restitution for damages to their health, they complained of physical symptoms and did not even think of mentioning emotional symptoms. Occasionally survivors mentioned that they had been beaten over the head and now suffered from headaches. It fell to some psychiatrists, particularly a few psychoanalysts, to recognize and describe what Niederland (1961) termed the "problem of the survivor." He told of a group of psychodynamically oriented psychiatrists and psychoanalysts who were reviewing and appealing "case after case" of claims that were rejected by the German restitution authorities. Among the therapists mentioned by Niederland were Bychowski, Eissler, Hammerschlag, and Schur. This paper is typical of early Holocaust publications containing descriptions of patients' complaints and persecution histories and explanations of the psychodynamics of the damaging experiences. A parallel process was going on in Germany, where a group of leading psychiatrists had been struggling to change the prevailing organic-descriptive orientation. By their own reports, and by reviewing for the restitution authorities the case evaluations sent in from outside Germany, they were implementing changes in attitude and procedure.

It took a few years for survivors to settle down and reestablish a (family) life pattern before they could renounce the denial and numbness. The emerging descriptions of survivors' problems helped both to shape awareness of the post-traumatic pattern and to form a prototype of what came to be recognized as PTSD in DSM-III. They also helped prepare us for understanding Vietnam veterans and other populations of trauma survivors (Cohen, 1985; Hoppe, 1971). Lifton's (1963) work on Hiroshima survivors was useful as well; in fact, he participated in workshops on the Holocaust that were held at Wayne State University (Lifton, 1968). As a result of this and other parallel efforts to understand the problems of Holocaust survivors, symptoms could be clustered into chronic anxiety and startle reactions (or hypervigilance), and dysphoric reactions in which depression was predominant. We also began to discern problems of survivor guilt and shame, a gradually increasing freedom to vent anger, and results of the destruction of basic trust (Chodoff, 1980; Krystal & Niederland, 1968; Niederland, 1968).

Some authors also pointed to disturbances of memory: amnesias, hyperamnesias, and disturbances of consciousness, which in retrospect we later recognized as trances (Jaffe, 1968; Niederland, 1968). In addition, they were hearing about nightmares (but, for complex reasons, not flashbacks), sleep disturbance, and the connection of nighttime symptomatology with bad (depressed, anxiety-filled) days that followed. We found that depressive reactions were related to multiply-determined masochistic life-patterns. Study proceeded to problems of treatment, the dynamics of specific experiences in the context of traumatic situations (with acknowledgment of pretrauma history), the psychic reality of the experience, and the vicissitudes of the survivor's life after liberation (Hoppe, 1968; Tanay, 1968).

However, at the same time we still struggled with models of traumatic neurosis left over from World War I and general psychoanalytic concepts that had not been changed since Freud's formulations. We had to reconsider the nature of trauma, of the "stimulus barrier," even of affect. Much of the psychoanalytic conception of affect was still dominated by the economic point of view of psychoanalysis, and gradually a literature had developed in which affects were recognized as the organism's system of signals. By changing this view, we could identify the genetic history of affects and find the developmental paths of affect differentiation, verbalization, and desomatization. We could then see that unlike the infantile form of affects, which was mostly a somatic reaction, the adult form had cognitive, physiological (customarily called *expressive*), hedonic, and activating components. The hedonic component had

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to be reviewed. The problem of anhedonia, and the discovery of a complex anatomical and physiological system of pleasure regulation, forced us to realize that pleasure is not synonymous with gratification, nor pain with suffering. We thus gained a new model for pain addiction by realizing that pain can be accompanied by unconscious gratification. This new view of consciousness led us to believe that the idea that mental content was conscious or not conscious was too simplistic and that there were several spectra along which consciousness varied. The same step made it possible to recognize the Holocaust survivor's emotional responses and behavior in analytic treatment as alexithymia. Alexithymia involves a regression in affects, so that they are not useful as signals to oneself in information processing and one tends to resort to operative thinking. Such patients cannot associate or use dreams in therapy and cannot name or locate their emotions. Consequently, they also have a greater predisposition to psychosomatic illnesses and addictions. They are unable to soothe or regulate themselves, as they feel this function is reserved for their primary love object. Their affect tolerance is impaired because they experience affects as signals of the return of trauma and are not able to keep emotion within a tolerable range of intensity, or, recognizing their own feelings, use them in information processing. The kind of transference they form is an idolatrous one, with much preverbal content and regressed development of the transitional process (Krystal, 1988).

As a result, most severely posttraumatic patients do better in group therapy than in individual therapy. Danieli (1989) helped pioneer the integration of group, family, and community therapy into the comprehensive treatment of Holocaust survivors. Reviews and bibliographies on the intergenerational transmission and treatment of the psychological effects of the Holocaust on survivors' offspring (children born after the war) can be found in Sigal and Weinfeld (1989) and Steinberg (1989). Danieli's (1988) descriptions of the impact of the postwar conspiracy of silence between survivors, their children, and society, including mental health professionals, and of the heterogeneity of adaptation and quality of adjustment of families of survivors, caution against the simple grouping of individuals as "survivors" who are expected to exhibit the same "survivor syndrome." Danieli (1985) provides detailed descriptions of at least four differing adaptational styles of survivors' families—Victim families, Fighter families, Numb families, and families of "Those who made it."

There has been an important self-psychological view of the Holocaust and recovery, represented in the work of Ornstein (1981) and Laub and Auerhahn (1989). There also have been observations on the aging process, which can be difficult for survivors (Krystal, 1991, 1993; Ornstein, 1981). Krystal's (1991, 1993) conception of posttraumatic alexithymia predicts increased depressive and psychosomatic symptoms as survivors age because they cannot grieve effectively. The careful sociological research of Harel et al. (1993) indicates that contemporary factors such as the availability of and capacity for social engagement, as well as the ability to confide and stay involved, are important factors in determining the nature of the aging process. Results such as these suggest why alexithymia is a devastating problem, namely because it produces emotional isolation by impairing self-insight and the capacity for using affects to empathize with others.

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LIFTON, R.J. (1963). **Psychological effects of the atomic bomb in Hiroshima.** *Daedalus, 92,* 462-497.

LIFTON, R.J. (1968). **Observations on Hiroshima survivors.** In H. Krystal (Ed.), *Massive psychic trauma* (pp. 168-189; discussion, pp. 189-204).

SELECTED ABSTRACTS

CHODOFF, P. (1980). **Psychotherapy of the survivor.** In J.E. Dimsdale (Ed.), *Survivors, victims and perpetrators: Essays on the Nazi Holocaust* (pp. 205-218). Washington: Hemisphere. Chodoff has written a number of important papers about Holocaust survivors, the best known being a 1963 paper that helped shape the conception of the posttraumatic syndrome. However, we chose to abstract his 1980 paper because it focuses on problems of therapy. Based on his experiences, Chodoff feels that psychoanalysis is not applicable. This challenging point suggests many areas that need to be explored to help us understand the nature of the deformation of psychic structures and the function of affects. Chodoff states that survivors cannot use psychotherapy because of the destruction of their "basic trust" and the retroactive idealization of their childhood experiences. Regression is experienced as too dangerous for fear of the return of the traumatic state. He sensed that survivors' need to suffer was an expression of an unconscious need to "rescue their dead from the limbo of insignificance." Indeed, the need to be an angry and suffering "witness" is contrary to any motivation for relief. [HK]

COHEN, J. (1985). **Trauma and repression.** *Psychoanalytic Inquiry, 5,* 163-189. Cohen asserts that psychoanalysts' concept of neurotic repression does not fit the phenomenology or the dynamics of psychic trauma. In trauma it is conceivable that the destructive mental element cannot be registered, but is subjected to what Cohen came to call "Primal Repression." Utilizing the work of Matte-Blanco, Klein, Kardiner, and his own work with Kinston, he proposed that primal repression is the precursor of repression proper and is the *essence* of the traumatic state, characterized by loss of effective functioning, diffuse aggression, severe anxiety, inability to sleep or dream, and physiological disturbance. Cohen then proposes the "hole metaphor." The patient may have to test the therapist by provoking a life-endangering situation before he or she can dare to confront the "hole" containing the traumatic wound. [HK]

DANIELI, Y. (1985). **The treatment and prevention of long-term effects and intergenerational transmission of victimization: A lesson from Holocaust survivors and their children.** In C.R. Figley (Ed.), *Trauma and its wake. Vol. I: The study and treatment of post-traumatic stress disorder* (pp. 295-313). New York: Brunner/Mazel. The heterogeneity of responses of families of survivors to their Holocaust and post-Holocaust life experiences, described within and beyond the current notions of post-traumatic stress

disorder, emphasizes the need to guard against expecting all victim-survivors to behave in a uniform fashion and to match appropriate therapeutic interventions to particular forms of reaction. Four differing adaptational styles of survivor's families – the Victim families, Fighter families, Numb families, and families of "Those who made it" – illustrate life-long and intergenerational transmission of Holocaust traumata and ensuing conspiracy of silence. The discussion delineates the meanings of the victimization rupture, preventive and reparative goals, and principles and modalities of treatment (professional and self-help) of the long-term effects of the traumata. Highly needed training, which is traditionally absent, should include working through therapists' "countertransference" difficulties. [Adapted from text]

DANIELI, Y. (1988). **Confronting the unimaginable: Psychotherapists' reactions to victims of the Nazi Holocaust.** In J.P. Wilson, Z. Harel & B. Kahana (Eds.), *Human adaptation to extreme stress: From the Holocaust to Vietnam* (pp. 219-238). New York: Plenum Press. To explore psychotherapists' participation in the "conspiracy of silence" about Holocaust experiences in treating survivors and their children, this study identified and systematically examined 49 countertransference reactions and attitudes reported by 61 psychotherapists. It also compared therapists who were survivors or children of survivors and therapists who were not victims of, or children of survivors of, the Holocaust. The finding that *Holocaust stories* seemed to be the source of these reactions led to the concept of *event countertransference* crucial to training. [YD]

DANIELI, Y. (1989). **Mourning in survivors and children of survivors of the Nazi Holocaust: The role of group and community modalities.** In D. Dietrich & P. Shabad (Eds.), *The problem of loss and mourning: Psychoanalytic perspectives* (pp. 427-460). New York: International Universities Press. Tracing Holocaust and post-Holocaust historic and psychological obstacles to mourning, the article describes: the goals and multiple treatment modalities of the Group Project for Holocaust Survivors and their Children, emphasing the unique reparative and preventative value of group; and technical issues such as use of the family tree, language, meanings of setting, medications and survivor guilt, and illustrative case material. [YD]

EITINGER, L. (1971). **Organic and psychosomatic aftereffects of concentration camp imprisonment.** *International Psychiatry Clinics, 8,* 205-215. Eitinger has been studying the problems of Jewish and non-Jewish concentration-camp survivors for almost 40 years, and it is difficult to pick one paper that best illustrates his views. Very early, he was part of the Scandinavian group, which looked for the aftereffects of starvation and physical injuries. He reports on 226 Norwegian concentration-camp survivors. Almost all (99%) had "psychic deviations," including: poor memory and inability to concentrate, nervousness, irritability, restlessness, increased fatigue, sleep disturbances, loss of initiative, anxiety phenomena, emotional liability, dysphoric moodiness, vertigo, and nightmares. In this paper, Eitinger tries to distinguish those aftereffects that are due to neurological injuries from the psychologically caused aspects of the concentration-camp syndrome. He concludes that prognosis is dismal in survivors with persecution-connected personality changes. [HK]

HAREL, Z., KAHANA, B. & KAHANA, E. (1993). **Social resources and the mental health of aging Nazi Holocaust survivors and immigrants.** In J.P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 241-252). New York: Plenum Press. The authors compared the well-being of four samples, each with over 150 individuals: Holocaust survivors and "immigrants" in the United States and Israel. They measured the correlation of well-being with indicators of social affiliation, social interaction, self-disclosure, and social support given and received. Holocaust survivors engaged in more social interactions and reported a higher frequency of self-disclosure than did controls. Relative to controls, survivors also were more likely to lend support to others and to receive less support from others. The authors concluded that aging Holocaust survivors are doing very well in terms of social networks, social interaction, self-disclosure, and social support. The authors suggest that the availability of social support and of communication with members of one's primary group and friends are important contributors to higher levels of psychological well-being. [HK]

HOPPE, K.D. (1968). **Re-somatization of affects in survivors of persecution.** *International Journal of Psycho-Analysis, 49,* 324-326. In Hoppe's study, 144 out of 145 patients had psychosomatic symptoms, regardless of age, sex, sociocultural background, or psychiatric diagnosis. Hoppe studied these symptoms in relationship to anger, depression, withdrawal, and anxiety. He distinguished between psychosomatic *reactions* such as tension headaches, insomnia, and gastrointestinal disturbances, and psychosomatic *disorders* like asthma, peptic ulcer, and hypertension. Hoppe proposed two pathways by which these conditions originate: a spectrum of desomatization to resomatization, and a spectrum of sublimation to regression. His data suggested that resomatization and psychosomatic illness are correlated with aggression, identification with the aggressor, hate addiction, survivor guilt, shame, permanent mourning, loss of self-esteem, and loss of basic trust. However, individuals who are able to express some emotion and to use some sublimation tend to develop psychosomatic symptoms but not major resomatization and illness. [HK]

HOPPE, K.D. (1971). **The aftermath of Nazi persecution reflected in recent psychiatric literature.** *International Psychiatry Clinics, 8,* 169-204. This survey reviews English and German publications. The German literature contains the most comprehensive and detailed studies in this field. The survey is organized under the following headings: pathogenesis, symptomatology, and diagnosis; psychodynamics; psychosomatics and psychosocial studies; rehabilitation and psychotherapy; legal considerations and experts; related contributions. [Adapted from text]

JAFFE, R. (1968). **Dissociative phenomena in former concentration camp inmates.** *International Journal of Psycho-Analysis, 49,* 310-312. Although many authors have commented on spontaneous dissociative phenomena in concentration-camp survivors, Jaffe was the first to describe them so carefully that one can see the elements of trances in these cases. She refers to "short attacks" during which the contact with the outer world is disturbed. In other attacks, the experience of the trance impinges on reality, resulting in a double consciousness. In severe cases, which Jaffe calls "quasi-psychotic," the trances may last longer and be accompanied by delusions or hallucinations. Explaining these phenomena in psychoanalytic terms, Jaffe emphasizes the weak ego-defenses of such patients and links this weakness with a psychic "closing off," or constriction, of cognition, resulting in a robot-like state. She adds the insight that these traumas may be associatively linked with infantile material and that such phenomena may make their appearance in psychoanalytic treatment. [HK]

KRYSTAL, H. (1988a). **Integration and self healing: Affect, trauma, alexithymia.** Hillsdale, NJ: Analytic Press. This book represents the reworking of 18 papers that I published between 1974 and 1987, in which I went through psychoanalytic concepts related to trauma. Many old concepts were developed (and suitable) for working with "good neurotics," but were not appropriate for therapy with posttraumatic, alexithymic, anhedonic, psychosomatic, or drug-dependent patients. Probably the greatest obstacle was our attachment to metaphors derived from the economic point of view, which made us look at emotions as a means of discharge of drives (into the body) and interfered with the view of affects as the major component of our signaling and information-processing system. I studied adult catastrophic trauma as the state of submission to unavoidable danger. A key point is that fear and anxiety are signals of avoidable danger and are activating. Once the subjective evaluation of total helplessness is made, the affect changes to the catatonic reaction. The residue of the fear of affects as the signal of the return of trauma causes a regression in the form of affects back to the infantile one, and we then see alexithymia and operative thinking. In J.H. Krystal's chapter on assessing alexithymia he advocates early diagnosis because alexithymic patients may not be able to use psychoanalytic psychotherapy. The rest of the book is devoted to considerations of individual psychotherapy. [HK]

KRYSTAL, H. (1988b). **On some roots of creativity.** *Psychiatric Clinics of North America, 11,* 475-491. Descriptions of alexithymia uniformly include statements that it consists of two components: an affective one, in that the patients cannot recognize, name, or even localize their emotions; and a cognitive one consisting of operative thinking, in which their thoughts are thing-oriented. Many survivors of adult catastrophic trauma, especially Holocaust survivors, are unable to verbalize, which is why they have such high rates of psychosomatic and other illnesses. In this paper I addressed a different aspect of the alexithymic problem that I had described in my 1988 book but did not then understand. Alexithymic patients also have a severe inhibition in regard to wish-fulfillment fantasies, particularly those that might be involved in self-solace. The early transitional object precursors simply provide the same physiological effect as the mother does. But as the child grows, caregivers help to make the transitional objects more abstract, symbolic, artistic, and sophisticated. The very young child learns to accept a lullaby or a story as a soother, and as he grows he is encouraged to be creative and to produce things that make the creator and the object feel good. On this process hangs not only much of our ability for sublimation and creativity, but most important, our ability for self-solace, self-care, and wish-fulfillment fantasy. [HK]

KRYSTAL, H. (1991). **Integration and self-healing in posttraumatic states: A ten year retrospective.** *American Imago, 48,* 93-118. In this paper I focus on the relationship of certain posttraumatic constellations to survivors' revision in old age of their evaluation of their life, in an attempt to show that the major task of senescence is identical with that of psychoanalysis or psychoanalytic psychotherapy. [HK]

KRYSTAL, H. (1993). **Beyond the DSM-III-R: Therapeutic considerations in posttraumatic stress disorder.** In J.P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 841-854). New York: Plenum Press. In order for psychotherapy to be fully successful, it is necessary for the traumatized patient to form a therapeutic alliance and rebond in a trusting relationship characterized by empathy. One difficulty in treatment is that the presence of anhedonia and alexithymia may prevent the patient from identifying and confronting feelings that were defensively numbed for purposes of survival. Furthermore, the layers of defense associated with affect regulation may be so strong that the victim fears that by letting go of them, he or she will be rendered vulnerable again and regress back to a catatonic state approximating death itself. In such a case there is often little transference that would permit systematic interpretation and working-through of traumatic material. [HK]

KRYSTAL, H. & NIEDERLAND, W.G. (1968). **Clinical observations on the survivor syndrome.** In H. Krystal (Ed.), *Massive psychic trauma* (pp. 327-348). New York: International Universities Press. To form a clinical profile of survivors, we examined 149 consecutive cases seen by the first author (HK) in therapy. Virtually all patients (97%) presented anxiety as their most persistent problem: chronic worry (39%), hypervigilance and multiple phobias (77%), diffuse fears about the return of the traumatic state (31%), and a general expectation of catastrophe (24%) were also seen. Sleep disturbances of some kind were mentioned by all patients. Closely related to those phenomena were disturbances of consciousness, cognition, and memory. Chronic depression and marked masochistic trait disturbances were found in 79%. Survivor guilt was a "given"— a background to their lives that was taken for granted and not talked about. Self-reproach for not having saved someone close could virtually always be found, but generally was covered by the "conspiracy of silence." The history of pre-persecution adjustment was a factor in the selection of adjustment pattern, and especially, a history of pre-persecution mental illness seriously worsened the present status and prognosis. We also saw many psychosomatic diseases. [HK]

LAUB, D. & AUERHAHN, N.C. (1989). **Failed empathy — a central theme in the survivor's Holocaust experience.** *Psychoanalytic Psychology, 6,* 377-400. This article argues that massive failure of the environment to mediate needs will throw into question the existence of empathy, human communication, and ultimately one's own humanity, to which any mirroring ceases to exist. Such a life experience will represent, to the trauma survivor, failure of a responsive empathic agent or function. Because representations of need-satisfying interactions provide the basis for links between personal existence and social connectedness, undermining the individual's representation of need-mediating context will deconstruct the link between self and other. Deconstruction of the victim's reconstructional matrix of interpersonal relatedness results in a vulnerability and loneliness in his or her internal world representation which is the *sine qua non* of human-made trauma. [Adapted from text]

NIEDERLAND, W.G. (1961). **The problem of the survivor: The psychiatric evaluation of emotional disorders in the survivors of Nazi persecution.** *Journal of the Hillside Hospital, 10,* 233-247. Reprinted in: H. Krystal (Ed.), *Massive psychic trauma* (pp. 8-22). New York: International Universities Press. This paper will consider, from a psychiatric and psychodynamic point of view, some of the medical, mental, and social problems encountered among the survivors of former German concentration camps and other forms of persecution (years of hiding, of physical and mental uprooting, emotional and intellectual erosion, etc.).

NIEDERLAND, W.G. (1968). **Clinical observations on the "survivor syndrome."** *International Journal of Psycho-Analysis, 49,* 313-315. Niederland observed that patients limit their sleep out of fear of their dreams, which re-run the oppression too vividly for them to bear. He also comments on other symptoms: chronic depressive states and masochistic character changes related to

specific traumata such as loss of children and history of rape; isolation, withdrawal, and seclusion; "psychotic" and "psychotic-like pictures," which are more in the nature of periodic "waking dreams or reliving something" rather than a "process schizophrenia"; and psychosomatic illnesses. He considers the "living corpse" and "shuffling corpse" to be of great importance, especially as evidence of the aftereffects of confrontation with death and a form of "death imprint." He explains that many patients hide their problems under a "somatic mask," but the alterations of the ego are much more profound than is generally recognized. Failing to understand these profound changes represents further traumatization, and Niederland cautions that we must keep this problem in mind in preparing to handle future trauma victims, including disaster victims [HK].

ORNSTEIN, A. (1981). **The effect of the Holocaust on life-cycle experiences: The creation and recreation of families.** *Journal of Geriatric Psychiatry, 14,* 135-154. The author emphasizes the recuperative powers of the human psyche. She highlights survivors who adjusted to the conditions of the camps while preserving the core self. She finds that in nonclinical groups of survivors there are recollections of small groups that were involved in intense mutual protectiveness. Moreover, the group relationships continued after the war. Having such a group, particularly if a member knew one's family, helped to maintain the sense of nuclear self. Having preserved one's intactness, both psychologically and physically, made it possible to resume parenting function, actual or vicarious, and thereby facilitated psychological recovery. Although Ornstein's comments are very important and helpful, they seem to refer to transports of survivors who had not arrived in Birkenau totally devastated and regressed by four years in a deadly ghetto. People who were relatively intact indeed were able to support each other and prevent the onset of potentially deadly catastrophic trauma. [HK]

SIGAL, J.J. & WEINFELD, M. (1989). **Trauma and rebirth: Intergenerational effects of the Holocaust.** New York: Praeger. We are struck by the variability in the survivors' experiences and in the degree to which they, and certainly their children, have overcome the traumas of the past. In this observation we present a counterpoint to most of the clinical and academic literature on Holocaust survivors, which has emphasized impairment or dysfunction. This book consists primarily of findings drawn from two sample surveys of Jewish residents of Montreal. One survey focused on Holocaust survivors; the other, on children of survivors. Both included control groups, and both were drawn from unbiased, nonclinical, and non-self-selected populations. [Adapted from text]

STEINBERG, A. (1989). **Holocaust survivors and their children: A review of the clinical literature.** In P. Marcus & A. Rosenberg (Eds.), *Healing their wounds: Psychotherapy with Holocaust survivors and their families* (pp. 23-48). New York: Praeger. This review emphasizes the different ways psychotherapists over the years have conceptualized survivors' symptoms and clinical intervention. The earlier literature often focused on the psychopathology of survivors and their children while more current publications emphasize the adaptive potential and strengths of survivors and their families. [Adapted from text]

TANAY, E. (1968). **Initiation of psychotherapy with survivors of Nazi persecution.** In H. Krystal (Ed.), *Massive psychic trauma* (pp. 219-233). New York: International Universities Press. Few survivors request psychotherapy, and even fewer participate in it. The survivor has to be "seduced" into treatment by the therapist. Even a single interview is quite distressing for both patient and therapist, and many patients are reluctant to discover the depth of their hurt because they think of such a possible discovery as a "victory for Hitler." The impact on the therapist may be so painful as to set up an unconscious resistance against taking on such patients. The therapist has to develop tolerance for the patient's suffering. Vigorous efforts to alleviate symptoms in the initial stages will lead to an abrupt termination of the therapeutic relationship. The most important obstacle to psychotherapy is the patient's aggression, which is experienced as extremely destructive, and in the transference may give rise to fears of destruction of the therapist or of the patient's self. [HK]

A useful source of information about the Holocaust:

EITINGER, L. & KRELL, R. (1985). **The psychological and medical effects of concentration camps and related persecutions on survivors of the Holocaust: A research bibliography.** Vancouver: University of British Columbia Press.

COMMENTS ON THE LACK OF INTEGRATION BETWEEN THE HOLOCAUST AND PTSD LITERATURES

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Drs. Krystal and Danieli provide an insider's view of the events that led to the clinical literature's recognition and description of the "survivor syndrome." They also describe the struggle to develop a suitable intellectual and clinical framework for discussing the aftereffects of this trauma. This review shows that early descriptions of the "survivor syndrome" arose as clinicians began to realize that classical psychoanalytic views of depression, mourning, and responses to trauma did not provide an adequate framework for understanding and treating Holocaust survivors.

The development of the Holocaust literature provides an interesting paradigm for understanding how ideas about trauma exposure and its aftermath evolved over time, and specifically, how these ideas became incorporated into the intellectual framework that gave rise to the diagnosis of PTSD. It also is interesting to track the parallel development of the Holocaust literature with the non-Holocaust PTSD literature, and to note that these two bodies of work are by no means synonymous.

There are several noteworthy observations to be made. First, the literature reacts to descriptions of the profound impairment resulting from extreme human sadism and trauma by providing counterbalancing descriptions that may mitigate the role of the stressor in favor of other factors that actually serve to exacerbate a stressor's impact. Second, there appears to be a reluctance to "cross-foster"

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information about the aftereffects of the Holocaust with the aftereffects of other traumatic events. Third, despite attempts to describe the unique characteristics and sequelae of particular traumas, parallels between these and adaptations to other traumas do emerge, and do, in the end, serve to validate the constructs that led to the development of PTSD. We expand on these points below.

One of the most striking features of the Holocaust literature is that it contains a rather polarized spectrum of opinions regarding the long-term effects of the Holocaust on survivors. Only a few authors have attempted to describe heterogeneity among survivors, most notably Danieli (1980) in her account of differing types of survivor families. Nonetheless, the literature as a whole presents diverse opinions that have not arisen simultaneously. The Holocaust literature began with classic observations describing severe symptomatology, maladjustment, and impairment of functioning in treatment-seeking individuals, many of whom were being evaluated for compensation (e.g., Chodoff, 1963; Eitinger, 1961; Krystal, 1968). In contrast to these findings, a literature arose describing exceptional coping skills among survivors and focusing on predictors of subsequent well-being, particularly in non-clinical populations (Dimsdale, 1974; Harel et al., 1988; Leon et al., 1981). These studies focused on the remarkable adaptive and reintegrative capacities of Holocaust survivors, who demonstrated good social and family functioning, high socioeconomic achievement, good coping skills, and other personal achievement. Interestingly, the describers of coping and resilience chose to call into question the earlier observations of impairment (Harel et al., 1988) on methodological and other grounds rather than resolve the diversity of opinions by acknowledging the broad spectrum of responsivity to trauma (see Danieli, 1994).

Perhaps in partial response to the psychosocial literature, observations of severe impairment in Holocaust survivors have now been noted in nontreatment-seeking Holocaust survivors (Eaton et al., 1982; Nadler & Ben-Shushan, 1989; Rosen et al., 1991). However, even in this literature, there really has been no systematic or scientific attempt to account for the wide diversity of opinions about the aftereffects of the Holocaust. That is, what appears to be conspicuously absent from the Holocaust literature are references to PTSD, especially in articles that have been published after 1980. The heterogeneity that is reflected in the Holocaust literature is compatible with (and may have contributed to the development of) the now well-established idea that the long-lasting effects of trauma, as reflected by the presence of PTSD, appear in some, but not all, severely traumatized individuals. Only a few studies to date (Kaminer & Lavie, 1991; Kuch & Cox, 1992; Yehuda et al., 1994) have applied the formal diagnostic criteria for PTSD to Holocaust survivors. However, if Holocaust survivors had been considered from the vantage point of either having or not having post-traumatic stress syndrome, this might have helped clarify prior observations of other aspects of post-traumatic adaptation, such as affect dysregulation, character changes, psychiatric comorbidity, and resilience, and might have provided a more cohesive literature.

Why has the Holocaust literature tended to bypass arguments about heterogeneity that might have resulted in an integration of some of these ideas? There is no certain answer to this question; however, McFarlane has proposed (personal communication) that the lack of integration between the Holocaust and PTSD literatures might be due to the unique nature of the Holocaust itself. In particular they have suggested that the lack of integration may have arisen because the Holocaust literature not only documents the effects of extraordinary adversity on individuals but also can be seen as a testament to racial persecution. The literature is therefore in part a record of the cultural experience of the Jews, a record which, whether intentional or not, can be influenced by a series of social and political forces. On the one hand, there is a need to document the horrors of racial prejudice, and on the other, to demonstrate the dignity of the Jewish people and its capacity to survive. To describe Holocaust survivors as vulnerable, particularly if this has biological dimensions, is to document traits similar to the ones that were actually used to justify the extermination of the Jews. To mitigate the scars of the Holocaust is equally problematic. These complex forces may have added to the difficulty of clinicians and researchers to embrace emerging concepts about psychiatric illness, particularly PTSD, to describe the experience of Holocaust survivors.

This, of course, leads to another point about the relative compartmentalization of the Holocaust literature. It is inarguable that the Holocaust was a trauma of absolute catastrophic magnitude. As a result, describers of the Holocaust and its aftermath may have been reluctant to compare this event to other traumas. For writers who are not themselves survivors, it may have been equally difficult to assert that the Holocaust was comparable to other traumatic events, for fear of minimizing the suffering of those who survived the Holocaust, and risking that survivors would feel diminished and misunderstood. In this regard, it is significant that the early describers of Holocaust survivors did not attempt to build on earlier observations of war neurosis or combat fatigue. True, these early observations were obviously known and sometimes even referenced by the describers of the Holocaust. However, the references to writings describing "combat fatigue," "traumatic neurosis," or "shell shock" were usually in the context of explaining how these descriptions were, at best, incomplete analyses of the aftermath of the Holocaust. For example, Krystal (1968) concluded that existing nosological categories were not appropriate for characterizing concentration-camp survivors and that the impact of the Holocaust is far more diverse and multivaried than has been contained in previous descriptions.

Ironically, however, despite the reluctance of the Holocaust literature to build on observations that may have predated the Holocaust, this literature has been an important influence on post-Holocaust observations. The paradox here is that although describers of the Holocaust may not have seen the relevance of observations about WWI or

WWII combat veterans, they did see how describing the aftermath of the Holocaust would be relevant to describing the aftermath of traumas of lesser magnitude than the Holocaust. For example, Krystal and Niederland (1968) assert, "We have reason to believe that our observations apply to victims of natural disaster. In the end, we hope that the knowledge gathered will be useful in the treatment and prevention of massive traumatization in general" (p. 348). In this context we can probably also credit the Holocaust literature for allowing researchers and clinicians to better understand the distinctness of stress and trauma.

It has largely been left to clinicians who are not Holocaust survivors to dissect out the generic relevance of the Holocaust-related observations. In response to Eitinger's (1985) seminal ideas of the possible biological basis of the concentration-camp syndrome, Kolb (1985) implored clinical researchers to consider the biological aspects of concentration-camp syndrome in the context of the older term of "physioneurosis." Kolb also makes a plea for cross-fostering of the Holocaust literature with other observations of trauma, saying "[W]e should compare the psychopathology of the stress disorders...derivative from a variety of catastrophic experiences of varying intensity" (p. 121). This type of forward thinking has led to the establishment of a diagnosis that bypasses the particular type of trauma sustained in favor of emphasizing the general nature of post-traumatic adaptations.

Despite the fact that literatures about the effects of particular traumas occurred in parallel ways, there are commonalities in the way these literatures have evolved that have paved the way for an integrative approach to the study of the trauma. For example, as Krystal and Danieli note, initial observations of the survivor syndrome focused on describing the clinical symptoms of severely affected treatment-seeking patients who often found themselves in charity clinics and who were usually evaluated by mental health professionals in the context of evaluation for restitution. This is reminiscent of the initial observations of WWI and WWII veterans, and later of Vietnam combat veterans, that were also made in the context of evaluating VA patients who are severely disabled, unlikely to seek help in the private sector, and looking for compensation.

Our current work with Holocaust survivors is really aimed towards viewing the survivor with a lens similar to that which we have used in studying war veterans. Specifically, we hope to utilize the diagnosis of PTSD to subgroup Holocaust survivors. Although it might be argued that they are substantially different from Vietnam combat veterans in several regards (e.g., length of time since the focal trauma, nature and severity of the trauma, occupational functioning of survivors, incidence of substance abuse, etc.) we believe that it is essential to study Holocaust survivors with the same paradigms — both descriptive and biological — that have been used to study veterans in an attempt to further explore both the similarities and differences between these two groups. To the extent that there are commonalities in behavioral and neuroendocrine parameters between Holocaust survivors and other groups of trauma survivors, these variables explain core features of the post-traumatic syndrome. Also, to the extent that there are differences between groups of trauma survivors that are based on the nature of the trauma in such parameters, the findings may be less applicable to features of the general response to trauma. This type of approach allows an operational scientific perspective with relatively unbiased observation, and is hypothesis-driven.

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