McGILL UNIVERSITY

THE HOLOCAUST SURVIVOR"S EXPERIENCE OF DEATH AND DYING: A MODEL FOR SOCIAL WORK ASSESSMENT AND INTERVENTION

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M. D. F.

ABSTRACT

This paper investigates whether or not the experience of survivors of the Holocaust through the dying process follow the stages and tasks of dying as defined in the theoretical literature and the ramifications this has for the social worker serving these individuals and their families. The methodology employed was a library search to overlay the literature on death and dying upon the literature concerning Holocaust survivors. The study concludes that, for the most part, there is little congruence between the theories of dying and the coping mechanisms of the Holocaust survivor and that a different model of death and dying is required for this population. In order to provide a preliminary model and guide workers who might encounter terminally ill survivors and their families as patients and clients, approaches for engagement, assessment, and intervention are proposed and analyzed.

RÉSUMÉ

Le présent document examine si l'expérience des personnes ayant survécu à l'holocauste obéit au processus des tâches et des étapes terminales de la vie telles qu'elles sont définies dans la documentation théorique. Il étudie également les tenants et les aboutissants pour les travailleurs sociaux qui s'occupent de ces personnes et de leurs familles. La méthode employée a consisté dans la recherche documentaire afin d'établir un parallèle entre la littérature sur la mort et le mourir, et celle qui concerne les survivants de l'holocauste. L'étude conclut que, dans l'ensemble, il y a peu de concordance entre les théories du mourir et les mécanismes d'adaptation des survivants de l'holocauste, et qu'il faut élaborer un autre modèle de la mort et du mourir pour cette population. Afin de fournir un modèle préliminaire et d'orienter les travailleurs qui devront s'occuper de personnes en phase terminale et de leurs familles en tant que patients et clients, nous proposons et analysons des approches de participation, d'évaluation et d'intervention.

I. INTRODUCTION

I i. Rationale for the Study

The genesis of this study lies in the author's clinical experience in palliative care. It was from this vantage point that the research question was generated. The author observed that, in many cases, survivors of the Holocaust appeared to exhibit different coping abilities than other patients when encountering death and the dying process. It also appeared that Holocaust survivors did not engage in certain aspects of the process of dying that appeared in the literature. Thus was the research question formulated. Does the experience of survivors of the Holocaust through the dying process follow the stages and tasks of dying as defined in the theoretical literature? If these patients do not fit into the categories proposed by the theoretical literature, what is the impact of this upon the assessment and intervention of the social worker for these patients and their families?

I ii. Death and Dying Literature

In 1969, Dr. Elizabeth Kubler-Ross published her groundbreaking work, *On Death and Dying.* This represented a major step in the study of death as Kubler Ross' work attempted to delineate the stages a person traverses throughout the dying process. This was the first systematic exploration of the range of feelings and reactions a terminally ill individual experiences. Kubler-Ross studied dying patients with whom she had worked and suggested an approach for understanding these emotions and reactions. From this initial effort followed the development of death and dying studies and theories.

In the first part of this paper, theories of death and dying will be examined. Beyond Kubler-Ross, theories of death and dying up to the present day will be discussed. This discussion is by no means exhaustive. However, those theories that will be explored have been chosen to represent the range of thought that has emerged on this subject over the past decade (e.g., Corr, 1992; Buckman, 1993, and Doka, 1993). Moreover, this discussion will include theories of current researchers in the grieving process, such as William Worden (2000) and Therese Rando (2000). In the case of Worden, he recently turned his attention to what is involved in having an appropriate death. Rando, on the other hand, has written concerning the anticipatory grief of the mourner and this material has been adapted by Rando for the dying patient.

Following the discussion of the various theories, there will be a brief critique of the theories. This critique will include a suggestion as to which theories may be most compatible with what the Holocaust survivor experiences when encountering terminal illness.

The second part of the paper will investigate the literature concerning survivors of the Holocaust and their responses to the traumatic events they lived through during World War II. Before this is discussed, it is important to briefly provide some information on the experiences these survivors actually underwent and witnessed.

I iii Holocaust Survivors and Their Experiences

When we look at the experiences of Holocaust survivors, the number and magnitude of the traumas inflicted upon them is simply overwhelming. Benz (1999) has examined the Holocaust and, in the process, recounts the Nazi's actions against the Jews. In Germany, Jews were declared second-class citizens in 1935. In 1937 and 1938, Jewish doctors and lawyers lost their licenses. On November 9, 1938, 7,500 Jewish shops were destroyed, millions of dollars worth of shop windows were smashed, and more than one thousand synagogues were destroyed. As of January 1, 1939, Jews were forbidden to run retail businesses and by 1941, they had been stripped of their civil rights as German citizens.

As eastern Europe was occupied by the Nazis, Jews were forced from their homes and placed in ghettos in order to concentrate the Jews in the larger cities. In 1942, ghetto inmates began to be deported to concentration camps or were murdered in mobile gas vans. Those who remained in the ghettoes were forced into slave labor for the German army and, in many cases, expired due to starvation. In some cases, instead of forced relocation to a ghetto, the Nazis simply massacred the Jewish population, e.g., the murder of more than 33, 000 Jews at Babi Yar outside the city of Kiev in the Ukraine (Benz, 1999).

In order to specify the kind of trauma Jews were exposed to during the Holocaust, the details of the Nazi roundups are instructive (Benz, 1999). First, a painstaking search of belongings took place and this consumed many hours. In one room, suitcases were searched and jewelry, money and other items were confiscated. In a nearby room, personal papers had to be handed over. Many Jews were left with nothing more than a wedding ring, a watch, and perhaps an identity card. In a third room, a humiliating body search was carried out. Every orifice in the body was examined to ensure that nothing was being smuggled out. In a fourth room, a writ of summons was issued making the property loss official and identity cards were stamped with the term ‘evacuated’ (Benz, 1999)..

The Jews being deported were led to believe that they were being sent east in order to be resettled. They were loaded on trains. The trip to the camps normally required two or three days. No food or drink was available and the deportees were tormented by the accompanying SS(Security Police) guards. Depending upon the camp, the Jews were forced to march to the destination from the train station. The SS guards often beat their prisoners.

The prisoners were housed in barracks that lacked any heat. The food was inadequate and the sanitary conditions were appalling. There were so many deaths that the corpses had to be burned upon funeral pyres (Benz, 1999).

The date of September 3, 1941 marked a turning point in the Nazi effort to exterminate the Jews. On that day, in the cellar of block 11 in the Auschwitz camp, The gas Cyclon B was first trialed in the killing of human beings. Massacres, shootings, and beatings were replaced by perfectly organized mass murder. In most cases, up to 90 percent of those who exited the transports were deemed unfit for work. These deportees were brought to barracks where they were forced to undress. They were led into what appeared to be shower rooms. They were actually gas chambers where they were put to death. Those who could work were placed into forced labour. Young, healthy men usually were kept alive to work; they would often never see their parents, sisters, wives, and daughters again (Benz, 1999).

The experiences described above reflect some of the most horrific and widely recognized aspects of Holocaust survivor history. These, however, do not represent the only narratives of survival.. Among some of the smaller camps, for instance, there was some resistance to Nazi subjugation. In the Sobibor camp in western Russia, the Jews revolted and succeeded in burning down the camp in 1942. In addition, there were other internment facilities aside from the concentration camps, most notably the forced labour camps; those who the Third Reich could utilize as labourers remained alive and were sent to these facilities. There was no systematic slaughter in these camps as the inmates were performing tasks to aid the Nazi war effort. This is not to say that the conditions in these camps were significantly better than those of the concentration camps. Many Jews also died in these camps, from disease, starvation, while others were shot by the German guards. Still, those chosen to work in these camps were not marked for immediate extermination and probably had, on the whole, a greater likelihood of survival than those in the concentration camps. For, as long as they could work, they were of some value to their oppressors.

Another group of survivors is made up of those who remained in the ghettoes in localities under Nazi control. In cities such as Lodz and Warsaw, Jews were restricted to these ghettoes and the conditions under which they lived were comparable to those found in the concentration camps. Nevertheless, there were certain ways in which these ghettoes differed from the concentration and labour camps. There was literary, educational, and cultural activity. There was a sense of community in these cities.. In addition, in the case of the Warsaw ghetto, there was opposition to the Nazis and their rule that culminated in an uprising of startling force (Hilberg, 1961; Hilberg, Staron and Kermisz,1979).

There exists another category of survivors who underwent a different experience during World War II. This group can be characterized as hidden survivors. They, too, saw their way of life irrevocably altered and many were forcibly separated from their families, most of whom they never saw again. However, these survivors fled from the Nazis. They were not incarcerated in German camps, although some were imprisoned in camps set up by the countries in which they hid, e.g., Russia. Many of these survivors were fugitives; they were constantly trying to remain a step ahead of the Nazis. Others, particularly young people and, in some cases, entire families, were hidden by non-Jews. Others escaped to locales in which they remained throughout the war. This writer has encountered a number of survivors who fled from Poland to Siberia and remained there until the war ended. There is also, for example, the well-known story of the refugees of Shanghai, China (see e.g., Hilberg, 1961, Guang, 2001). An entire group of German Jews escaped to Shanghai in the early 1940s. This was group was largely made up of people who had been unable to secure visas to countries in North and South America. They went east and traveled through Russia and found shelter in China. Many of these people immigrated to the West Coast of Canada and the United States after the war.

The effects of these horrendous traumas have been examined by numerous researchers as survivors have attempted to adapt to new surroundings and rebuild their lives. Here, as in the case of theories of dying, the review of the literature has by no means been exhaustive. Nevertheless, a number of major researchers and theoreticians will be discussed. While psychodynamic theories concerning the ongoing damage of traumatic experiences upon survivors have been utilized (Krystal, 1981), the major focus taken herein has been more in keeping with social work(Danieli, 1981, 1988; Rosenbloom, 1983, 1985; Kahana et al.,1988, 1993,1997; Botwinick,2000). Therefore, this paper has focused on survivors' interactions with others, in particular, with the members of their postwar families and with other caregivers. The effects of the Holocaust upon these relationships, as well as upon the general relationship with the outside world are quite significant and varied. Survivors have developed different means of coping with these effects. Nonetheless, this paper will not be strictly pathological in outlook. Survivors' strengths and resiliencies will also be part of this examination. Indeed, it is very important for the reader to understand that many survivors have shown tremendous adaptational capabilities and have created new lives for themselves.

I iv. Purpose of the Study

The main objective of this paper is to overlay the major components of theories of death and dying upon the experience of the survivor of the Holocaust and see if there is any congruence. In order to show this, the aspects of assessment of the dying Holocaust survivor will be presented with particular attention paid to the applicability of the frameworks of the dying process to this population. This is where the research question plays its greatest role and where the specific connections between the theories and the lives of survivors are most clearly visible. In order to provide guidance to workers who might encounter terminally ill survivors and their families as patients and clients, suggested interventions are also mentioned and elaborated upon. In the concluding section of the paper, the results will be summarized and areas and issues of further research will be proposed.

II. REVIEW OF THE THEORIES OF DEATH AND DYING

The first major attempt in recent times to develop a theoretical framework on death and dying was, as referred to above, the five-stage theory of Kubler-Ross(1969). Utilizing interviews with over 200 dying patients, Kubler-Ross postulated that the psychological response to dying involves five stages. These stages are denial, anger, bargaining, depression, and acceptance. Kubler-Ross believed that the dying person responds to the shock of news of an incurable illness by first, refusing to believe that it is true and denying the situation. The next stage is characterized by anger over this diagnosis. This anger may be directed at God, the physician, caregivers, and family members. It can be projected in any and all directions. In the following stage, that of bargaining, the person may try to obtain more time to live by making promises to God, to himself, or to others. This is followed by depression as the person comes to realize that the progression of the disease can no longer be denied. The fifth and final stage of acceptance may ensue, if time and assistance are provided sufficiently for the individual to work through the grief and sense of loss.

The idea of 'stages' is derived from childhood development theory and is appealing as it provides an orderly sequence to the unfolding of human experiences during dying. Yet, it is just this orderly progression which has yielded the most important criticism of this theory, that is, that stage-theory posits a mechanistic approach with every dying person progressing through these five stages. Moreover, albeit that Kubler-Ross (1969) indicates that a patient should not be rushed through these stages, nevertheless there appears to be an implicit suggestion that this process is resolved through arrival at a final reachable destination of 'acceptance'. Thus, the theory's descriptive element can be misinterpreted as prescriptive, and some health professionals have attempted to guide dying patients through the stages

(Pattison, 1977; Rainey 1988). Indeed, clinical practice has not yielded evidence to support a unidirectional movement of the dying process as is indicated by this theory. If anything, the movement is pendulum-like, moving back and forth. Kubler-Ross' work has also been criticized on the basis that it focuses solely on psychosocial dynamics, to the exclusion of the physical and spiritual dimensions (Corr 1992). Given the multifaceted elements of death and dying, this theory, while of great significance in raising consciousness about death and dying, appears quite limited.

A model which attempts to correct some of the perceived shortcomings in Kubler-Ross's theory is the three-stage theory proposed by R. Buckman (1993). Buckman contended that individuals, when facing impending death, respond in a way that is consistent with their character and their coping styles. For Buckman., patients' reactions are not a product of a particular stage or diagnosis. He argues that it is more useful to view a patient's emotions as sources of insight into their make-up. Moreover, such emotions are 'mosaic' in form, and most likely to occur simultaneously, not *in seriatum* as in the theory of Kubler-Ross (1969). Buckman also pointed out that several emotions and responses, e.g., guilt, hope, despair and humour, are commonly seen in clinical practice with the dying and their families and are not included in the Kubler-Ross model.

Two principles form the basis of Buckman's argument for this model. The first was referred to above: the concept that the mixture of emotions and responses manifested by a person facing death are characteristic of the individual, not the stage of the dying process. Second, during this process, the individual's progression is marked, not by a change or shift in the type of feelings experienced, but rather by resolution of the elements of those emotions that can be processed for closure.

Buckman's (1993) model posits an initial stage, a chronic stage, and a final stage. He calls the first stage, 'facing the threat'. It contains eleven emotions, e.g., fear, anxiety, shock, anger, denial, and hope. Buckman states that a person has passed through this stage when elements of these initial emotions have been resolved, with or without assistance. The chronic stage, named' being ill', may or may not occur. This depends on whether resolution of the person's emotions has been achieved as it does not refer to physical condition. If this resolution takes place, a kind of equilibrium, albeit time-limited, ensues. In those cases where this resolution does not take place and the chronic stage does not come into existence, Buckman (1993) suggests that the patient may need further help in finding emotional resolution. In this stage, the intensity of all emotions is diminished (Buckman describes this as the 'monochrome state'), and depression is very common. The final stage, 'acceptance' manifests itself through the experience of further diminished emotional intensity and is defined by acceptance of impending death. Buckman adds here, though, that this stage is not essential as long as the patient is not distressed, is communicating and making decisions in their normal fashion.

It appears that, at a micro level, Buckman has addressed a number of the limitations of the Kubler-Ross model, such as seeing emotions as reflecting the person rather than the stage they are in during the dying process. Nevertheless, as a theoretical model, this construct still is confronted with many of the criticisms expressed against conceptualizing the dying process through stages. At the macro-level, it appears 'mechanistic'. It is based solely on emotions/reactions of individuals. Thus, it approaches a multifaceted process, dying, in a one-dimensional fashion.

. C. A. Corr (1992) argues that, after the passing of more than a decade, it is essential to reexamine previous models and theories. Moreover, in order to do this, it is necessary to draw upon knowledge from other disciplines, such as grief and human behaviour studies. This knowledge, according to Corr, allows for a fresh look at how models guide our understanding of how individuals cope with the dying process.

Corr proposed a task-based approach to coping with dying as a paradigm for understanding the work of those who are dying and those who care for them. Corr posited that individuals who are dying confront four primary areas of task work. The first area is the physical realm. This relates to satisfying bodily needs and minimizing physical distress. The second area is the psychological one. This includes maximizing psychological security, independence, and richness of living. The third area is the social area. This involves sustaining and enhancing interpersonal attachments of significance to the person, and addressing the social implications of dying. The fourth area is that of spirituality. This concerns the need to identify, develop, and affirm sources of spiritual energy and to foster hope.

Corr (1992) pointed out that, in contrast to the phase-based model for bereavement work, this model operates from the perspective of individuals and their coping tasks. This is necessary as there is no single coping style among individuals and no single way of dealing with dying. Corr further argues that, although adapting to dying can take various forms and have various outcomes, the basis for conceptualizing this process should be the work done in the fields of coping and stress reduction. Corr adds that coping involves more than responding to life's events and challenges, it also includes an awareness of these events and challenges and planned efforts to confront them.

Another essential component of Corr's model lies in the basic premise that dying is not confined to the dying person. The experience affects all who play roles in the person's environment, family, friends, caregivers, and others. Corr contends that any model of dying must meet the following criteria: it should contribute to improved understanding, empowerment, participation and guidance for caregivers in coping with the dying process and the dying patient.

Indeed, the concept of tasks in this context is dependent upon the notion of active participation by the dying person and by those involved to assist in the process of coping. However, Corr (1992) proposed this theory on the underlying assumption that tasks are central and elemental to the fundamental concerns of those dying. There was no attempt to take the analysis to deeper levels. For example, Weisman (1992) pointed out the need to examine in more depth the different tasks and sub-tasks related to coping, particularly within the terminal phase. Issues requiring further analysis include the relationship between tasks and dying, and the nature and extent to which tasks of the dying process differ from those involved in regular, daily life.

Steinhauser, Clipp, McNeilly, et al., (2000) explored the observations of patients, families and caregivers as to perceptions of what constitutes a so-called 'good' death. Six themes emerged from this study: pain and symptom management, clear decision making, preparation for death, completion, contributing to others, and affirmation of the whole person.

Pain and symptom management reflected the participants' fears of dying in great pain. Bad deaths were associated with inadequate analgesia during aggressive, cure-directed therapies. In addition, patients were concerned about control of future symptoms. Intrusive thoughts of breakthrough pain or respiratory difficulties produced significant anxiety that called for appropriate reassurance in order to be relieved.

Participants stated that fear of pain and inadequate symptom management could be lessened through communication and clear decision making with health care professionals. Participants observed that involvement of patients in treatment decisions empowered the patients. On the other hand, bad deaths frequently included scenarios in which treatment preferences were unclear. These scenarios left patients feeling ignored, family members experiencing confusion and concern about suffering, while care providers felt out of control and apprehensive that they were not providing good care. Decisions that had not been discussed previously often had to be made in the midst of a crisis, when emotions run high yet emotional reserves may be low.

Participants stated that they felt a need for greater preparation for death. Patients usually wanted some notion of what to expect during the course of their illness and wanted to plan for events after they had died. Family members voiced a need to learn about physical and psychosocial changes that would occur as death approached. Participants shared situations in which lack of preparation adversely affected patient care. Nonphysician care providers spoke about the importance of exploring one's own feelings about death and the effect of these feelings upon the ability to care for terminally ill patients.

The next theme, completion, includes issues of faith, life review, conflict resolution, spending time with family and friends, and saying good-bye. In western culture, completion may be mainly a process of individual life review that is shared subsequently with family and friends. In other cultures, such as in the Far East, completion may be more explicitly communal and may involve rituals important to the family during the dying process and after death. Issues of faith were often mentioned by participants as essential for healing at the end of life and frequently became more important as the physical state of the patient declined. Nevertheless, it was also noted that such issues are highly individualistic and that cues about their particular expression must come from the dying person.

Several groups of study participants mentioned the importance of the theme of contributing to the well-being of others for the dying patient. The contributions can take the form of gifts, time, or knowledge. With the approach of death, many patients reflect on their successes and failures and discover that the power of personal relationships is greater than professional or monetary attainments. Many patients want to share this new understanding with others. Mitch Albom's book (1998) on conversations with his professor, Morrie Schwartz, reflects this point very well.

Study participants repeatedly emphasized the importance of affirming the patient as a unique and whole person. Patients appreciated empathic health care providers who carried out such affirmation. Family members were comforted by and expressed great respect for those who did not treat their loved ones as a 'disease' but understood them in the context of their lives, values, and preferences. From another vantage point, health care providers, in describing good deaths, also focused on personal relationships with patients and families. These relationships were even present in the most dire medical crises. These participants were touched when their final or penultimate interactions were between two people, not doctor and patient or nurse and patient.

Doka (1993) takes a task oriented approach to the terminal phase. He lists nine tasks dying patients may need assistance in completing. They are: 1.Dealing with symptoms, discomfort, pain, and incapacitation 2. Managing health procedures and institutional procedures 3 .Managing stress and examining coping 4. Dealing effectively with caregivers 5. Preparing for death and saying good-bye 6. Preserving self-concept 7. Preserving relationships with family and friends 8.Ventilating feelings and fears 9. Finding meaning in life and in death.

A number of these tasks should be familiar to the reader from other schemas. Nos. 1 through 7 are a part of many models, albeit in a different ways than they are expressed here, e.g., Buckman (1993), Corr (1992), and Worden (2000). No. 8 refers to emotional issues of the terminal phase, such as anxiety, sadness, depression, and guilt, the airing of these emotions by the patient and the goal of achieving to the degree possible, emotional balance and comfort.

Yet, it is in the final task that Doka (1993) enters into a realm that many other theories have left untouched. This is the realm of the existential. Doka points out that in the face of death it becomes important for many people to understand and interpret not only their deaths but also their lives. Developmental psychologists have recognized that the awareness of finitude can initiate an intense inquiry to find meaning in one's life. One means of conducting this search is to engage in life review. In this process, individuals reminisce and review their lives, seeking to find significance.

Doka (1993) further observes that this inquiry can also proceed in another direction. Families and individuals may need to struggle with the issue of suffering. They may wonder what purpose God has for putting them through such pain. They may question if they can still believe in God. They may choose to explore their own religious and philosophical beliefs in order to answer these questions. Moreover, as individuals struggle with impending loss, other spiritual questions may arise, for example, the question of hope and life beyond the grave. Hope may be found in religious, transcendental, or other belief systems. Doka (1993) adds that caregivers involved with the terminally ill need to be sensitive to spiritual needs. These needs are distinct from religious ones. He points out that effective spiritual care allows patients to define their own spirituality and present their own spiritual needs. This may range from religious observances, such as prayer, to secular activities, e.g., reading poetry. Doka adds that such activities remind us that, even for the dying person, the possibility for continued personal development and growth exists. The dying person's life should not be viewed only in terms of the past tense.

Worden (2000) uses the term 'appropriate death' and defines it as one in which the person can experience a dying that reflects personal goals, values and lifestyle. It is a death that one might choose for oneself. He notes that even though appropriate death refers to the individual and what has been important to him or her, nevertheless, there are certain psychosocial parameters that define this type of death for all patients. One of these is adequate palliation of symptoms. However, Worden's focus is on five psychosocial parameters that he claims define appropriate death and that can be evaluated after a person's passing.

The first of these parameters is what Worden (2000) calls 'Provision of Continuing Support'. Some patients, Worden asserts, are considered short survivors. These are patients who succumbed to early death, were less cooperative and compliant with hospital staff and hence received less emotional support from the staff and from others. Moreover, they often had histories of poor social relationships. For these patients, depression was the affect that characterized the terminal phase. If these patients exhibited anger, it tended to be destructive and alienating.

On the other hand, Worden (2000) contends that patients who survived longer than medically expected were cooperative with hospital staff, compliant with staff directions, had histories of good social relationships, and had a great deal of emotional support while they were dying. In addition, Worden writes that these patients did not want to die and, in fact, exhibited some denial of the facts and implications of their conditions. They might express anger over their fate, but this anger was neither alienating nor destructive.

These points suggest that length of survival involves more than physical matters and interpersonal aspects of patients' lives during their illnesses. They indicate that differences in life experience and psychological characteristics may also play major roles. Worden (2000), thus, agrees with LeShan (1969) that there is significant evidence that deep psychological isolation, the loss of the ability to relate and to love, shortens the patient's length of survival.

Worden (2000) writes that a second psychosocial dimension of an appropriate death is sensitive communication. He contends that willingness to talk about one's death can be an intermittent phenomenon. Some patients want to talk about it now but not later, others later but not now. Patients are also selective regarding those with whom they chose to speak, choosing some family and/or staff members and remaining silent with others. Sensitive communication, in one sense, means being sensitive to when a patient wishes to talk about their death and with whom.

Worden (2000) also writes in this context concerning denial. He observes that denial of facts of the illness and its impact occurs intermittently throughout the illness' course. Denial such as this, in contrast to denial at the time of the initial diagnosis, is usually triggered by a threat to an interpersonal relationship or by some intrapsychic conflict. If the threat abates, so does the denial. Therefore, according to Worden, the most effective intervention sees denial as a fever and searches for the underlying cause rather than confronting the denial directly. The patient must require the denial for some purpose. Identification of that purpose and helping the patient understand why they are holding on to this coping mechanism will cause it to pass.

The next psychosocial dimension Worden investigates is that of fears and how to reduce them. He refers to his earlier work (1989) with terminally ill patients that shows that they tend to be more afraid of dying than of death itself. Although one can posit that fear of dying is only a displacement of the fear of death, nevertheless, most people have some type of fear regarding dying. Some fear that in dying they will lose control over personal decisions and lose the accompanying self-esteem. Others are afraid of being alone. Some are frightened by pain. The concern that one's quality of life will be significantly compromised as a by-product of treatment is also found among dying patients. Other patients fear that they will not know what is happening to them. For most patients, the wish to know is the rule rather than the exception. Yet, there are patients who experience this need more strongly than others, and the ambiguity of not knowing is a major focus in their dying.

According to Worden (2000), a fourth dimension of appropriate death concerns the patient's ability to complete unfinished business before dying. Worden comments that he is not referring to wills and funeral arrangements, though these are important considerations. Instead, he is discussing the patient's and family's saying what needs to be said, expressing appreciations, resentments, and disappointments so as not to leave significant things unsaid. There are patients who perform this task naturally and there are families who also do this naturally, while other patients and families require encouragement. Some families look for permission from caregivers to initiate this task.

When hope for recovery is no longer feasible and treatment goals shift from curative to palliative, patients often relinquish hope, show symptoms of depression, and turn away from other people. Worden suggests that this reaction leads to a response which characterizes the final dimension of appropriate dying, the accessing of what he terms 'mini-hopes'-hopes not related or dependant upon recovery.

In concert with Worden (2000), Engel (1968) found that when patients no longer have any hopes, death follows quickly, sometimes despite prognoses that are not particularly grim. These mini-hopes range from being able to take a walk in the park to living until a significant event takes place, e.g., the wedding of a child. Worden cautions that not all patients have mini-hopes; some require encouragement to identify them. For Worden, the assessment of the dimensions of appropriate death needs to include the evaluation of the patient's ability to maintain some form of hope to the end. This is not, as noted above, the hope for cure but the mini-hopes that can enhance the quality of life and even extend life to some degree.

Worden (2000) concludes his review of the dimensions of an appropriate death with a brief critique of Kubler-Ross' (1969) stage of acceptance. He observes that many of the patients he has worked with never reached the stage of acceptance. These patients resented their deaths right to the end, and this was true irrespective of age. Nevertheless, this lack of acceptance in no way precludes the patient from experiencing an appropriate death. Yet, according to Worden, this is difficult for the dying patient as a common reaction to the possibility of death is that death is senseless, it has no meaning. He believes that the patient needs to seek meaning in death, in whatever way this may occur, and use that meaning to reframe one's current life. The objective is to move death out of the realm of senselessness into the realm of personal meaning.

Rando (2000) has also made one of the latest attempts to theorize about death and dying. She connects traumatic stress to post death grief and mourning and medical illness. Rando suggests that the natural intersection of these two areas lies in the realm of the experience of anticipatory mourning. Rando (1994), in her earlier discussion , makes several points of importance for her argument concerning anticipatory grief. First, there is the pivotal association of anxiety as a central dynamic in and manifestation of acute grief. Second, Rando refers to the diagnostic criteria for acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) as delineated in the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (1994), which is known as the DSM-IV.(See Appendix A).

With these in mind, Rando (2000) turns to three discussions of traumatic stress in anticipatory mourning. These are (a) separation anxiety associated with the death of a loved one, (b) the characteristics of the anticipatory mourning situation, and (c) the exposure of and demands placed upon the anticipatory mourner or, in the case of this paper, the dying patient.

According to Rando (2000), the dying person and his or her loved ones need to separate from each other. As a result, significant separation anxiety is likely to arise in the dying person, family members, and concerned others. In post death grief, physical separation has already taken place. In anticipatory grief, the separation is taking place and this tends to provoke enormous pain and anxiety. A number of factors contribute to this situation: the sadness of watching the dying process, the hope, often futile, that the situation could be altered, the urgency to do and not do things while the patient remains alive, the awareness that death is yet to be actually faced, the ongoing experience of loss, the balancing of conflicting demands and emotions, being in the middle of the intense feelings and anxieties accompanying the process, and being suspended between life and death.

Rando (2000) notes that none of these factors necessitate a negative dying experience. Nonetheless, it should be appreciated that when and if they do occur, it is usually within the context of some level of separation anxiety. Rando writes the majority of factors, characteristics, or elements associated with a traumatic event are present in anticipatory mourning. In this context, Rando adapts from her earlier writings (1994) six generic factors that predispose a particular death to be traumatic: 1) suddenness and lack of anticipation; 2) violence, mutilation and destruction; 3) preventability and/or randomness; 4) loss of a child; 5) multiple deaths; and 6) personal encounter with death secondary to either a significant threat to survival or a massive and/or shocking confrontation with the death and mutilation of others. Rando also cites Green's (1997) four fundamental similarities between loss and trauma: a) disorganization and disruption; b) helplessness and loss of control; c) severing of an important attachment and the protection it provides; and d) concerns about annihilation.

Rando (2000) next turns her attention to the exposures and demands placed upon the anticipatory mourner. A major cause of traumatization of the anticipatory mourner is the psychic and physical assault that can be experienced as secondary stimuli to the life threat that is taking place. Sensory perceptions include mutilation, disfigurement, hemorrhages, foul odors, purulent discharges, expressions of pain, and diminished capacities. These confrontations, possibly terrifying, with the impacts of oncoming death can result in horror, helplessness, anxiety, hyperarousal, vulnerability, threat, shock, and a perception of absurdity. Raphael (1986) agrees with Rando and notes that the individual's distressing encounter with the deaths of others- the sights, smells, sounds, etc.,-produce reactive traumatic phenomena that require integration. Situations and stimulus cues may trigger memories and produce the emotional intensity of the original experience. Rando extrapolates from Raphael's views that an individual helplessly watching a loved one ravaged by illness and pain may undergo similar experiences. One could add, as well, that this could also apply to the dying person.

Rando (2000) then discusses how traumatic stress is created in anticipatory mourning through the multiplicity and chronicity of the losses associated with a life-threatening or terminal illness. The point here is that process, as well as content, can result in traumatic reactions. Undergoing loss and disruption of one's life repeatedly and over an extended period of time in and of itself takes a psychological toll on an individual. . This trauma is over and above that related to the specific content of the experiences themselves.

Regarding multiple loss, the notion of bereavement overload is significant. Kastenbaum (1969) introduced this term in reference to the serial loss of social contacts experienced by the elderly. The term has been used subsequently for individuals who sustain multiple bereavements either concurrently or serially. In either case, the person's past and/or current experiences of loss leave the individual depleted emotionally and unable to address the loss and other demands of the current situation.

Rando (1993) found conceptual and clinical differences between serial and concurrent loss. In simultaneous multiple loss- a very common situation for Holocaust survivors- the mourner faces relatively more difficult choices than in cases of serial loss, no matter how brief the interval between losses. In concurrent loss, the individual must first prioritize the losses, differentiate them, navigate through conflicts that arise due to the differing issues generated by them, work through the overwhelming nature of the situation, decide whether to address the losses in sequence versus simultaneously, and, at times, struggle with guilt and/or loss of support. In addition, the individual needs to manage, according to Rando(2000), the completion of the six 'R' processes of mourning (Rando, 1993). Rando argues that these processes must be successfully accomplished for a loss to be accommodated in a healthy way. These six are: a) recognizing the loss; b) reacting to the separation; c) recollecting and reexperiencing the deceased and the relationship; d) relinquishing the old attachments to the deceased and the old assumptive world; e) readjusting to move adaptively into the new world without forgetting the old one; f) and reinvesting in other people and other aspects of life. In either serial or concurrent loss, the ego struggles to maintain homeostasis. This struggle is made more difficult by the overwhelming nature of so many losses. It is common for this overload to leave the person psychically numb and lacking self-direction. This can result in complete immobilization or acute reactivity to all stimuli and challenges. Difficulties surrounding one loss may be generalized to others. The chance of complicated mourning becomes increased. How can these challenges be managed? Rando (2000) suggests that individual losses need to be identified and differentiated and caution exercised that defense or resistance does not become inappropriately generalized to other losses.

Rando (2000) also comments upon the role of the caregiver in responding to these cases of multiple losses through the deaths of loved ones. She writes that anticipatory mourning will likely involve, in these cases, greater intensity, slower pace and longer time intervals than is the norm. The sensation of not knowing where to begin in situations involving multiple losses is typical and great empathy is required in responding to such feelings. The person can be told of the ongoing nature of loss and the need to pay attention to losses suffered during life. It is suggested that it is best if the mourner can concern him or herself with issues as they arise, they will not accumulate and an unhealthy situation can be avoided. However, there are events which present multiple losses and traumas all at once, and a leisurely approach to confronting these losses is not possible (e.g., when emergency surgery with concomitant significant health ramifications is needed).

Rando (2000) also notes four ‘areas of information’. These ‘areas’ are conceptual categories that inform the anticipatory mourner’s experience of illness-induced trauma because they affect those who work with the mourner. Although these are beyond the purview of Rando’s research here, she does mention them as ancillary categories which may affect those working with illness-induced trauma and add to the difficulties of the anticipatory mourner in coming to grips with trauma. The first category is stress management. This includes loss-related stress and trauma-related stress. The others are counter transference, impact of loss and trauma on family, and the impact of vicarious bereavement on persons not directly affected by the loss.

In summing up her position, Rando delineates the conditions that may generate trauma in the experience of anticipatory mourning. The conditions germane to our topic include: a) personally witnessing the physical and psychosocial suffering or traumatization of another; b) personally sustaining losses, trauma, or victimization as a result of one’s own experience of anticipatory mourning(e.g., helplessness or loss of assumptive world elements); c) perceiving traumatic stimuli(e.g., stimuli that are related to death, or that are horrific, terrifying, or grotesque); d) experiencing trauma due to the type, nature, and conflicts of the demands imposed upon one by the situation; and e) having one’s own personal fears, concerns, or sensitivities touched or resurrected. These points will be reviewed later in the context of the terminally ill Holocaust survivor. Suffice it to say here that all of these conditions apply to the various survivor experiences.

Rando (2000) concludes this section of her paper by referring to Raphael (1983). He writes that bereavement is often not limited to the here and now, but is connected to past losses and concerned about future losses. Rando asserts that in anticipatory mourning, one contends with past present and future losses that take place over an extended period of time. Rando ends her discussion by noting that trauma that stems from multiple, repeated, or long-standing exposure to extreme events, often of intentional human design differs in response from a single, discrete, overwhelming event that traumatizes. As examples of the former, Rando suggests sexual abuse or torture. In these cases, the unfolding of events creates a sense of anticipated trauma from which the person attempts to protect and preserve the self by defenses. She states that these defenses may include massive denial, repression, dissociation, self-hypnosis, identification with the aggressor, and aggression turned against the self. Rage, relentless sadness, and psychic numbing are also common, along with fear. These reactions and defenses often lead to profound character changes and ongoing interpersonal problems. Once again, here, Rando (2000) could well have been writing about numerous Holocaust survivors.

It is appropriate to look at the assumptions behind these theories and how these assumptions strengthen or detract from them. As was mentioned above, there are serious questions concerning the so-called ‘stage’ theories of Kubler-Ross and Buckman. Is it possible to see the variegated process of dying as linear and one-dimensional? Granted the advantages of Buckman’s approach versus that of Kubler-Ross, nevertheless, the question remains. Moreover, is it realistic to think that every patient will achieve some resolution with or acceptance of death? Experience in palliative care settings indicates that there those persons who choose to end their lives in struggle, who never acknowledge that death will have the final say. For such people, the fear of dying is so great that they refuse to seek resolution towards life's end. Albeit that Buckman acknowledges that his final stage of acceptance is not essential, nevertheless, this is conditioned upon the patient not being distressed, communicative, and making decisions in their normal way. Yet, are not these criteria aspects of having resolved oneself to one's fate? Is it not questionable that these conditions would be commonly found among those persons who are engaged in struggling with death?

As for the 'task-based' approaches, Corr's (1992) approach may be criticized, as mentioned above, on the underlying assumption that tasks are central and elemental to the fundamental concerns of the dying. This would seem to be validated in Corr's first area, the physical realm. Minimizing distress and satisfying physical needs are elemental aspects of palliative care. If this were not to be adequately addressed, what is the point of speaking of 'tasks of the dying'? No other tasks can be addressed if this one is not properly undertaken.

However, it can be argued that the same cannot be said of some of the other tasks Corr proposes. In the psychological realm, Corr writes that the task is to maximize psychological security and independence. Yet, in cases of acute anxiety, one questions the feasibility of this. Indeed, a dying person experiencing this is not concerned with independence; this person is seeking relief from the anxiety, some form of calming and soothing. In the social area, the task concerns enhancing interpersonal attachments of significance to the dying person. Yet, there are dying patients and families who do not wish to talk or engage with others. They do not want visitors and they may cut short any visits that they receive. As to the final area in Corr's model, spirituality, it is correct to include this area in the discussion of 'task-based' dying. It is certainly helpful to access spiritual support and sources of hope. Having said this, though, this writer, an ordained clergyman working in palliative care, must acknowledge that a number of patients and families never engage this realm due to choice or happenstance. The 'spirit' is not accessed in certain cases, although it is possible that families and patients do connect with this aspect of support in ways not evident to caregivers or outsiders. Still, it should be admitted that the spiritual task is not taken up, even in those deaths that might be considered 'good' or 'appropriate'.

Doka (1993) also approaches the terminal phase with an orientation involving tasks. A number of these tasks are instrumental. These include symptom and pain management, managing health and institutional procedures, coping with stress, dealing effectively with caregivers, preserving family relationships, and preparing for death and saying good-bye.. One would be hard-pressed to argue with Doka on these task areas. However, in the area of ventilation of feelings and fears, there are patients who find this very anxiety-producing. They are afraid of dying and/or the process of dying and the idea of talking about their fears can be terrifying. Doka also includes a task-area he designates as 'preserving self-concept'. This activity is somewhat vague and undefined. If it refers to preserving a sense of personhood and value as an individual, it could then be placed alongside those other tasks that are clearly elemental to the dying process.

As to the final task, finding meaning in life and death, it differs from Corr's (1992) area of spirituality. As was noted above, Doka (1993) is introducing the realm of the existential and the possibility of hope for the terminally ill patient. Doka connects this to the task of life review, a topic that can be a source of conflict for many individuals. He also discusses spirituality as it relates to the matter of suffering and finding meaning in that suffering. He notes that patients or families may introduce God here. They may ask for what purpose they are undergoing this ordeal. They may question whether they can still believe in God. He also suggests an expanded notion of spirituality in secular activities, such as reading poetry, have a role. To carry this one step further, art and music therapy, aside from being soothing and diverting, may have a spiritual/ existential role in a palliative care setting. Patients and families may be drawn to discussing these matters through these kinds of experiences. This model is also very instructive in understanding a key source of adaptive strength for a number of Holocaust survivors.

The last three sources are the most recent. We shall deal here, for the sake of expediency, with Steinhauser, Clipp, McNeilly, et al., (2000) and Worden (2000) together. Both papers concern what constitutes a 'good' or 'appropriate' death Steinhauser et al., approaches this from the point of view of patients, families, and caregivers while Worden approaches it from a clinical/ academic perspective. What is noteworthy is where these schemas intersect. Steinhauser et al.., found that two important themes in experiencing a 'good death' were pain and symptom management and clear decision making. It appears the former depends upon the latter. Effective symptom management is facilitated through communication and clear decision making. Worden's first parameter concerns continuing support for the patient and contends that those who worked well with hospital staff received more emotional support from caregivers and tended to live longer and die more peacefully. Worden's second psychosocial dimension of 'appropriate' death is sensitive communication. It can be argued, from these two papers that those families and patients who were able to build constructive relationships with hospital staff for the purpose of support and pain/symptom management tend to have 'better' or 'more appropriate' deaths. Families, patients, and caregivers who were able to communicate well and successfully with each other enhanced the palliative care experience. As Worden (2000) further observed, patients and families who knew with whom they can talk and with which staff members it is best to remain silent had more positive episodes in the hospital. At the same time, those staff members who knew which patients wished to talk and who did not and who could delicately discover what the patient was willing to talk about and share helped produce the same effect for patient and family.

In the Steinhauser et al., (2000) study, participants expressed a desire for greater preparation for death. Patients were concerned as to what to expect during their illnesses. This fits in very well with Worden's (2000) discussion of sensitive communication. But, does sensitive communication include no communication? What of those who do not wish to explore the topic of their deaths? Does the notion of preparation for dying have any meaning when the subject itself is off-limits? Steinhauser's et al., cohort may have been particularly receptive to this idea; the findings may well not be generalizable to a larger population.

In the context of communication, it is appropriate to further comment on Worden's (2000) view of denial. He claims that denial of reality and facts is an intermittent phenomenon of illness In contrast to denial at the time of diagnosis, this form of denial usually has a trigger in an outside threat or an internal conflict. He suggests that helping the patient to identify the purpose for holding onto the denial will cause it to pass.

Denial, however, appears to be more complex and powerful than Worden proposes. Palliative care units are populated by families who appear to cope through denial. One suspects that, internally, there is acknowledgement by patient and family as to the outcome of the illness. Nonetheless, for others in the families and outsiders, the façade remains. Family members or friends may work together to ensure the façade remains for patient, spouse, child, etc. Moreover, as Rando (2000) has pointed out, in trauma, denial may be a very strong and common defense mechanism.

Both the Worden (2000) and Steinhauser et al., (2000) studies discuss the matter of unfinished business. The topics are the usual ones connected to this- life review, conflict resolution, saying good-bye, etc. In particular, Steinhauser et al., indicates that the participants in their study, participants focussed on matters of faith as significant for healing at the end of life. Worden, on the other hand, writes of hope and the need to access what he calls 'mini-hopes'. These hopes, while significant, are not related to recovery. He believes that, without the ability to maintain some form of hope, a life span may be shortened and quality of life may deteriorate more quickly. According to this author, without any hope there truly cannot be an 'appropriate death'.

As was mentioned above, the concept of unfinished business creates difficulties for some death and dying theorists and the concerns expressed above apply here as well. Worden (2000), though, has touched upon a very provocative idea-can there be a 'good death' without hope of any kind? In addition, how is one to distinguish between absence of hope due to clinical depression and absence of hope due to existential causes? And for the survivor of the Holocaust and other traumas, is it not more difficult to access even the idea of hope, let alone the 'mini-hopes' Worden describes? Worden writes that acceptance is not a sine qua non of an appropriate death. He seems to be saying that hope is.

The approach of Rando (2000) differs from all of the other models discussed in that it brings together the traumatizing effect of deprivation and loss with anticipatory grief. Rando discusses anxiety deriving from separation from loved ones. This is more specific than the fears elaborated upon by Worden (2000) Others include loss in their schema but only Rando notes the elemental and essential qualities of the loss of a loved one.

Rando (2000) observes that the anticipatory mourner, or the dying person, is under assault , both physically and psychically Even the best of care cannot protect family and patient from physical stimuli. Patients sometimes may vomit, hallucinate, have bowel and urinary difficulties, cry out in pain, bleed, and have difficulty with mobility. Moreover, the effects upon all involved are real and need to be acknowledged. Rando connects the reactions these engender with response to trauma.. Worden (2000) and Steinhauser et al., (2000) pointed out the importance of pain and symptom control in their schema. Even Doka (1993), who acknowledges the need to deal with pain, symptoms, etc. does not discuss the kind of responses these stimuli engender nor does he talk about their management. Rando, it seems, has begun to examine those aspects of the process of dying that have not yet been explored.

Rando (2000) makes another point of significance. She claims that the trauma of loss goes beyond the specific content of the losses. Undergoing illness and the losses associated with it over an extended period of time is itself traumatizing and anxiety-producing. This suggests that some of the other models, that have as a task or dimension controlling anxiety and managing stress, may be underestimating the extent of these. It is not only the content of illness and deficits that the patient undergoes that stresses the patient and family; it is the process of being ill and, indeed, dying that compounds the stress. Thus, one can understand the tension and anxiety manifested by patient and family. Family members may be short-tempered and overwhelmed. Family conflicts may reemerge and family and patient may keep secrets from each other. Life-threatening illness is often a situation of stress upon stress. This taxes the coping ability of patient, family, and other caregivers.

Bereavement overload, as Rando (2000) observes, applies to the case of multiple losses, either concurrently or serially. Past and/or present experiences of loss can lead to emotional depletion. This is likely more common than might be imagined. A gentleman may be in palliative care, attempting to manage his own losses as well as the loss of a wife, child, and sibling, all within the space of five to ten years. The energy needed to mourn these losses, deal with symptom management, perform unfinished business, and find meaning in life is simply staggering. Despite the notion that bereavement overload may be fairly prevalent among the terminally ill today, it does not appear as a major factor in the other theories (e.g., Corr (1992) who does mention the notion of managing losses).

Rando's six 'Rs', processes to be completed in order for a loss to be accomodated can also be applied to the dying patient. The reader may recall that these are: a) recognizing the loss; b) reacting to the separation; c) recollecting and reexperiencing the deceased and the relationship; d) relinquishing the old attachments to the deceased and the old assumptive world; e) readjusting to move adaptively into the new world without forgetting the old one; f) and reinvesting in other people and other aspects of life.

Recognizing the loss(es) and reacting to the separation can be viewed as preparatory work for the dying patient. Recollecting the deceased/ lost object and the relationship could certainly apply as well. The dying patient mourns the loss of family and friends and recalls the relationships that will be soon coming to an end. Relinquishing old attachments and the old assumptive world is part of the 'letting go' process for the dying. Readjusting and reinvesting would, however, appear to be more problematic as the dying person who has no concept of what follows.

Some dying patients will have belief systems that include a belief in an afterlife and/or a belief in joining those already dead and for such patients, reinvestment in a future would be more accessible and tangible. It may be possible to view these processes as tied into engaging in unfinished business. The dying person may want to close all matters of family and other interpersonal business prior to dying. It should be noted here too that, as with the other models, every terminally ill patient and family does not necessarily complete these processes. Nevertheless, Rando 's six 'Rs' can be considered, with some adaptation, as a model for what the dying individual experiences.

There is another important point made by Rando (2000) which the other models appear to have ignored. She often refers to the myriad means of defense that a patient or family may call upon to help avoid accomplishing tasks or endeavors surrounding illness and death. Although some of these are usually associated with trauma, they can also be utilized in a terminally ill setting. Denial is probably the best known of these defenses.

There is also repression, dissociation, self-anesthesia, psychic numbing, rage, and relentless sadness. Often, these defenses are accompanied by great fear. Needless to say, these defenses do not necessarily come into play in a palliative care situation but there are patients and families who do experience psychic numbing, for instance. This could be a way of defending against the physical and psychic stimuli described by Rando and controlling overwhelming emotions. The same can be said for rage. Certain patients and family members may scream at hospital staff for the most innocuous error or omission. The anger may defend against other emotions the individual does not wish to confront.

Fear is included in several models. Yet, these other responses are all but ignored. Rando would probably contend that they are significant in the dying process and that, in fact, they can play havoc with any ordered task/process paradigm. After all, is it not these so-called tasks from which people are seeking protection? In circumstances where a person is dying and losing everything that they have come to know and cherish or where a loved one is dying, it seems likely that responses akin to those that characterize trauma would arise. Therefore, the models described are lacking this perspective and adjustment in approach. What resonates for this paper is the fact that it is just these aspects that Rando cites and others ignore that play an important role in the adaptational capabilities and quality of life of the survivor of the Holocaust.

III. HOLOCAUST SURVIVORS AND THEIR TRAUMAS

It should be clear to the reader that Rando (2000) is the only theorist who incorporates trauma into a theory of anticipatory grief and the process of dying. Albeit that there is great diversity among Holocaust survivors, nevertheless, it is trauma that is a commonplace in this plethora of human suffering and adaptation, unimaginable degradation and incredible strength. A proper assessment of death theory as it applies to Holocaust survivors and, in particular, the applicability of Rando's model of anticipatory grief to this population, involves discussion of the kinds of trauma these survivors underwent, the effects of these traumas upon later, postwar life, and the adaptational mechanisms that were called upon in adjusting to that new life.

The overwhelming nature of the catastrophe that befell German and east European Jewry during World War II is clear. The assaults that took place include the following: loss of home, property and community; loss of personal dignity; loss of livelihood; separation from family; witnessing the murder of family members; physical attacks; malnutrition; imprisonment and constant unrelenting fear of capture or death. It appears that there is no way that anyone who lived through this terror could be unaffected by it. The scope is too breathtaking; the losses seem too monumental. Nonetheless, after the war, people left the ghettoes, the hiding palaces and the displaced persons' camps and had to begin life anew. In a very real sense, for many survivors, the comment made to the author by a man who emerged from the concentration camp at Auschwitz is true. He said that he celebrates the anniversary of his liberation as the day of his rebirth. We will now turn our attention to these postwar lives and how they were affected by what had happened to them.

III. i. Danieli's Taxonomy

Moore and Fine (1990) offer a clinical definition of trauma. This definition asserts that trauma is caused by the disruption or breakdown that occurs when an individual psyche is suddenly presented with stimuli that are so powerful that the ego is overwhelmed and loses its mediating capacity. This results in a state of helplessness. This helplessness may be manifested through total apathy and withdrawal to an emotional reaction bordering on panic. The Holocaust survivor underwent this kind of experience not once or twice, but on multiple occasions, and often in the space of a very short amount of time (See Introduction).

These experiences of the Holocaust shattered nearly everything the survivor depended upon to mediate life. Families were lost and/or dispersed. Friends and extended family was missing. Housing and property was destroyed or confiscated. Communities, towns, and villages were no more. Thus, it should be not surprising that survivors should experience significant difficulty in adapting to life subsequent to these enormous disruptions and losses. Moreover, survivors have also manifested great strength and resilience and this will also be noted. In order to describe and organize the coping responses, both adaptive and maladaptive, of Holocaust survivors to the traumas they witnessed, we now turn to the postwar families survivors built and how these families have functioned. Among the most prominent researchers in this area is Yael Danieli.

Danieli (1981, 1988) classified survivor families into four categories: victim families, families of fighters, numb families, and families who made it. These categories have provided significant insight and understanding of behaviour patterns in these families. It is an attempt to comprehend how the intersecting of particular factors and attributes create a particular type of family dynamic. It is also a useful way to perceive the intersection of all of the Holocaust survivor's suffering and loss along with a number of their resiliencies (Danieli herself acknowledges that her focus precludes discussion of pre-Holocaust background considerations as these affect postwar adjustment).

Danieli's first category is characterized as victim families. Most survivors who headed these families had been inmates in concentration camps. Danieli characterizes these families as being depressed, worried, mistrustful, and afraid of the outside world. This is likely as a result of a pervasive sense of victimization, which is a response to traumatic events. The sense of a world operating in chaos and without control created the need for a vigilant posture toward future adversity. The environment was perceived as chronically threatening and foreboding. Generally, feelings of vulnerability and perceived threats of victimization lead to one of two coping strategies that are not mutually exclusive. One of these strategies is avoidance and withdrawal. The other one is vigilance. Vigilance leads to hyper alertness to threats from the environment Survivors of this kind of family would usually utilize vigilance in order to cope.

Among these survivors, everyday changes elicited overreactions and panic. Rosenbloom (1983) observed that anxiety is considered an elemental reaction to the Holocaust experience. This type of survivor illustrates this point very well, as the survivor could become quite agitated at even the thought of a hospital or nursing home. The confiscation of clothing and personal effects, the changing of room without fully comprehending the reason for the change, even being escorted into a shower room, these actions can provoke great anxiety in survivors. Any hint of political upheaval or uncertainty can cause survivors and their families to begin making preparations to flee as some were able to do in Germany in the late 1930s. The need to know the whereabouts of a child or loved one at every moment is also an anxiety reaction prompted by life under the Nazis. In an effort to prepare for future horrors, children were warned to keep a low profile in the outside world. A Palestinian *intifada* in the Middle East would likely precipitate great anxiety and tension in this survivor group, in particular for survivors living in Israel and those whose family members live there. Material survival was also central for this type of family as there was always fear of another holocaust. Somatization was often seen among the parents, as physical problems were much more acceptable to these families than psychological ones.

Krystal (1981) writes of what he calls the catastrophic adult psychic trauma which, he believes, is found among many Holocaust survivors. Two sequelae that are often present subsequent to the trauma are anhedonia and alexythymia. Anhedonia, as the name indicates, is a state in which an individual cannot experience joy, pleasure, or gratification. Alexithymia is a disorder of affect that causes an inability or difficulty in describing or being aware of one's emotions or moods. In the case of posttraumatic stress syndrome, it may include the elaboration of fantasies connected to the trauma. Krystal (1981) notes that, in aging, there is a gradual lessening of the potential for pleasure and gratification. Some people enter old age with already diminished hedonic capacity and with problems of guilt and masochism. This, he claims, is the case with many Holocaust survivors. Moreover, he adds, these losses force a shift, from doing to thinking and from planning to reminiscing. Yet, this transition is frightening and stressful to survivors of the Holocaust, who have spent much time and energy avoiding their memories of the past. Some go to great lengths to resist any contact with any historical material.

Krystal's description of these sequelae also describes the victim family. For this kind of family, security was the paramount concern. Joy, pleasure, and self-fulfillment were seen as frivolous. Within these families, though, the normal establishment of boundaries, as an assertion of independence and privacy needs, was condemned if attempted by the children as a threat to family integrity. Such efforts were equated with disloyalty, ingratitude, and betrayal. These parents needed their children to work through their own needs of development and fulfillment. As a result of this intrusive dynamic, enmeshed relationships developed. Role reversal was also common. The children were usually very protective of the parents and mediated between them and the outside world as well as within the family.

Kahana, Kahana, Harel, Kelly, et al., (1997) mention several of the difficulties facing survivors in coping with the aging process. Physical illness is very threatening as it was a death sentence in the concentration camps. Short-term memory loss leaves the survivor to deal with the memories of horror and destruction which may become more vivid as long-term memory becomes sharper. Danieli (1981) argues that, in fact, moving to a nursing home and being hospitalized could be very traumatic as it brings to mind experiences of being uprooted and incarcerated, generating feelings of fear, helplessness, and humiliation. The example of the elderly female survivor who refuses to enter the shower in a nursing home due to her memories of the fatal gas that poured forth from the showers in the death camps is a case in point. Similarly, Cohen (1977) has written that patients may feel helpless and dependent upon doctors and nurses, whom they may have difficulty trusting. It is understandable how survivors may be reticent and afraid to trust medical staff in an unfamiliar environment, particularly following the experience of being led to believe that families would be cared and provided for during the Holocaust.

The literature also refers to the importance that survivors have placed upon body image, mobility, and strength. Cohen (1977) notes that in the concentration camps, inmates were forced to cut their hair, walk around unclothed, and often appeared skeletal as a result of malnutrition. Inmates were chosen for survival on the basis of strength and mobility. Illness would almost certainly lead to the gas chambers. It is thus understandable how aging survivors would become fearful of torture and death when they begin to lose function of body parts or suffer dramatic weight loss as a result of disease. In addition, survivors who lose control of bodily functions may recall the humiliation and helplessness experienced in the concentration camps when they were forced to void their bladders and bowels in overcrowded boxcars and barracks. A request for a survivor to disrobe might result in fear or humiliation and prescribing medication could trigger a paranoiac reaction.. The survivor in a nursing home may hide bread in the closet or drawers due to the fear that food will not be available. A survivor in a seniors residence may become panicked in the presence of a security guard whose uniform somehow reminds him of the SS, Gestapo or Iron Cross guards. As these old memories reemerge more clearly, the survivor is at risk for undergoing this kind of transference. Aging and the losses associated with it may well strengthen the sense of despair and victimization this type of survivor experiences.

The next category in Danieli's classification is families of fighters. Fighters, in this context, describe the way these survivors looked at their physical and spiritual activities in the Holocaust. They viewed themselves as active participants in the struggle for resistance and survival in the camps and in the ghettos. This led to the creation of homes filled with the desire to build and accomplish. Waxman (2000) cites Magids (1998) who suggests that that some survivors of the Holocaust not only managed to resume their lives but tended to be quite successful. The resiliencies that enabled them to survive throughout the Holocaust, such as adaptability, initiative, and tenacity may account for this success. It needs to be acknowledged that the characteristics that empowered these people to overcome and master the trauma of the Holocaust are strengths that have, in many cases, been overlooked in the search for expected and anticipated psychological problems. Still, it is important to differentiate between social or financial success and psychological or emotional adaptation. Outer and inner lives of survivors, as Danieli 's taxonomy indicates, may be very different. For the fighter survivor, any behavior that might indicate self-pity or weakness was shunned. Thus, explicit mourning was not acceptable as it could well foster a sense of self-pity and helplessness. Depression and anxiety also could not be exhibited for, as in victim families, physical illness was more acceptable than psychological disturbance. This again, as in victim families, increased the likelihood of somatization among these survivors. Yet, even concerning physical illness, it could only be faced when it became a crisis. Control and readiness for change were stressed. There was no place in these families for disorganization, ambivalence, or surprise. Pride was considered an important virtue. Relaxation and pleasurable feelings were seen as superfluous and a waste of time in these families. Confidence and strength were praiseworthy. Thus, it is easy to see how anhedonia might also develop in these families.

Yet, it is mistrust that is a central attribute of the fighter family type, particularly mistrust of outside authority. A pervasive response to trauma that is experienced by many survivors is the pervasive sense of victimization, which may bring about mistrust of strangers, authority figures, or anyone who is not a survivor. The experience of uncontrollable and non-normative events during the Holocaust conditioned a view of the world as out of control and chaotic. This created the need for a vigilant posture toward all possible future adversity. A continuing sense of vulnerability may cause the physical and social environment to be experienced as chronically threatening and foreboding.

Survivors may not fully acknowledge the internalized stress posed by engulfing fear and mistrust. They may not find a direct referent for their fears. This, of course, makes the marshalling of appropriate coping strategies difficult. Generally, as Wilson (1989) has observed, feelings of vulnerability and perceived threats of victimization lead to one of two coping strategies that are not mutually exclusive. One is vigilance, which is more characteristic of fighter families and the other is avoidance and withdrawal, a strategy most likely to be utilized by victim survivor families. Vigilance leads to hyper alertness to environmental threats.. Yet, unlike victim families in which children were taught to maintain a low public profile, assertion and even defiance of outside authority was permitted among fighter families. These children might be placed in the untenable position of being told not to listen to any authority figure as they were not to be trusted while, at the same time, they were expected to accept *in toto* the authority of the parents. This kind of dynamic inhibited the sharing with and delegating of responsibility to others, both interpersonally and professionally. It also would inhibit reminiscing and sharing within the family concerning the survivors' Holocaust experiences. This sharing of one's past and its traumas were seen as representative of a lack of independence to these families. This was something that was unacceptable to a fighter family for, in such an environment, the problems of one's past did not require explication or elaboration. These were signs of weakness when what was called for was strength and battle.

The next family type, according to Danieli, is the numb family. In many cases, these were homes in which both parents had been previously married and had lost their partners in the Holocaust.. The atmosphere in these homes was one of silence. Absence of emotion was almost pervasive. The nonverbal message communicated in these families was that of no agitation and no unnecessary stimuli. In these families in general, more than a minimal amount of pleasure or pain was intolerable. Anhedonia and alexithymia were very likely among these families. Children could not exhibit spontaneity and joy to any significant degree and were normally kept uninformed as to their parents' war experiences. The parents alone shared these experiences and created a powerful dyad often to the exclusion and neglect of the children. There was little stimulation of or involvement by the parents with the children. They were, more or less, expected to grow up by themselves. Verbal and physical contact was almost non-existent in these families and so the parents were viewed by the children as withdrawn and distant. According to Danieli (1981), these survivors appear to have suffered most acutely from posttraumatic syndromes such. This group of survivors manifested apathy and social withdrawal, a low threshold for stimulation, isolation of affect, and inability to verbalize trauma except among themselves. These survivors appear to exhibit avoidant personality traits usually associated with poor mental health and low self-esteem. These survivors generally have poor affect tolerance that affects the mourning process and may bring about even greater emotional paralysis among this type of survivor. Kapieluk (1997) found that remembrance might be a way of working through painful losses. By keeping the memory of the lost ones alive, the survivor tries to revive the pre-traumatic positive memories in order to 'neutralize' the destruction and gain some comfort. These memories may function both as a consolation as well as a painful reminder of the searing losses. The numb survivor cannot deal with the pain and, therefore, also relinquishes any beneficial effects of memory as well.

In severe traumatic experiences, grief and loss tend to be too overwhelming for resolution. The pervasive nature and magnitude of the destruction and loss of the Holocaust made incomplete mourning inevitable. A number of authors have commented that inability to mourn among survivors. For instance, Danieli (1981, 1988) has written concerning the mourning among survivors. She noted that, during the war, mourning endangered victims' lives. The inmate's behaviour had to be totally obedient to the Nazi officers. Grieving–related actions, like the open expression of any emotion, had to be suppressed in order to prevent retaliation. Even the inner experience of grief and other mourning-related emotions endangered the fragile psychological balance of the physically oppressed and exhausted captives during the Holocaust. The same could be said for those in hiding and those living in ghettos. According to Krystal (1981), mourning processes have qualitative and quantitative limits. In the case of the Holocaust, when one's entire people and way of life perished, it is surely very possible that the quantity or quality of these losses, combined with the individual losses experienced, may be beyond the individual's capacity to integrate and the only alternative is the emotional shutting down characteristic of the numb survivor.

There were other factors that interfered with the mourning process. Many survivors did not witness the deaths of their family members and did not grieve through proper burial ceremonies. Another way of coping with the prolonged horrors of the Holocaust was to imagine and sustain the hope of being reunited with their families (Frankl, 1959). This led many survivors, when physically able, to return immediately to their hometowns to find their communities obliterated. Waiting for the return of family members proved futile for most. Eventually, they learned that their families were killed and, at times, they learned the manner and horrible circumstances surrounding the deaths. Some could never even recover any record-photographs or other mementos-of their past, their lives prior to the war. Krystal (1981) observed that this loss of so-called 'transitional objects' exacerbated the sense of rupture, of total destruction, that their whole people and civilization had perished. Survivors' visits to hometowns, to concentration camps, and to Holocaust monuments are part of the search for roots and the need to adequately mourn, not only family members but also loss of youth, of educational, economic, communal, and socio-cultural possibilities and hopes, of innocence and the capacity for joy, of faith in humanity and in God. It should not be surprising that, among this group of survivors, grieving, combined with ongoing stress of fear and lack of trust, would often serve to trigger depression in the survivor.

Danieli's (1981) final type is, as she puts it, those who made it. These survivors aspired to great achievement and status as a means of defeating the Nazis. Having a well-known and esteemed reputation consciously or unconsciously reversed the namelessness, shame, and humiliation they had experienced at the hands of the Third Reich. These survivors often exerted great effort in striving for higher education, wealth, as well as political and social status. Money was used primarily to assist the children, almost never for one's personal enjoyment, similar to other types of survivor families. These survivors were, compared to the others previously mentioned, almost completely assimilated into the culture and society in which they lived. For some, this assimilation was achieved through denial and avoidance of the past and any reminders thereof. Of the groups that have been described, this group often contained families wherein the children had no knowledge of their parents' experiences during the war. Some of these children felt cheated and bitter when they found out, usually indirectly, about their parents' pasts. In some cases, children had no notion a parent was a Holocaust survivor until that parent was on his or her deathbed. The defense mechanism of denial, frequently called upon in connection with the past, resulted in inner numbing, isolation, and somatization. Unlike the other types, these survivors viewed psychotherapy as a socially acceptable treatment for psychological and emotional difficulties. However, they probably almost never considered the Holocaust as a significant factor in their psychological lives. The children in these families were candidates for emotional neglect and they have been found to exhibit some of the same characteristics as children from numb families manifested.

In the context of these families, it is appropriate to mention two phenomena, the first is what is known as the survivor syndrome and the second being survivor guilt. .According to Chodoff (1969), the syndrome consists of the following: chronic depression with insomnia and nightmares connected to persecutory experience, apathy, and social withdrawal; chronic anxiety accompanied by vegetative and psychosomatic symptoms; personality changes, especially a low threshold for stimulation; guilt; isolation of affect; memory disturbances; avoidance of psychiatric help or an inability to verbalize traumatic events._ Concerning guilt, Niederland (1968) wrote that survivor guilt is a form of unresolved grief and mourning. Moreover, this guilt was often mixed with rage and resentment toward deceased parents for failing to protect survivors from oppression. Krystal (1987) wrote that mourning must be resolved through a process of gradual detachment. For Holocaust survivors, though, such gradual detachment is unachievable because the memories these survivors possess are all connected to horrible destruction. Guilt intensifies this connection. Moreover, as Rosenbloom, (1985) has observed, survivor guilt may resurface in later life when aging survivors once again encounter the loss of loved ones. Thus, the guilt may well be felt even more keenly by the aging survivor. Many survivors maintain loyal bonds to deceased relatives. The guilt might be unbearable if these bonds were loosened. These bonds can be viewed as pathological, based in self-blame and guilt. On the other hand, guilt can be seen as a symbol of resiliency, a symbol of a renewed need for psychological cohesiveness. It can be part of an attempt to mourn for the numerous losses of family, friends, and community. For many survivors, guilt, thus, can also serve a commemorative function as a vehicle of loyalty to the dead.

It appears that both uses for guilt can be found among this final group. Guilt may be a means of survival for some of these survivors; it is possible that it was a factor motivating them to make a reputation for them selves and to provide for their families as they could not do for their families of origin. Alternatively, the persistence of denial among this group suggests a powerful role for guilt and an inability to undertake the process of bereavement and to come to terms with the overwhelming memories of their pasts.

IV.STRENGTHS PERSPECTIVE

Based upon Danieli's taxonomy and its supporting literature, one could infer that most, if not all, Holocaust survivors could be considered symptomatic or maladaptive, either as individuals or families or both. Yet, this is certainly not the case. People, if they are functioning in life, are coping; some may be coping less well than others but all are coping. Given the mix of positive and negative mechanisms seen in the families Danieli (1981, 1988) described, it is clear that these families were, to a greater or lesser extent, coping. As Bistritz (1987) quite properly observes, psychiatrists and other mental health clinicians have tried to turn that which is made up of infinite shades of grey into black and white. Labeling and categorizing involves several dangers. There is the danger of overgeneralization from the theories. There is the danger of overpathologizing, of placing too much emphasis on illness and maladaptation without paying sufficient attention to the overall human potential for recovery and positive functioning.

The reality of the lives of survivors after the war calls into question the assumption of a 'survivor syndrome' and the psychopathology that has accompanied it. Albeit that such a syndrome may clearly describe the situation of some survivors, there are others for whom its relevance is called into question. It appears to be necessary to widen our understanding of the Holocaust survivor experience beyond the assumptions of the 'survivor syndrome' and pathology in order to see a different side of people's responses, that is, the side of coping, adaptation, and strength.

There are Holocaust survivors who have not only adapted but who have shown extraordinary energy in creating new lives, achieving material success, raising families successfully, and contributing to society at large. Reference was made above to tenacity and perseverance as adaptive traits and to remembrance as a positive attribute. There were those who were able to transcend the experience and reorder their lives on solid footing. In addition, there was heterogeneity in the experience of the Holocaust. There are differences in coping strength and readaptation ability between those, for instance, who were interred in the camps and those who were in hiding. There were also differences among countries and areas as to the treatment survivors received and the stability of their positions. In terms of those in hiding, there were some who could have been turned over to the Nazis at any given moment while others found themselves in surroundings of relative safety. This heterogeneity is also applicable to survivors' experiences both before and after World War II and this variety has implications for coping and adaptational strengths manifested by survivors.

IV i. Pre-War Experience

Ornstein (1985) believes that how the survivor lived and coped prior to the war directly affected the ability to survive the ordeals of the Holocaust. Despite the severity and uniqueness of the situation in which they found themselves, the mode of adaptation to extreme conditions may very well be linked to the pre-Holocaust personality of the survivor.

Those who support this point of view point to the spontaneously arising reciprocal relationships among inmates of the camps. According to this view, the inmate survived by participating in an evolving camp social organization. One could not exist in the camps without somehow being involved in a relationship of sharing. There existed in the camps an understanding of the common predicament and of the need to act in a collective fashion. Camp life reinforced the notion that the need to help is as basic as the need for help.

Thus, it would seem that those who were better able to build reciprocal relationships within the camp were more likely to emerge from their experiences capable of adapting to new lives than those who did not build such relationships. One of the key variables affecting the building of such relationships would be how the survivor was raised in the family of origin and his or her encounters with others prior to the rise of the Third Reich. In this view, it is not pathology but personality and the ability to share which become determinative of the survivor's success in rebuilding life after World War II. For example, one who shared food or clothing , one who smuggled religious articles into a camp, one who helped organize cultural activities in the ghetto; these survivors likely carried these experiences into their postwar lives and utilized the same skills and talents in creating new lives. Those who were raised and developed personalities that interacted with and were open to other people were able to learn how create the kind of positive relationships with others that helped them survive and succeed both during and after the war.

IV. ii. Social Support

Building upon the above, these reciprocal relationships created a small but sustaining social support system that allowed many concentration camp survivors to endure their imprisonment with fewer long-term difficulties (Luchterhand,1970). Eitinger (1980) noted that this social bonding was decisive in in the individual's ability to retain part of his or her personality and self-respect, and therefore the capacity for survival. Des Pres (1976) claimed that that the relationships, solidarity, and interchange that existed in the concentration camps point to one of the essential means of surviving in the ghetto or camp, that is, creating a constructive social life in the extreme conditions of concentration camp and ghetto..

Those who adjusted to this life in the camps and ghettoes benefited, it appears, after the war. Kahana et al.,(1988) and Harel et al., (1993) found that, in general, survivors tended to have somewhat more extensive social networks and slightly higher levels of social interaction than comparison groups. Survivors were also more likely than comparison groups to share everyday and important concerns with family and friends. Survivors were also more likely to give and receive assistance and to help others during illness and crisis. These findings produce a different picture of the Holocaust survivor than earlier studies. They show survivors doing very well in terms of social support, social interaction, and social networking.

IV. iii. Coping Styles and Strategies-The Search for Meaning

The Nazi system, uncannily sensing what the human spirit lives by, could diabolically design conditions that were deliberately aimed at destroying the human spirit. The will to live dies without a sense of meaning. The Nazis created a Kafkaesque world in which the rules governing human existence were senseless, capricious, and often mutually contradictory. As Chodoff wrote, "If a diabolical intelligence were to plan an experimental situation which would be maximally productive of disordered behavior in human beings, the German concentration camps could not be improved upon for this purpose." (1963, p. 329)

In light of what they underwent, that there were survivors who possessed the resilience and strength to refuse to capitulate under the stress of extraordinarily difficult circumstances is certainly remarkable. These survivors acted on behalf of their fellow inmates who broke down under the strain, made it their mission to spiritually resist the evil to which they were being subjected. These individuals continued to uphold humane values that lent a sense of great meaning to their lives even under the most horrific circumstances.

It is here that the well known author and therapist, Victor Frankl, (1967) has made a significant contribution to our understanding of the Holocaust experience. In Auschwitz, he found, in the rags of a former inmate who had already been sent to the gas chamber, a single page from a Hebrew prayer book. The page contained a central Jewish prayer, *Shema Yisrael*, the command to 'love thy God with all thy heart, and with all thy soul, and with all thy might.' Frankl took these words as a challenge to living in the concentration camp. Witnessing the demise of human values as in the midst of the fierce struggle for survival in the camp, he realized that an active embrace and resolute practice of such values was essential if he was not to lose his sense of individual identity and human worth. In this way, he believed he could avoid falling victim to the dehumanizing and demoralizing influence of camp life. In making the effort to resist feelings of despair and meaninglessness, he was uplifted by the sense that he was being presented with a future task, to understand and explicate the psychology of the concentration camp. He would make himself and his problems the object of psycho-scientific study. This enabled him to rise above the current travails and to view his entire situation from a perspective of meaning. As he wrote: "Suffering somehow ceases to be suffering, the moment it takes on meaning" (Frankl,1967, p. 25). Indeed, it may be argued that, from a bereavement perspective, this is also an important observation. An important task in resolving mourning and the suffering accompanying it is to find meaning in a new life, a life lacking the presence of a significant loved one. Frankl believed that the key element of survival in extreme and traumatic circumstances is the knowledge of a task that gives meaning to life, even if that task could be nothing more than suffering bravely.

One of Frankl's students, Shantall(1999), did a study on the experience of meaning among survivors. She found that if the survivor was able to choose a course of action that seemed dictated by his or her conscience as the morally right or courageous thing to do, this kind of choice sustained and strengthened the survivor. If the survivor did not follow the course of least resistance and accept a morally problematic or cowardly action, they felt imbued with a sense of meaning, moral well being, and self-worth. They grew in human stature and psychological maturity. They could endure the worst suffering and emerge with a sense of integrity and spiritual, moral triumph. Although they were scarred by the severe trauma they suffered, nevertheless, they were able to take up their lives after liberation and, over the ensuing years, create meaningful lives for themselves and their families.

In all fairness, Shantall (1999) acknowledges that this kind of survivor is few in number. Moreover, no blame can be attached to the victims who succumbed to the pressures and sufferings of camp life. However, what the stories of the survivors upon whom this study focussed do teach is that suffering, in itself a tragic and meaningless process, can acquire meaning when an individual somehow can succeed in coming to moral grips with it. This is a notion that will be revisited in the context of the Holocaust survivor and the dying process.

IV. iv. Coping Styles and Strategies-Religiosity

Sara Botwinick (2000) conducted an in-depth study of four survivors focusing on the ways in which a religious Jewish upbringing contributed toward a special resilience that aided a person facing severe persecution. She also looked at how this influence impacted upon survivors adaptations both during and after the war. She notes how actions such as making personal decisions informed by Jewish values and beliefs, performing acts of kindness, telling stories about Jewish life in the home, and believing that God has chosen them to survive, helped these individuals survive the horrors they encountered. In these survivors' postwar lives, faced with the challenges of raising families and adjusting to life in new lands, religious coping abilities held up very well, even when new traumas were encountered. Botwinick mentions the case of one survivor who, in the early 1950s, lost his four-year-old son to a brain tumor. This man had lost his wife, his twin daughters, and his entire family of origin in the Holocaust. For many, this additional trauma would have brought on lifelong melancholia. Yet, what is this man's outlook? He puts it this way: "God will help. And thank God, He helped me, I'm well, and not sick, and I'm still alive." (p. 231) In terms of mates, these four religious survivors were looking for someone through whom they could revive emotional attachments to lost family members and someone who could join them in a life devoted to Judaism and the fulfillment of its religious obligations. These survivors grieved for their loved ones in small increments. Their grief did not become overwhelming due to the special demands of their religious lives that regulated daily living. This also, Botwinick notes, appears to be the case in terms of feelings of guilt.

Botwinick (2000) takes issue with Krystal (1981) who views religious practice as merely a defensive mechanism against potentially consuming anger and mournful feelings.

Botwinick argues that ritualized forms of mourning ensure that these emotions are not cut off. On the contrary, they allow for their expression in manageable amounts so that they can be resolved and integrated into the survivors' present lives. The ritualized public commemorations of grief throughout the Jewish calendar year also provide the survivor with ongoing group support.

Botwinick also argues that an object relations perspective on trauma allows for the integration of the religious dimension (Auerhahn and Laub, 1989). Religion, thus, functions as a protective shield for the victim as it reinforces the primordial relationship with his or her internalized "good objects." Moreover, writes Botwinick, the radical emphasis on self-enactment and human freedom and responsibility in rabbinic Judaism appears to have distinct psychological utility for Holocaust survivors. Through the performance of the commandments, the individual experiences a sense of control and reassurance. The mere act of concentration while reflecting on one's limitations in relation to God seems to have the potential to diminish feelings of resentment, anger, and fear. At the same time, these actions may conjure up the context of early childhood upbringing, enabling the person to unconsciously connect to memories of family and parental nurturance. It is the focus on the 'here and now' that is integral to the religious life and that can strengthen, on a daily basis, the survivor's coping abilities.

Botwinick concludes, however, on a cautionary note. Aging survivors may find that their memories of the Holocaust may become more intrusive as regular adult preoccupations move into the background and defenses become weaker. This process, combined with frailty, illness, and loss of family and friends, may allow for an onslaught of posttraumatic memories to which even the religious survivor is vulnerable. She believes that it is important for caregivers to intervene in order to reinforce these survivors' coping mechanisms.

V. ASSESSING THE TERMINALLY ILL SURVIVOR

This paper has reviewed the literature on death and dying and on the experience of the Holocaust survivor. We now turn to the bringing together of these two bodies of work and how these findings inform the assessment for social work intervention of the dying survivor. Once again, it should be noted that an assessment of a Holocaust survivor, as with any other assessment, should incorporate both strengths and weaknesses, both adaptation and coping difficulties. There are a number of themes that have been raised within both literatures. These need to be a part of any assessment of the survivor who is facing the dying process. Prior to this, though, the initial meeting and interactions with the various kinds of survivors and survivor families will be considered.

V.i. Engagement-Victim Survivors

It is likely that the worker's presence will be met by those survivors Danieli characterizes as victims with profound worry, fear, and mistrust. It is not too difficult to envision patient, spouse, and even family, overreacting with panic to the presence of any health care or support staff. Even those who have access to the patient, e.g., the physician, may be 'shut out' in the sense that as little communication as is possible may take place between them and the patient. Instead of communication, somatization may ensue and the patient may identify pains and discomforts previously absent. The normal fear and anxiety may be dramatically magnified. Any new staff member who enters the room may not get only a cold reception, but a frightened one. The survivor may seek to have the family rally around him for protection. The children may act as gatekeepers for the patient while, at the same time, attending to all of the parents' needs. . It is also probable that any contact with outsiders would be mediated by the survivor's children. Moreover, in general, these survivors were very cautious about making decisions. Making the right choice and being in control, even if magically and arbitrarily so, appears to have compensated for the survivor's prevailing sense of passive helplessness and demoralization during the Holocaust. The worker then should expect to encounter obstacles to interaction as indicated above. It will likely be necessary to establish a relationship with the children and/or the spouse in order to gain access to the survivor patient. The worker should also be aware that even the most elemental decisions concerning care and activities of daily living will likely be examined very closely and will engender much deliberation.

V. ii. Engagement-Fighter Survivors

For the so-called fighter survivor, activity and drive are important. Weakness or victimization was not tolerated. Illness was faced only when it turned into a crisis. Self-dignity and pride are viewed as very important virtues. The ability to overcome obstacles and withstand stress are praiseworthy attributes to these survivors. As in the case of victim families, outside authorities are not to be trusted. In contrast to victim families, however, defiance and aggression toward such authorities is encouraged.

The worker may encounter a patient and/or family that will not feel there is any need for any intervention. "Everything is fine. We don't need anything" the worker may be told. It may be necessary to describe what services are being offered so the patient and family will understand why the worker has come and what kind of assistance is available. It may be necessary to come back more than once in order to connect with this kind of survivor. The worker may also encounter outright defiance and may need to reflect this back to the patient and family so it can be worked with and resolved.

V. iii. Engagement-Numb Survivors

Numb survivors will, in general, be difficult for the worker to engage. The notion of being a patient in a hospital room may only heighten the sense of shock and resignation these survivors carry with them at all times. They may respond to the worker's presence by not responding, that is, with no reaction and no affect. It is here that the worker may need to engage with the family and provide service to the patient through them. Although the children of these survivors often provide protection for the parents, they would be less likely than in fighter families to block access to the worker or keep the worker away.

V. iv. Engagement-'Those Who Made It'

Probably the easiest access to survivor patients lies with this final grouping, the survivors who were outwardly successful in adjustment to postwar life. They would likely be those with the greatest awareness and understanding of the social worker's functions. The family, in many of these cases, tended to be subordinate to the survivor. Therefore, the worker should discuss matters directly with the patient.

In terms of instrumental needs and daily activities, the worker should be able to provide assistance, guidance, and support. However, as denial of the effects of the Holocaust is so pervasive in this group, the worker may find that this is one area where access is blocked and discussion is not permitted. The worker may be able to learn of a survivor's activities surrounding Holocaust commemoration; the worker, though, will probably not be able to explore the emotions stirred up by these ceremonies and their effect upon the survivor.

V.v. Shared Components of Death Theories

The various theories of death and dying include at least one component involving completion and/or resolution. Doka (1993) calls it preparing for death and saying good-bye. Worden (2000) refers to completing unfinished business before dying. Rando (1993) refers to relinquishing the old attachments and the old assumptive world. Steinhauser, Clipp, McNeilly, et al.,(2000) list a number of aspects making up what they call completion. These include issues of life review, reconciliation, spending time with family and friends, faith, and saying good-bye.

V. vi. Life Review-Victim and Numb Survivors

The remembrance of past trauma is difficult for the victim. For victims of the Holocaust, reminiscence is excruciating and painful. How does one engage a patient in a life review that will cause feelings of profound helplessness, passivity, loss, humiliation, and depression to emerge? If, at the very least, a helping professional seeks to do no harm, may it not be a problem to even engage in life review with a patient or family. Indeed, there are survivors who deliberately shielded family and children from the Holocaust by not sharing what happened to them at all, by keeping it secret. Workers must tread very delicately here. It cannot be assumed that survivors can or want to perform a life review. It cannot be assumed that families know about the survivors' experiences in any depth or detail. Having said this, workers can assist in partial life review, before the war and/ or after it. Indeed, this can be very valuable as it can shed light on coping and adaptational strengths that could be summoned through the dying process.

V. vii. Life Review-Fighter Survivors and Those Who Made It

It would seem that survivors in these two groups would be more likely candidates for life review. They feel that they have adapted through, in one case, assertion and fighting, and, in another, through material and social success. These survivors would probably wish to look back upon what they overcame and what they accomplished. Nevertheless, what these survivors may not engage in is emotional reflection on their Holocaust experiences. For the fighter, this would be a sign of weakness and for the one who made it, there would be denial that there was any emotional impact upon their lives due to the Holocaust. Thus, even those survivors open to engaging in life review may do so in great factual depth while avoiding emotional depth.

V. viii. Reconciliation

Unfinished business is an essential element of death and dying theory. In this context, this does not refer to business or financial affairs. Instead, it concerns interpersonal matters, in particular, conflict resolution and reconciliation among families and friends.. In this issue, as well, caution and deliberateness are called for. Looking at Danieli's (1988) taxonomy, it is once again, not surprising that this may not represent a viable goal for many survivors and their families. Numb survivors would likely choose simply not to engage in the discussion at all. The low threshold for stimulation, along with the apathy and social withdrawal would preclude such a resolution. Victim and fighter survivors could, in general, view any attempt at conflict resolution within the family as a threat to family integrity and unity. With Danieli's so-called 'those who made it' group, would the use of denial occur in the context of conflict resolution as it often did in the context of sharing Holocaust experiences with family members? In all likelihood, the answer is yes.

Despite the above, a worker needs to be sensitive to the individual personalities and family dynamic in any given case. As in any scenario of death and dying, reconciliation and/or conflict resolution may or may not be applicable or realistic. The life review, even a partial one that only concerns prewar or postwar life, may be very valuable here as it may indicate whether or not conflict resolution is a viable task of completion for a patient or not. Such a review that reveals an ongoing commitment to religiosity or purpose, a history of social interaction, or a family of origin that encouraged discussion and airing of views; this survivor patient may well be encouraged to engage with family in the resolution of problems and tensions. These causes are not mutually exclusive; the survivors influenced by them consider the notion of 'making peace' significant in their lives. As such, their value is likely increased as the end of life approaches.

V. ix. Family and Friends-Numb and Victim Survivors

The survivors in these groups often exhibit no affect; they present symptoms of alexithymia and do not necessarily wish to speak with the doctor and nurse much less with anyone else. It is likely ill-advised to encourage such a patient to have many visitors or send in the art and music therapists, for instance. If a patient and family have coped by closing themselves off in the past, they will do so as well during the dying process. The worker can usually learn very early in a visit whether or not visitors will help a patient. This can be gleaned from the way the worker is received as well as the reaction the worker receives to suggestions to involve other members of the multidisciplinary team. In addition, many of these survivors will have a very small coterie of visitors. These visitors will normally be immediate family members and possibly one or two very close friends. Other friends and even extended family members will often never be seen visiting these survivor patients.

V. x. Family and Friends-Fighters

The theme of spending time with extended family and friends (e.g., Doka, 1993) can be problematic for some patients and families. As was noted in the discussion of Danieli's taxonomy, a number of survivors and their families tended to be insular and isolate themselves from outsiders. Outside of the immediate family, terminally ill survivors may not be open to having friends and other relatives visit and see them in an ill and weakened state. The survivor who is a fighter does not want vulnerabilities and neediness revealed to others. Such a survivor, as indicated above, cherishes pride and may want to limit his visitors to only a select few.

V. xi. Family and Friends-'Those Who Made It'

In contrast to fighter survivors, these survivors may wish to be surrounded by many people. These survivors have generally been the dominant personalities in their families and may well desire to maintain this role, even in the midst of illness and the increasing threat of death. In addition, those of this group involved in commemoration, combating genocide, and the arts, may gain strength and support from the presence of their cohorts involved in these activities. In many cases, the issue of family and friends providing support may not need to be raised by the worker; their presence with the ailing survivor will speak for itself.

V. xii Faith

Steinhauser, Clipp. McNeilly, et al., (2000) add issues of faith to the theme of completion. This is insightful, though, it can be argued that this aspect of completion should be broadened beyond matters of faith. It should include any means of finding a purpose for one's life and death, as suggested by Doka (1993). Shantall (1999) and Botwinick (2000) discuss the strength survivors gained through religious faith and the search for meaning in their lives. It appears that, for many survivors, this entire area of faith and meaning is off limits; it is taboo. However, it also appears that there can be a positive relationship between finding meaning in life and bringing that life to a close. For this writer, practice, combined with the literature cited above, suggests that survivors who have sought and found this meaning, whether or not that meaning possesses religious content, are more likely to review their lives, seek resolution, and bid farewell to family and friends. It seems these survivors are able to transcend the trauma and loss they have known. However, it may be counterproductive to attempt to engage survivors and their families in an undertaking that they simply may not be capable of facing.

V. xiii. Saying Good-bye

Saying good-bye is a basic task identified by theorists writing about death and dying. Corr (1992) includes it in the discussion of the social implications of dying. Rando (1993) refers to it as part of the task of relinquishing old attachments. However, Rando (2000) also properly notes that one of the traumatic aspects of anticipatory mourning is the resurrection of one's own personal fears, concerns, or sensitivities. This kind of reaction may be properly seen in many survivors. First, in many cases, survivors never had the opportunity to say good-bye to their families when they were separated during the war and this engenders guilt and great sadness. Saying good-bye reminds the survivor of the mourning they may not have resolved. It is important here to bear in mind that these responses are also found among the general population. However, in the case of survivors of the Holocaust, the losses were uniquely horrific and overwhelming and thus, the reactions can be magnified. The grief and emotions may, at times, seem unbearable.

Moreover, according to the Danieli classification of survivor families, saying good-bye could undermine the coping styles of each of these types. The victim type was often protected by the family and losing through death that family and protection can be terrifying. For the fighter type, the dying process could represent resignation and giving up hope. This may be almost unthinkable to many of these survivors. They never ceased fighting and they are likely not to change at the end of their lives. At the same time, numb families may be too frightened to engage in this aspect of completion. Survivors who made it may simply deny the need to undertake this effort as they may cope by denying what is happening to them. It is probably best for a worker to develop a profile of patient and family and then determine whether this is a viable task. It appears that, for a significant number of survivors, it may well not be viable.

V. xiv. Denial

Worden (2000) includes among his psychosocial dimensions the reduction of fears. Buckman (1993) describes the task of resolving elements of emotions that can be processed for closure. Doka (1993) suggests that the dying person should be encouraged to ventilate fears and feelings. The worker, working with a Holocaust survivor, would do well, though, to approach the discussion of feelings and emotions with hesitation. Krystal's (1981) discussion of anhedonia and alexythymia are relevant here. Many survivors have managed to maintain themselves by not even allowing for connection to their emotions or for the experience of their feelings. This is likely common among survivors or witnesses to trauma in general. However, what may be unique among Holocaust survivors is that this has become, for many of them, a way of life. If one considers Danieli's classification, in each group, the exhibition or expression of emotion was seen as a sign of weakness or a breach of family security. In addition, any sign of affective, i.e., psychological illness or difficulty was deemed problematic as, among these survivors, only physical illness was deemed appropriate for professional or medical intervention. It would appear that the idea of difficulties in emotional life was unbearable to survivors because the emotions that had so overwhelmed them during the war would return and the survivor would be thrust into a situation of regrieving. This was simply too much for many survivors. Once again, as above, what is essential here is for the worker to assess coping strategies and strengths. Survivors with good social supports and those who restored to their lives a sense of purpose may be able to talk about fears and feelings and, in fact, may be able to resolve some of these feelings. Others will struggle not to engage them; still others may respond by showing even less affect. It may not be a helpful for the survivor and worker to attempt to revisit the source of such anxiety, depression, and suffering.

It was noted in the first section of this paper (p. 31) that Worden's (2000) view of denial as an intermittent phenomenon that can be resolved appears to be overly simplistic. It is acknowledged by Rando (2000) that denial is commonly manifested as a defense mechanism in trauma. So, too, it may function in this way for the dying patient. Yet, for many survivors, denial is another aspect of their way of life in that it is the outward expression of the unwillingness to reengage long suppressed emotions. Moreover, it would appear to be an elemental adaptational response by survivors. For, if one can deny the affects of trauma, one can control its effects and this is very important for many survivors, as was indicated in the discussion of Danieli's taxonomy. Denial equals containment. Containment is the way to continue living after tremendous dislocation and loss, loss of family, friends, and community. These losses often occurred with little warning and in quick succession. For many survivors, the only way to assimilate these catastrophes was not to assimilate them. Rather, they were suppressed and their impact denied.

Among that group characterized by Danieli as 'families who made it', their adaptation was based on a kind of reverse assimilation. They assimilated into the surrounding culture and society through denial of and avoidance of their pasts. In other words, they assimilated in one direction by not assimilating in another. Their denial was often so complete that even their children remained uninformed about their parents' experiences often until well into their adulthood. It should not be surprising that , as the threat of dying increases, such people should once again turn to denial in order to manage their interpersonal and emotional lives.

Here, too, as before, denial is not ubiquitous. Among this group of survivors, there are those who attempt to work through the impact of their pasts through communal work and Holocaust education. Some of these survivors are steadfast in attempting to ensure that the horrors they witnessed will not be repeated. There are also those survivors who have come forth and participated in videotaping their stories so a record of what happened will be preserved for future generations. Yet, one here must also look at the particular strengths and resiliencies this group of survivors possesses. The experience of this writer in working with this population is that these survivors tend to have developed networks of social and/or existential support. They may also have developed strengths from their families of origin and their prewar lives. For example, it was noteworthy for the writer, working in a hospital palliative care unit, to find many of the survivors who were admitted to the unit unwilling to even acknowledge they were Holocaust survivors. This information usually was learned through the family or caregiver. On the other hand, one male patient, a survivor, immediately acknowledged that he had been in labour and concentration camps and described, in great detail, his experiences. He could even recall exactly the amount of bread, in grams, that he was given in the camp. This same patient has been a member of two synagogues and had already received visits from three rabbis. This does not mean, of course, that denial has no role in a case like this or that every survivor connected to a synagogue or Jewish community will speak of and acknowledge their personal histories. Nevertheless, there does appear to be a relationship here. The worker can more likely inquire about war experiences with a survivor who has been able to find or access social and existential supports and be told about them. For other survivors, though, the denial appears to be essential for them in the dying process and this defense will likely remain in place and should be respected.

V. xv. Summary

The assessment of the terminally ill Holocaust survivor involves assessing the patient's and family's openness to engage in the tasks of death and dying. In many cases, before this can be determined, the patient and family may erect considerable obstacles to the worker's access. Of course, this may be seen among the general population as well. However, it is the strength of these boundaries and their impermeability that is striking and workers unfamiliar with the survivor population may be taken aback by this. Albeit that in aging and dying, even survivors with much support may put up such boundaries. Still, these boundaries are probably more easily overcome by the worker and such a survivor will be accessible to the worker. It is also probable that such a patient will be open, given some time, to engage in at least some of the dying work that has been discussed above. The greater difficulties arise where access is difficult to achieve. There may be some cases where assessment is almost impossible and the worker can do no more than indicate availability and readiness to help and go from there. There may be cases where a Jewish professional would have more access than a non-Jewish one and the worker may have to look to colleagues or other members of the team for assistance. There are cases where the worker will only be engaged by the family and/or patient for instrumental or administrative needs. Again, here, such cases exist among the general population, too. Among the survivor population, though, it is the incidence and power of these types of cases which distinguishes them. Moreover, there is another type of survivor case which may be seen and poses special challenges to the worker. This is what might be called ‘the patient/family dichotomy’ case. In this scenario, which this writer has found to be fairly common in his work, the patient may give very little access to the worker while members of the family are quite open to discussing feelings, needs, etc. Some families are open to engaging in, from their side, life review, saying good-bye, expressing fears and feelings, etc. It is therefore, essential for the worker to initially discover if there is a role for him or her to play with the family, even if the interaction with the patient is marginal. Some perseverance and presence may yield results. It must always be kept in mind that the patient and family are not necessarily approaching the situation in the same way. One of these parties may be aware of needs and issues and be amenable to intervention while the other may not be open to exploring these matters at all.

VI. INTERVENTIONS

What kind of interventions should the worker have in mind in approaching survivor patients and their families? It would appear that, in general, there are three kinds of activities that the worker can utilize in these cases. None of these are mutually exclusive; they may be used in different ways at different times and under different circumstances. The first of these activity sets is strictly instrumental. As was indicated above, survivors and their families may create boundaries to the intervention of a worker due to mistrust of outsiders and these boundaries are often difficult to cross. Many of these survivor families fit into Danieli's classification in which the outside world is seen as threatening and family unity and loyalty is paramount. In such cases, the theories and tasks of the dying process do not come into play or, if they are manifested, this is limited to the family itself. Nevertheless, the worker does have a role to play in terms of basic life activities. The family, even the patient, will have concerns that the worker can address. These include questions concerning home care if the patient is hoping to return home, bathroom aides and modifications, obtaining walkers, wheelchairs and other ambulatory devices, and accessing government programs for financial and other assistance. For these needs, the family may be looking for help. Moreover, the family and patient often do not know where to turn. This writer, also being a clergyman and chaplain, has often encountered the situation in which a family or patient asks him about matters such as these. He, sharing religious and ethnic background with them, gains access more easily than the non-Jewish social worker and families feel comfortable asking him about these issues. So, the referral is made to the worker, whom the family has often already met, but without knowing how the worker could be of assistance. With the suggestion of chaplain, nurse, or physician, the worker is usually allowed in for these instrumental needs.

The worker should also be aware that death and dying work may take place with these kinds of cases but with other members of the team. The nurse, physician, or psychologist may develop a relationship that allows for some of these tasks to be explored. More frequently, the chaplain, art therapist, or music therapist engage the patient or family in ways that may involve matters such as reconciliation and life review. Nonetheless, such engagements may be limited in scope and may not have the broad perspective of the worker. In some cases, pain management and keeping the patient comfortable may be all that the palliative care team can do for this patient and family. Denial will likely be utilized or some kind of fighting back will be called upon. These defenses do not allow for confrontation with all that is happening to and around the dying patient.

The second set of activities concerns the patient who possesses the strengths to overcome the results of the multiple traumas in the life of a survivor. This patient will probably be open to engaging, to some degree, in life review, expressing feelings, saying good-bye, reinvesting in future, etc. Such a survivor will have likely participated in video testimony and other Holocaust commemorative activities. Such a survivor will have social connections and positive family ties. They may or may not have worked through existential and religious issues such as the meaning of life or death. The worker can bring up various tasks of death and dying and attempt to help the patient undertake them. The family may choose to be involved, but that is certainly not so in all cases.

It is also of great importance for the worker to be sensitive to how far a patient wishes to go in exploring these areas. This should always be a concern, but it is especially significant in the case of a Holocaust survivor. For the experience of dying may reactivate trauma for any survivor. If to this is added the issues arising from institutionalization, it is not difficult to conceive of overanxious, frightened reactions by survivors. The writer has witnessed survivor patients' response to being shifted to a different hospital room. Suddenly, all their belongings were gathered up and they were taken, on their hospital beds, to the elevator. Even among the kind of patients described here, overreaction and panic took over. In a similar vein, survivors may talk about their past lives in great detail, with the exception of the war years and, in some cases, the postwar years, as well. If they are asked about these, their mood may quickly shift to silence and gloom. Does it make sense to force the issue and try to explore these traumatic reactions? It is always best, in such scenarios, to take one's lead from the patient. Still, it is likely that this exploration should not be undertaken. The terror, trauma, and loss are too great. The time remaining may be too short. The physical and emotional strength are often insufficient. Yehuda, Kahana & Schmeidler, et al., (1995) argue that an important component in the psychotherapeutic process in posttraumatic stress syndrome is to focus on how current stressful events are viewed through the lens of past traumata. However, this writer questions whether this approach is fruitful in the context of the many losses and the physical deterioration of the dying process. It seems an emotional overload can descend upon survivors and they will turn to the coping styles they develop throughout the war and afterwards. The worker should respect these limits and work within them. An example of the kind of intervention possible under these circumstances is to refer to the art therapist to help the patient relive the prewar experience that the patient has shown a willingness to talk about. If this is the only reminiscing a patient can undertake, let the worker help the patient explore that aspect of the past to the fullest.

The third activity set concerns a patient who closes off intervention in the dying process and a family who is open to this kind of intervention. For the patient, concrete services will probably be sufficient. In terms of the family and for the sake of taking a first step in developing interventions, we will consider the four family types described by Danieli and juxtapose this to Rando's six 'Rs' as her approach is particularly well-suited as it is designed for anticipatory mourning which is certainly relevant to the experience of the family of the terminally ill Holocaust survivor.

Danieli (1988) writes that children in families of victims were not allowed to establish their own personal boundaries. Any assertion of independence or privacy was viewed as a threat to the intactness of the family. Often, these children provided the only meaning and content in their parents' lives. Family goals and symbiotic devotion were demanded of them. They were also called upon to mediate between mother and father and between the parents and the outside world, to serve as confidants, and, in many cases, to parent their parents. Guilt, the notion of "they have suffered enough. How could I possibly add to their pain?" kept many adult children from asking their parents about their war experiences, from expressing anger toward them, and from sharing their own pain with their parents.

If we turn now to Rando's schema, there are areas where interventions might be very helpful to this family, if they are open to exploring these areas. The worker might help the children acknowledge their reaction to the separation and to express the symbiosis and what that meant to them. The process of recollecting and reexperiencing the relationship might be useful in helping a child in this kind of family understand his or her need to mature quickly and be adults for their parents. Perhaps this could serve as an opportunity to grieve for a lost childhood and to confront the anger this loss has engendered. This could also be an opportunity to fill in, perhaps with the help of family and friends, the details of the parent's life, those things that were either never shared or merely hinted at.

The readjustment to a world without the survivor parent could be an opportunity to resolve feelings of guilt about not sharing their own pain with their parents. Of great significance is Rando's notion of reinvesting in other people and other aspects of life. It seems many of these children were raised without developing themselves as individuals and without independence. Often, according to Danieli, the over involvement in and overprotection of their parents' lives diminished the capacity to foster outside relationships in general and marital and sexual relationships in particular. Thus, these offspring possessed the major identity of being a child. As such a person contemplates and prepares for the death of a parent and the relinquishing of part of that identity, they may need much support and guidance in so doing. The process of refocusing one's life under such circumstances is at best, slow, and at worst, terrifying. These children may actually have no other people in whom to reinvest; they may find it awkward to look at engaging in parts of life they never could before. The worker's interventions here could be of great benefit in guiding these children to a different view of their lives and how they can be lived. Referral for therapy may be necessary; referral to community organizations may be, as well. Holocaust programs and second-generation resources may be accessed. These processes can all begin with the help of a worker even while the survivor is a palliative care patient.

In fighter families, the main identity was that of the fighter/hero. The children preferred 'taking charge', 'fighting for', or 'being against'. Consequently, sharing was difficult as was delegating responsibilities to others. These children dreaded passivity and helplessness in themselves and others and, thus, had difficulty with peer and other relationships.

In the fighter families this writer has encountered, sometimes during palliative care treatment, the family lets down its guard. The children may recognize the loss and need help in relinquishing old attachments to the parent. This may be difficult for them and they may need to be allowed to remember the survivor parent as they really were. They may need assistance in acknowledging the separation and the powerlessness a terminal illness engenders. They may have no concept that they can relate to others without viewing them as threats or adversaries capable of harming them. The search for validation and esteem may have to turn away from parents and family, difficult as this may be. The worker would have numerous ways of helping the child of a father family. Example, role playing might be valuable in the context of looking at different approaches towards relating to others and sharing with them.

Children in numb families tended to be either numb themselves or quite angry. These children could be, like their parents, quite fearful. They often looked to peers and outside authorities in an attempt to find models of maturation. They often did not see their own needs as worthy of attention. Since they rarely felt important at home, this is not surprising. In cases like this, exploring the emotional reaction to separation may be important, if a worker is allowed to do so. Reinvestment could also be significant here. The worker, though, may have to adapt to being viewed as an authority figure by these children. It may also be useful for the worker to identify him or her as working toward helping them meet their needs because often, in these cases, they have not seen themselves as worth the trouble and effort. One might question, with validity, how many of Rando's themes can be managed by this kind of family. Indeed, this type of work is quite difficult as the results may be limited in the end. Still, whatever amount of work this kind of family will undertake would be very valuable and might lead to opening up other issues for them. Thus, it is difficult to know where this work should begin and which of the 'R's is relevant for this family as they may be so fragile that to have a loved one in palliative care may be enough to totally overwhelm them. Nonetheless, it needs to be attempted. Given the proper circumstances and surroundings, the children may be ready to work and even discover aspects of their own past and the relationship to their parents of which they had never been aware.

Children in the families characterized by Danieli as "those who made it' often experienced inner numbing and isolation. This led to distant but cordial relationships between family members. The denial that often operated among these families interfered with the creation of intimate family relationships. The survivor's role in these families was the dominant one; other family members took subordinate positions. The children reported feeling emotionally neglected by their parents, except in those areas leading to professional or financial success. In addition, many of these survivors tended to, not surprisingly, deny any long-term effects of the Holocaust upon their own lives and those of their children.

It is possible that this kind of survivor child could benefit greatly from intervention by a worker. To return to Rando, recollecting and reexperiencing the relationship could be very helpful, despite the pain it would engender. It could also be argued that this task is important to the sub-group of this type of survivor who devoted much of their time and energy to commemoration and attention to the Jewish experience during the Holocaust and honour for its victims. Some of these children feel that they are being emotionally suffocated by what they see as their parents' relentless pursuit of these activities and the neglect of their own emotional needs. This, of course, is similar to the children in the 'denial' families.

Moreover, the tasks of readjusting without forgetting and reinvestment may be very difficult for these offspring as they may have been caught in the conundrum professional and financial ‘adulthood’ along with emotional adolescence. How does one readjust without rebellion and dismissal of the dying person and their life? If an individual's goals and ambitions have been set by the dying person, how does this complicate reinvestment? These questions could also apply for children in the numb families, as well. A worker who is sensitive to these issues may find that there is much that can be done for families even while there may be little that can be offered to the dying Holocaust survivor himself.

VII. CONCLUSION

VII.i. The Research Question

The results of the investigation undertaken in this paper lead to a distinct conclusion. Based upon the material presented and analyzed, it can be concluded that the components of the theories of death and dying discussed here are not applicable to many survivors of the Holocaust. The fact is that, for many survivors, the tasks or objectives which make up these frameworks are simply unachievable. The terrible traumas of the war years and their accompanying effects upon the lives of these survivors do not allow these patients to undertake the life review, relinquishing all that has made up their lives, and reconciliation, to name a few, these theories propose as necessary in order to prepare for a good and appropriate death. Moreover, denial appears to be a major coping mechanism for many survivors and there is every reason to believe that it will continue to be so even as a survivor faces death. This reality, in and of itself, according to the theorists, is a major obstacle to engagement in the various tasks of dying. After all, if one is denying the emotional assault of the dying process, how can these emotions be felt, much less managed?

Having shown the inapplicability of the death theories for many survivors, it must be acknowledged that, as in the general population, those survivors who have found a means of giving meaning to their lives, through social connections, religiosity, or a combination of these, are usually in a better position to engage in the tasks of death and dying. From the literature reviewed in this paper and from clinical observation, such survivors possess the resiliency and strength to undertake life review, saying good-bye, etc. Denial is also not an issue for these survivors; these individuals could not have found some purpose to living if they had denied the emotional realities of those lives. Still, the literature indicates that these survivors make up a very small percentage of the survivor population.

Yet, it must be admitted that this paper is a work in progress. For the question remains as to a theory of dying that fits the survivor experience. This paper does not include an answer to this question. The writer would suggest, as can be seen in the discussion of assessment and intervention, that although the tasks of death and dying may not be accessible to survivors themselves, they appear to arise as issues for the families of these patients. Although this is not the focus of this paper, it is here where much social work intervention lies, as suggested in the paper. In addition, one who would seek to develop death and dying theories for the survivor population needs to be aware of this reality.

VII. ii. Suggestions for Further Research

Further research should focus, upon the children of survivors and how they cope with a parent's terminal illness. This requires examining the significant research already available concerning the second generation along with clinical observation. It will also be of great interest to explore how this second generation itself manages death and dying. Many of the children of survivors, though, are now in middle age so it will be some time before this study can be performed. This writer would also propose that such a study include a retrospective view of how these children coped with their parents as terminally ill patients. The congruities, or lack thereof, between the two would be very enlightening for both Holocaust and death studies.

Another key question that needs to be investigated is whether or not these findings are transferable. Does the experience of death and dying among elderly Holocaust survivor share anything in common with other survivors of terror and mass murder, for example, in Rwanda or Cambodia? Does the trauma these victims underwent produce similar issues for death and dying as have been described here concerning Holocaust survivors? Would a cross cultural study suggest different theoretical approaches as the theories presented in this paper reflect a 'Western' worldview? Is there as need for a separate theory of death and dying for those who have suffered monumental trauma? It would also be important, in this regard, to examine whether or not cultural differences in approaching death and dying remain in the face of traumatic onslaught. Does a person's cultural training remain intact even if that culture is being ruptured or destroyed?

Finally, it would be valuable to study what kinds of interventions are useful for palliative care social work. How can the traumatized patient and family be helped? How should a worker approach cultural difference as it effects the end of life? These, along with other questions of intervention, also deserve serious consideration and exploration.

VII. iii. A Final Word

The population of those who actually experienced the "Final Solution" at the hands of the Nazis is dwindling. Within ten to fifteen years, all but those who were very young during World War II will be gone. Those who wish to study this population, be it for death and dying studies, aging studies, or second generation Holocaust research need to move quickly or it will simply be too late. Studies of this special group of seniors must be undertaken in the very near future. So many have learned a great deal from the personal narratives of Holocaust survivors. Much time and effort has been expended in preserving these testimonies on tape for future generations. Yet, there is still much to be learned from these individuals who witnessed horror and tragedy beyond human comprehension. May they continue to teach, to inform, and to inspire.

APPENDIX A

The criteria for Posttraumatic Stress Disorder may be summarized as follows (American Psychiatric Association, 1994): 1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury and the person's response involved intense fear, helplessness, or horror; 2) this event is reexperienced persistently through recurrent and intrusive distressing recollections, recurrent distressing dreams about the event, acting or feeling that the event is recurring, intense psychological distress at exposure to external or internal cues symbolic of the event, and physiological reactivity on exposure to these clues; 3) persistent avoidance of stimuli associated with the trauma(e.g., efforts to avoid conversations about the trauma and activities, places, or people associated with it, inability to recall important aspects of the trauma, feeling detached or estranged from others, restricted range of affect, and a sense of a foreshortened future); 4) persistent symptoms of increased arousal (e.g., difficulty falling or remaining asleep, irritability or angry outburts, difficulty concentrating, hyper vigilance, exaggerated startle response); 5) duration of the disturbance is more than 30 days; 6) the disturbance causes clinically significant distress or impairments in social, occupational , or other important areas of functioning.

The criteria for Acute Stress Disorder may be summarized as follows (American Psychiatric Association, 1994): 1) same as number 1 for PTSD; 2)either while or after experiencing the distressing event, the individual experiences certain dissociative symptoms such as numbing, detachment, lack of awareness of surroundings, derealization, depersonalization, and dissociative amnesia; 3) the traumatic event is often reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashbacks, a sense of reliving the experience, or distress on exposure to reminders of the traumatic event; 4) marked avoidance of stimuli that arouse recollection of the trauma; 5) acute symptoms of anxiety or increased arousal (e.g., sleeping difficulties, irritability, poor concentration); 6) the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning ; 6) the disturbance lasts for a minimum of two days and a maximum of four weeks and occurs within thirty days of the triggering traumatic event.

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