A close-up photograph of an elderly person's arm, showing a tattooed identification number '98289' on the forearm. The skin is wrinkled and aged. The background is dark, making the arm and the tattoo stand out.

CARING FOR
H O L O C A U S T
S U R V I V O R S
WITH SENSITIVITY
AT END OF LIFE

A Guidebook for Clinicians

Dear Colleagues,

As clinicians and professional caregivers whose mission it is to manage pain and suffering, we are bound by an oath to “do no harm” and to provide culturally sensitive care. When providing services to Holocaust Survivors and war victims, it is important that we are mindful of our words and actions—particularly because we may be the last generation of caregivers and clinicians who have the honor, as well as the moral obligation, of delivering compassionate health services to Survivors.

As one of the largest hospice programs under Jewish auspices in the region, MJHS understands that members of the Jewish community have different levels of observance, and so we tailor our hospice program to meet the individual spiritual and religious practices of each patient. For those who wish to participate, we offer the *Halachic* Pathway—which is funded by MJHS Foundation and ensures that end-of-life decisions are made in concert with a patient’s rabbinic advisor and adhere to Jewish law and traditions. Our sensitive care to Holocaust Survivors and their families takes into consideration the unique physical, emotional, social and psychological pain and discomfort they experience when facing the end of life. This is one of the many reasons why we seek to share our insights and experiences.

This guidebook is for clinicians who have never, or rarely, worked with Holocaust Survivors. It is meant to help users gain a deeper understanding of end-of-life issues that may manifest in the Holocaust Survivor patient, especially ones that can be easily misunderstood or misinterpreted.

We are confident that this guidebook will:

- Be an educational tool and resource for professional caregivers serving Holocaust Survivors and their children, the Second Generation
- Educate clinicians about how post-traumatic stress disorder (PTSD) manifests itself at the end of life in Holocaust Survivors
- Raise self-awareness of their own comfort levels and reactions in clinicians and caregivers when working with Holocaust Survivors

The material in this guidebook has been compiled from multiple sources. It is, however, largely based on a keynote lecture by Irit Felsen, Ph.D., Clinical Psychologist and Trauma Specialist and an Adjunct Professor, Yeshiva University Ferkauf School of Graduate Psychology. Her lecture was part of an MJHS-sponsored educational program for clinicians and professional caregivers entitled “Their Last Days: Aging Holocaust Survivors Facing the End of Life,” which was delivered at the Museum of Jewish Heritage in New York City. In addition, her guidance, feedback and support helped us create this educational tool with practical application.

Baycrest, a Toronto-based geriatric care health system, renowned for its expertise in caring for Holocaust Survivors, is also a key resource. The Canadian organization’s practical manual called *Caring for Aging Survivors of the Holocaust* is a valuable reference book for all caregivers working with Holocaust Survivors.

MJHS is committed to delivering compassionate expert care while offering peace of mind and providing comfort. We were founded in 1907 by the Four Brooklyn Ladies. Generous charitable support from their community enabled them to establish the Brooklyn Ladies Hebrew Home for the Aged. Rooted in the core Jewish values of compassion, dignity and respect, the home offered frail, elderly members of the community quality health care and a safe place to live in their time of greatest need.

Today, those same core values continue to guide us. From the small building among the tenements, we’ve become one of the most expansive health systems in the region.

We offer patients and their families an opportunity to live life to the fullest. As a charitable not-for-profit, our focus is on easing suffering, upholding dignity, affirming values and improving quality of life for patients at home or in the hospital, assisted living communities, nursing homes or one of the exceptional MJHS Hospice Residences in Greater New York.

From the first to last pages of this guidebook, we hope you remain informed and inspired.

Sincerely,

MJHS Hospice Caregivers



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Section

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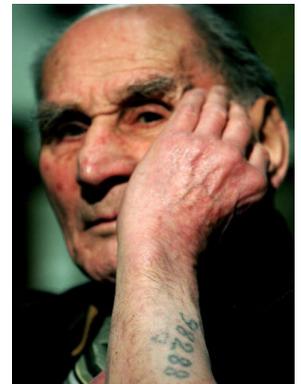
Learning Objectives and Context

In the course of this guidebook you will learn:

- Ways to provide care to Holocaust Survivors
- How post-traumatic stress disorder can manifest itself in routine care
- Ways to recognize and address relationships in the context of First and Second Generation family members

Historical Overview of the Holocaust

The Jewish Holocaust, or *Shoah* in Hebrew, refers to the systematic, deliberate and carefully planned attempt to annihilate all European Jewish communities and to exterminate all individuals of Jewish ethnic ancestry. In early 1933, the Nazi party came to power in Germany, and under Adolph Hitler's rule it implemented the persecution and segregation of the Jews in minutely organized stages. State-sponsored racism introduced and supported anti-Jewish legislation, economic boycotts and confiscations, as well as isolation of the Jews from all classes of the general population. This plan came to be known as the Nazi's "Final Solution to the Jewish Question."



On September 1, 1939, the Germans invaded Poland. This single event is most often cited as the start of World War II. During the next several years, much of continental Europe was conquered, subdued and devastated by Germany. Anti-Jewish proclamations escalated rapidly. This led to the imprisonment of Jews and eventually the murder of most European Jewry. First the Nazis established sealed ghettos to which they deported the Jews from Poland, Western Europe and the Balkan nations. These ghettos were extremely overcrowded and unsanitary, and the Jews suffered from starvation and contagious diseases, in addition to inhumane living conditions.

Section

1

Definitions and Terminology

Who is considered a “Survivor?”¹

Survivors of the Holocaust are defined as persons who lived in one of the countries that was occupied by, or under the influence of, the Nazi regime for any length of time between 1933 and 1945. Included in this group are those who were forced to flee their place of residence because of persecution by the Nazis. Survivors, therefore, may have experienced uprooting, deportation, labor and/or extermination camps. They may have lived under false identities, in hiding or been perpetually on the run. Depending on where they lived, individual Survivors may have suffered under Nazi persecution for up to six years.

Key Words²

Shoah:	Hebrew word for the Nazi Holocaust
Holocaust:	The persecution and murder of European Jewry during World War II
Nazi:	The ruling party of Germany during World War II and also a person who was a member of the party
Hitler:	Leader of the Nazi party who ordered and supervised the murder of European Jewry
Final Solution:	The official Nazi term for the extermination of all European Jewry
Ghetto:	A sealed and fenced/walled area of a city to which Jews were confined under overcrowded and unsanitary conditions
Camps:	All the locked and guarded areas where Jews were imprisoned. <ul style="list-style-type: none"> • Labor Camps: Jews were barely kept alive and used for slave labor • Concentration camps: Holding areas where people starved to death, were used in inhumane medical experiments or were eventually killed • Death or extermination camps: Set up for the specific purpose of systematically exterminating all inmates. (Near the end of the war, most camps became <i>death camps</i>)
Lager:	German word for “camp.” Often also referred to as the sleeping barracks in the concentration camps
Partisans:	Underground resistance fighters, including many Jewish men and women

¹ *Caring for Aging Survivors of the Holocaust* (Toronto: Baycrest.org)

² *Ibid*, p.63

Section

2

Helpful Strategies for Working with Holocaust Survivors

Ways to identify a Holocaust Survivor

Asking simple questions can help identify a Holocaust Survivor without directly asking. Clues include place of birth, date of birth, date of immigration to the United States, religion and languages spoken. Indications that a person is a Holocaust Survivor include heavily accented English, European languages spoken, lack of family members of same generational age and a number tattoo on the arm.

How to gather crucial information

It is often difficult to obtain information from Holocaust Survivors about their past. They may not wish to revisit and disclose details about their past experiences. Once a patient is identified as a Holocaust Survivor, it is imperative that health care providers explain how the patient's personal information will be used.



For example: When conducting a clinical assessment, be specific about required information and how it relates to appropriate care. This builds trust and assuages suspicion about the clinician's motives.

Be sensitive to the fact that during the war, doctors and nurses conducted human medical experiments and meted out inhumane treatments to the Jews. If you are a health care provider, you must be cognizant of the potential effects of certain behaviors and treatments.

For example: If a clinician asks for a blood or urine sample, explain how the sample will be used and when test results will be shared.

Section

2

Effective ways to communication with Holocaust Survivors include, but are not limited to:

- **Empathetic statements**—Let patients feel they are understood, emotionally supported and safe
- **Acknowledgment**—Assure patients that they are being heard and confirm that their message is of value and being taken seriously
- **Open-ended questions**—Invite and allow patients to share information rather than replying with “yes” or “no” answers, as simple responses are devoid of detail and valuable information, which may prevent a full understanding of patients’ situations
- **Reflective statements**—Show patients your level of understanding
- **Paraphrasing**—Allow listeners (clinicians) and speakers (patients) to verify information discussed to clear up potential misunderstandings
- **Gentle probing**—Suggest further discussion to gather additional essential information
- **Tone of voice**—Speak calmly and with kindness, because how you communicate is often more powerful than what you say

Active listening approaches include, but are not limited to:

- **Attention to total meaning**—Emotional content is especially important; at times it may offer more insight than verbal responses
- **Noted cues**—Observe nonverbal behavior to gain the “total picture”
- **Varied responses**—Verbal and body language may best emphasize engagement, ranging from paraphrasing and silence to gestures
- **Being honest**—Acknowledge when clarification or re-explanation is needed
- **Vocal empathy**—Avoid phrases such as “I know how you feel.” Although often well-intentioned, such statements are often perceived as patronizing



Section

3

Manifestations of Post-Traumatic Stress Disorder (PTSD)³

Exposure to traumatic experiences has been associated with full or partial symptoms of post-traumatic stress disorder (PTSD), depression, panic disorder, generalized anxiety disorder and substance abuse. Holocaust Survivors at the end of life may respond and react differently to everyday activities, sounds, conversations and experiences.

This section focuses on the following triggers:

- Traumas and suffering endured
- Personal hygiene
- Dehumanization
- Lack of personal safety
- Disclosure of personal information

³ *Caring for Aging Survivors of the Holocaust.* (Toronto: Baycrest.org) p. 52-59.

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Lack of personal safety – It is generally accepted that the greater the exposure to past traumatic events, the greater the probability of future struggles with depression. Traumatic experiences have also been associated with somatic symptoms and physical conditions like chronic pain syndromes, hypertension, insomnia, asthma and cardiovascular problems. While aging Holocaust Survivors might not explicitly talk about their traumatic past, they may express many somatic complaints, which need to be understood as manifestations of both emotional and physical (somatic) traumas.

Personal hygiene—Harsh smells, showering, bathing and being handled roughly can provoke flashbacks of being pushed and beaten, delousing procedures, horrific “medical” experiments conducted on camp inmates and even the poisonous gas that was piped into communal “showers,” i.e. the gas chambers.

Dehumanization—Clinically necessary shaving, identification bracelets, pre-surgery markings, pre-procedural line-ups in holding areas and lack of privacy can be reminders of past losses of dignity, individuality and personhood.

Lack of personal safety—Dogs, alarms, loudspeakers and loud voices were all part of the attacks and intimidation used against Jews in the camps. Religious symbols, like crucifixes, were part of the culture of the “enemy.” Distrust of the medical community is based on memories of “selections” (for death) and human experiments performed by Nazi “doctors” in the concentration camps. Separation from family members can be terrifying because, during the war years, family members were forcibly separated, never to meet again.

Disclosure of personal information—Refusal to share any personal, financial or clinical information is based on deep mistrust towards anyone who is not immediate family. In the camps, exhibiting any pathology could bring about being killed immediately. Advance planning is taboo since “living” and “surviving” are of paramount importance.

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4

Post Traumatic Stress Disorder Clusters

According to Irit Felsen,⁴ familiarity with the symptoms of PTSD can enhance compassionate care.

Signs include, but are not limited to, the following:

Re-experiencing of trauma—It is manifested by unbidden memories, including flashbacks that intrude on awareness in waking hours and in nightmares during sleep, often triggering irrational, as well as exaggerated, reactions to non-threatening stimuli.

Avoidance—Patients may resort to withdrawal from relationships and activities that might otherwise have been sources of solace. Such refusals to participate and be comforted might be perceived as negativistic and can easily frustrate caregivers and family members.

Numbing— Often misunderstood as remoteness or lack of engagement, this emotional constriction reflects depletion due to chronic states of physiological and emotional hyper-arousal.

Hyper-arousal—An important aspect of the “survivor syndrome,” it manifests as chronic anxiety, depression, guilt and sleep disturbances. It is evidenced by high levels of hyper-vigilance, irritability, exaggerated startle response, explosive reactions and intrusive or micro-managerial behavior patterns.



⁴ Irit Felsen, Ph.D., *Trauma, Aging and Implications for Treatment: When Holocaust Survivors Need Our Help Most*. (New York: 2011).

Section

5

Intergenerational Communication

A 2011 survey conducted by MJHS Hospice and Palliative Care revealed the following themes:

- Survivors do not talk about their health care wishes with their children, yet rely heavily on them for decision making
- Most do not have advance directives in place
- Children of Survivors do not want to upset their parents, so they avoid certain topics of conversation
- Caregiver burdens are enormous
- Children of Survivors are often overly protective of their parents

Children, and to some extent even grandchildren, of Holocaust Survivors often deeply identify with their loved ones' pain and losses. They feel responsible for protecting their aging relatives from further suffering. They often express deep commitment and obligation towards the parents, starting at an early age.⁵

Variety in Response

Themes of inter-generational communication of trauma are also prevalent, clearly demonstrating implicit identification with the traumatized parents. Some themes expressed by children of Survivors, and related to their need to protect their parents, include avoidance of conflict on the part of the children, difficulty putting their own needs ahead of the parents' and a wish for greater autonomy from the parents. Conversely, some children of Survivors wish for greater closeness with their parents who, though extremely devoted, are emotionally unavailable—either emotionally distant or over-reactive—so that real open communication is impossible.

The adult child of Survivors might feel profoundly distraught, helpless, desperate, guilty and angry when facing the reality of aging and ailing parents and the inevitable limitations and inefficiencies of the health care systems. End-of-life decisions are particularly difficult for the children of Survivors who know that their parents overcame extreme odds to stay alive. Now, in turn, these children will do everything to keep their parents alive, even if that life does not promise much quality of life.

⁵ Dina Wardi, *Bonding and Separateness, Two Major Factors in the Relations Between Holocaust Survivors and Their Children*. (The Horworth Press, Inc, 1994) 119-131.

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5

Four Typologies

Four types⁶ of Holocaust Survivors and their families, which differ in their styles of adaptation have been identified.⁷ Just as each differently impacts the children in these families, so too are the aspects of transmission of parental trauma to the Second Generation.

Types One and Two

The “victim” or “numb” type may tend to transmit anxiety, silence and lack of openness to relationships outside the family. They may also exhibit paranoid reactions to seemingly non-threatening stimuli.



Types Three and Four

The “fighter” or “I made it” type may transmit the need for over-achievement, social activism, toughness or “take no prisoner” attitude in order to live life to the fullest.

For example: Mrs. M. is a “fighter.” She lived her life to the fullest every day, with very little down time; became a larger-than-life figure to her sons and had a complicated relationship with them; wrote a book about her war experiences; and was very involved in organizations, synagogues and schools.

After Mrs. M.’s admission to hospice care, a social worker helped her accept her diagnosis. Mrs. M. embraced it as a natural process and was ready to live out her lifecycle in peace.

Mrs. M. resented it when community leaders and rabbis visited and told her that she had survived before and would be fine now. When her son, who lived on the West Coast, asked her to wait so he and his family could say a proper “goodbye,” she offered to oblige. At Mrs. M.’s eulogy, this son said his mother had always given him a lot of freedom, but added that he still felt suffocated in her presence.

6 Shira Hantman; Zahava Solomon, *Recurrent Trauma: Holocaust Survivors Cope With Aging and Cancer* (*Soc PsychiatryPsychiatric Epidemiol*, (2007) 42:396-402.

7 Danieli, 1981; 1985; Sigal and Weinfeld, 1989.

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Family Dynamics

“It is said that members of the Second Generation become ‘memorial candles’ to their parents and their murdered relatives, carrying with them unconscious aspects and identifying themselves with dead relatives.”⁸

This dynamic adds a burden of responsibility and guilt and complicates natural processes of development, which propel adolescents to separate, rebel, experiment and fully develop independent identities.

Issues of Separation

At every significant life transition, the Second Generation faces numerous additional conflicts around issues of separation and individuation. Reaching adulthood and establishing their own families and dual loyalties—with survivor parents on one side and a spouse, plus children—on the other, can often create conflicts. For the maturing Second Generation, confronting the aging process of parents, making health care decisions on their behalf and preparing for their inevitable death bring about a realistic need for role reversal. These changes



intensify the responsibilities borne by the Second Generation and can lead to anxious and desperate behavior by the adult children in their attempt to protect the aging parent. It might also be perceived as a huge burden and may foster resentment of the survivor parents by the Second Generation.

Members of the Second Generation are vicariously surrounded by death throughout their lives. Yet, they have never witnessed or experienced the actual death of an aging relative since most grew up without a circle of extended family, like (great) grandparents, uncles, aunts, etc. “Letting go” and mourning are foreign concepts and are overwhelmingly difficult in families of Holocaust Survivors. Instead of accepting natural death as part of the life cycle, it is experienced in the subjective context of traumatic loss.

⁸ Dina Wardi, p. 122.

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Reactions of Health Care Providers to Difficult Behaviors

The Holocaust was a span of years and an era in history marked by darkness and horror. The mass murder of six million Jews during the Holocaust has become the symbol of atrocity and merciless dehumanization. Today, the sadistic acts that were carried out against the Jews elicit reactions of total disgust, and even disbelief. Because these atrocities have been documented and described in first-person testimonies—both by the Holocaust Survivors and the perpetrators—we know that they did, indeed, take place. Learning of such extremes of torture and humiliation is so difficult to bear, let alone understand, that clinicians might consciously and unconsciously attempt to deny it.⁹

Responses to be Avoided

Superiority—By asking how the Nazis became capable of such cruelty and sadism, it is understandable that clinicians may think that they have nothing in common with such inhuman people. Yet, the Nazi perpetrators were not uncivilized “barbarians” or criminals. They were, in fact, a lot “like us.” Many of the elite Nazi leadership figures included highly educated professionals, such as physicians.

Irrelevance— Another way to deal with the difficult reality of the Holocaust is to find reasons to deny the idea that such atrocities could be committed today. Clinicians may try to rationally explain why it is impossible for such inhumanity to reoccur and to conclude that the Holocaust is of no relevance to our contemporary lives, or the future.

Judging—When faced with the victims of atrocities, some clinicians might find reasons to blame the victims. This offers the possibility of preserving a sense of justice, order and security and to deny the idea of such potential dangers repeating. Clinicians might also direct (consciously and unconsciously) anger at Nazi victims for presenting such a disturbing reality, which can even lead to a desire on the clinicians’ part to avoid or reject Survivors.

Doubling—Coined by Robert Jay Lifton,¹⁰ it is the process that allowed Nazi doctors in Auschwitz to do the diabolical things they did to the Jews in the concentration camp and yet continue to view themselves as humane physicians, husbands and fathers outside the

⁹ Irit Felsen, Ph.D., *Trauma, Aging and Implications for Treatment: When Holocaust Survivors Need Our Help Most* (New York: 2011).

¹⁰ Robert Jay Lifton has worked as a teacher, lecturer and researcher at the Washington School of Psychiatry, Harvard Medical School, and the John Jay College of Criminal Justice, where he helped found the Center for the Study of Human Violence. Dr. Lifton is the author of many books, including *The Nazi Doctors and Death in Life: Survivors of Hiroshima*, which won the National Book Award. He studied, lectured and wrote about how individuals coped under conditions of extreme war, torture and genocide

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camp. The important conclusion from Lifton's study of Nazi doctors who committed war crimes is that there are situations in which even a person without sociopathic tendencies, and who is not innately evil, can participate in atrocities without experiencing emotional distress. Lifton's work is documented in his work on "Nazi Doctors," an in-depth study of how medical professionals rationalized their participation in the Holocaust from the early stages of the T-4 Euthanasia Program¹¹ to extermination camps. It was doctors who murdered Jews considered to be physically or mentally handicapped. They were killed by medication, starvation or in gas chambers from 1939-1945.

Most relevant to our work as medical professionals is Lifton's observation that doctors (and other medical professionals) may be even more susceptible to doubling than others. In what he calls "medical doubling," a "medical self" is developed in order to be able to tolerate the repeated encounter with death and suffering and in order to deal effectively with the many difficult aspects of the job. Optimally, a medical professional does maintain the capacity to be warm and humane by keeping the necessary doubling to a minimum. However, a caregiver must guard against the tendency, a basically adaptive attempt to defend the self from difficult experiences, to become hardened to the pain of the patient or to become detached from the patient's humanity.

Recommendations for health care providers

1. Be cognizant of your own history and experience of personal trauma so you remain sensitive to the experience of others. Sometimes, when clinicians suffered trauma in their own personal history, it can be more difficult for them to recognize trauma in others and respond compassionately. The clinicians might not want to be reminded of their own trauma or may feel that their trauma was worse than the patient's.
2. Maintain professional boundaries. Adhere to the highest ethical standards of care and best practices to avoid comparing your own pain to the patient's.
3. Be tolerant of others. See each patient as an individual and equal, rather than a victim or someone "other."
4. Be aware of the tendency to become hardened or desensitized to trauma when dealing with pain and suffering as part of your daily professional experiences. Resist this tendency and remain compassionate as well as sensitive to the pain of patients and families.

¹¹ Source: Robert Jay Lifton—Nazi Doctors T-4 was the code word for the Hitler's Euthanasia program. It was named T-4 because the Euthanasia program was directed from an unassuming address that was actually a confiscated Jewish home in Berlin on Tiergarten Street #4 (hence T-4).

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5. When working with Holocaust Survivors, speak calmly and patiently.
6. When speaking with Holocaust Survivors or their children, ensure the content of what you are saying is understood.
7. When you interview or examine patients, establish a sense of trust and personal safety by explaining what you are doing and why you are doing it.
8. When physically handling patients, be aware of how you touch and move them. Avoid hard and harsh touching. Try to be slower and gentler.
9. When patients seem to be in pain or uncomfortable, let them feel that they are not being ignored and that you are trying to alleviate their pain or discomfort. They might be remembering times when others were indifferent to their suffering.
10. In order to help minimize medical doubling, and the inevitable distancing that occurs with very difficult and needy patients, clinicians must imagine the patient's humanity and identity—such as their profession, family life, hobbies and other interests—in order to prevent the psychological process that allows us to view another person as a non-person, a “case.” Photographs of patients when they were young and healthy, as well as with spouses or young children, are a powerful reminder of their humanity and of the time when they were “like us.” Placing such photographs on the wall by the patient's bed or on the bedside where all medical health providers can see them is a very simple, important and potent act.
11. Be cognizant of your verbal and body language when learning that your patient faced horrible atrocities at the hands of other human beings. The temptation to deny or minimize the trauma, or to reject the victim, may be an attempt to protect yourself from this terrible knowledge. Such responses are often driven by adaptive and self-protective behavior, but may prevent you from treating your patients with the care and dignity they deserve.
12. While there is documentation describing barbaric and dehumanizing acts on war victims during the Holocaust, America has its own history of human medical experimentation (e.g. Tuskegee Syphilis experiments—a 40-year study conducted by the US Public Health Service).

Commentary

Clinicians must learn to resist processes and tendencies that can lead a good professional to behave inhumanely. Left unchecked, any of us are capable of committing atrocities. We are duty-bound to treat our patients as no less human than ourselves.

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Case Study on Dual Loyalties

About the Family



Mr. D. is a Holocaust Survivor and Orthodox Jew. He has been hospitalized in a major New York City hospital several times in the past few months. Mr. D.'s wife, also a Holocaust Survivor, is the primary caregiver, although she has multiple ailments and is in declining health. The couple has two adult married daughters: one lives in the same building, one is out-of-state.

The Second Generation daughters accept the hospital social worker's recommendation for community-based hospice care services with MJHS, as

long as the words "palliative care" and "hospice" are not used. The daughters want to keep their parents at home and prevent future re-hospitalizations.

An MJHS Hospice nurse is sent to the home to do an evaluation. Because the patients are Jewish Orthodox and Holocaust Survivors, a rabbinic pastoral care provider participates in the visit to help create a stronger level of trust and confidence in the care team. As promised to the daughters, the nurse does not use the words "hospice" or "palliative care" in the evaluation process. Mr. and Mrs. D. sign on as patients.

The daughters are satisfied that their parents are receiving the best care possible. They are also happy that they are protecting their parents from the reality and severity of their individual diagnoses. Shortly after her admission to hospice care, Mrs. D. begins to further decline.

At the next family visit, the social worker urges the daughters to have an open discussion about the mother's condition with both parents. The daughters decline again because they want to protect their parents. At some point, Mr. D. asks his daughters about the clinicians who are making house calls. He wonders aloud whether these medical caregivers can take

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Mrs. D. to the hospital—so she can “get fixed like last time” and then return home. Learning of this, the social worker again suggests an open discussion to the daughters, to which they finally agree. The conversation takes place. Mrs. D. dies 24 hours later.

Observations

Mr. and Mrs. D. each received excellent clinical care. (Mrs. D. died peacefully and pain-free at home.) The Second Generation daughters are grateful for the care their mother received and their father continues to receive, as a community-based hospice patient. Yet, this case also presents a learning opportunity for clinical caregivers.

As is typical of Second Generation, both daughters felt a need to protect their parents from knowing the seriousness of their medical conditions. Therefore, they did not discuss potentially sad outcomes with their parents. The daughters also feared that their parents would break down because the diagnoses would be too difficult to bear. Fear and good intentions delayed an important conversation.

Later, the daughters discovered that Mr. D. knew that he and his wife were on hospice care because he overheard a conversation at the hospital. Ironically, he believed he was protecting his daughters from what he knew. In retrospect, all wish they had talked earlier. Mr. D. could have been part of the decision making process and would have had more time to say goodbye to his wife of 64 years.

Important and practical topics that emerge from this case study:

1. Truth-telling.
2. Disclosure of information about patient’s condition to family and friends.
3. Issues of privacy and trust.
4. Intervening in a client’s life.
5. Facilitating conversations between the patient, family and health care providers.

Questions for reflection:

- How might you address the daughters’ protectiveness?
- How might you assess the patient’s understanding of his medical situation?
- What bereavement issues might arise and how might you address them?
- What challenges in your own practice does the vignette bring to mind?
- What might be some of your own personal challenges in working with patients facing the end of life?

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- What should you do when the patient has no immediate family and denies the need for medical attention?
- When is the right time to address observable changes/declines in a patient's health condition?
- What tools and strategies might you use to intervene effectively?
- What information might you need to be comfortable making referrals for patients?
- How are issues of bereavement and complicated grief dealt with among social workers and health care providers on the one hand and surviving spouses and children on the other?

Commentary

For many Holocaust Survivor children, there is an overwhelming need to protect parents from “the worst,” lest they lose hope and the will to live. Adult children often project their fears onto their parents—as fears that they think the parents have. Very well-intentioned adult children seek to protect their parents from acknowledging approaching death, since their parents already survived death against great odds. At the age of 90, Mr. D. was not afraid of death; his children were.

MJHS Hospice offers pre- and post-bereavement care for children of Survivors. Conversations help adult children become cognizant of their own issues with loss or anticipated loss. Individual and group sessions are particularly helpful to adult children who are protective of their parents—the same parents who endured unspeakable traumas and defied death during World War II.

For more information on how MJHS Hospice cares for Holocaust Survivors call 1-800-HOSPICE.



Section

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Bibliography

- Trappler M.D., Brian; Cohen M.D., Carl I.; Tulloo M.D., Rajeshree. *Impact of Early Lifetime Trauma in Later Life: Depression Among Holocaust Survivors 60 Years After the Liberation of Auschwitz*. Am Geriatric Psychiatry, January 2007.
- Hantman, Shira; Solomon, Zahava. *Recurrent trauma: Holocaust Survivors cope with aging and cancer*. Soc Psychiatry Psychiatric Epidemiol, 2007.
- Metzger Brown, Eva. *The Transmission of Trauma Through Caretaking Patterns of Behavior in Holocaust Families: Re-Enactments in a Facilitated Long-Term Second-Generation Group*. Smith College Studies in Social Work, 1998.
- Wardi, Dina. *Bonding and Separateness, Two Major Factors in the Relations*. Toronto: The Haworth Press, Inc., 1994.
- *Caring for Aging Survivors of the Holocaust* www.baycrest.org/publications-02.php.
- Bernick, Laurie; Grinberg, Anna; Holynaty, Lucie; Rodgers, Marilyn. *Unending Loss: Caring for Survivors of the Holocaust* 2001, If Not Now e-journal, www.baycrest.org.
- Felsen, Irit, Ph.D. *Trauma, Aging and Implications for Treatment: When Holocaust Survivors need Our Help Most*. New York: PPT, 2012.
- Lichtenstein, Ruth, Editor. *Witness to History*; Brooklyn: Project Witness, 2009.
- United States Holocaust Memorial Museum; www.ushmm.org
- Lifton, Robert Jay. *Nazi Doctors: Medical Killing and the Psychology of Genocide*. Washington DC: Library of Congress Cataloging; The Perseus Book Group, 1986, 2000.

THIS GUIDEBOOK IS MADE POSSIBLE BY

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MJHS Foundation

MJHS Hospice and Palliative Care

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MJHS Foundation provides financial assistance for the charitable efforts of MJHS and its affiliated agencies.

The philanthropic spirit of the Four Brooklyn Ladies has been a cornerstone of MJHS for more than 100 years. The culture of philanthropy they inspired led to the formation of MJHS Foundation, which has been instrumental in raising the funds necessary for the provision of charitable health care as well as the development of innovative services and programs to serve our growing community. Our extraordinary Hospice program would not be made possible without grants from MJHS Foundation, which relies on the support of generous donors like you.



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