Late-onset of post- traumatic reactions in Holocaust survivors at advanced age *

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I. Introductory Remarks

Delayed, postponed or late-onset PTSD or equivalent post-traumatic (P.T) reactions at an advanced age in Holocaust survivors (H.S.) are a well known clinical phenomenon, as the ageing and aged H.S. themselves, as well as their spouses and adult children know, and as their family physicians and psychiatrists know as well.

Writing on this question almost seems like breaking through an open door. That is: it may not really be necessary. Yet it is still a historical fact that during the first few decades after WWII, following the H.S. ' s re-entry into the post-world war' this clinical course was not foreseen at all, nor was it expected that the acute and subacute post -persecution reactions would last longer than a few years. Long- lasting chronic or permanent P.T. reactions or P.T. personality changes must follow from hereditary or constitutional factors, so it was believed, especially by German psychiatrists (i.e., medical-historical research by Ch. Pross, 1988, and a summary by H. Freyberger et al, 1996, in Koblenzer Handbuch des Entschaedingsrecht, pp. 143-140). Nor was attention paid to the permanent P .T. changes in child survivors until many years later, in the 60s, 70s, and 80s. (H. Paul et al, 1967. E.Klimkova-Deutschova, 1971. R. Lempp, 1979; H. Keilson, 1979 in Holland; and M. Kestenberg in the U.S., 1982, 1985).

Chronic P. T. illness, rather than gradually easing up upon ageing, is instead aggravated in numerous cases. This fact came as a surprise to many clinicians, so no wonder that late, belated, delayed or late-onset P. T. reactions were not foreseen in the first two-three decades following the end of WWII in 1945, and yet now is common knowledge not only among professionals but through bitter personal experience among ageing H.S. themselves, their families and physicians. Not only Jewish H.S., but also massive numbers of others, passive victims or active participants from the WWII era, are reported to have suffered from late-onset P. T. reactions, as will be shown below.

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In what follows I will first clarify the concept of PTSD and P.T. reactions, their variants and equivalents, permanent P. T. personality changes, and the special vulnerability of H.S. versus other P.T.-WVVII survivors, as well as some other basic concepts of P.T. states and life-courses, and the juridical limitations of formal diagnoses.

I will then review a number of professional opinions and recent clinical epidemiological research publications and overviews on P. T. reactions in ageing H.S. and, by comparison, in other ageing WWII victims with:

a) Onset at any time during the life course,

b) Late onset, as well as brief reviews on:

c) Releasing factors/triggers of late onset, and

d) On the latency period or symptom-free interval preceding late onset at advanced age.

Finally, summary, conclusions and recommendations will be noted.

II. Clarification of Concepts

1) The current pararadigmatic definition of Post-Traumatic (P.T.) reactions is the PTSD concept of the American Psychiatric Association's DSM IV (1994). Originally defined in 1980, it came as a response to the new diagnostic challenges primarily in the wake of the Vietnam era and was then, subsequently, applied to the plight of ex-combatants of other wars (R. Yehuda et al, 1995), and to the P. T. reactions following a wide range of other extraordinary events (DSM IV- APA 1994,p. 424). However, massive genocide (such as the Jewish Holocaust in Europe) is not mentioned.

2) The DSM IV diagnostic criteria are, briefly, as follows:

Criterion A: Exposure to an extraordinary event out of the range of common experience (as in DSM IIIR) to which the exposed person responds with fear, helplessness and horror.

Criterion B: Recurrent, intrusive, distressing recollections and re-experiencing.

Criterion C: Avoidance of stimuli associated with the traumatic event, including avoidance of conversations associated with the trauma and further, estrangement and numbing. (In the classical

text on traumatic neurosis of ex-combatants, Kardiner (1941) defined this as constriction of the ego, and later as contraction of the personality).

Criterion D: Hyper-arousal, including: insomnia, outbursts of anger, physiological (hyper-) reactivity (as in DSM IIIR). This is mentioned under B in DSM IV.

Criterion E: Refers to the duration of the reactions and, finally,

Criterion F: Relates to the reduced functional capacity, impairment of social and occupational and other important areas of functioning.

Only under Criterion B are there mentioned briefly some specific childhood behaviours following exposure to traumatic events. (Other sequels of early childhood trauma in adulthood are not mentioned in DSM IV).

3) P.T. reactions other than PTSD. comorbiditv and diagnostic variants:

Investigators of post-traumatic states mention a damaged ability for basic trust manifested as mistrust bordering on paranoid states and behaviour. In the literature, anti-social behaviour is mentioned, as are substance abuse and/or addiction to alcohol, drugs or tobacco, and amnesia and dissociative states.

DSM IV mentions other psychiatric conditions frequently occurring after exposure to trauma as a part of the P.T. reaction pattern, or as the main or sole P.T. reaction, including: Chronic reactive depression, often to the degree of major depression, (chronic) anxiety reactions, specific phobias and obsessive-compulsive reactions, as well as shame and guilt feelings, but not as necessary criteria for diagnosis.

However, post-traumatic shame and guilt prevent the sufferers from readily approaching psychiatric or psychosocial agencies to ask for help in general. They tend to hide their suffering (see Criteria C) vis-a-vis medical doctors, especially psychiatrists, as well.

Post-traumatic Holocaust survivors (H.S.) often eschew psychiatrists (Prof. H. Lauter, 1997). Not being aware themselves of the causal relations to the past events, P.T. patients turn to their doctors for their frequent somatic complaints, these often being an expression of the physiological hyper-reactivity mentioned under Criteria B. P.T. patients avoid conversations, even with their doctors,

on the past events. Thus, medical doctors are misled and often fail to uncover the post-traumatic (psycho-physiological) roots of the somatic complaints. Shame and guilt, although not necessary diagnostic criteria, reinforce the persistent avoidance (Criteria C).

4) Permanent Personality Changes:

In many P. T. patients, the chronic symptoms may lead to "enduring personality changes" after catastrophic experience, according to the ICD-10 classification published by the WHO (1992).

Subjects afflicted by enduring post-catastrophic personality change may exhibit mistrustful and hostile behaviour, social regression, feelings of emptiness, helplessness and estrangement, and a perpetual awareness of fear of future threat. Because personality disorders (including post-catastrophic personality change) are not perceived by the subject him/herself as an illness, it is thus difficult or even impossible to elicit a clinical history, and it is necessary (according to the ICD-10 diagnostic criteria) to obtain confirmations of the victim's condition from a member of the family or from another person central to the patient's life, before a diagnosis can be established. Because the main features of their personality disorder have become ego-syntonic (that is, the patient lacks insight into his own condition), they do not go for help or claim compensation; they may not even be aware of the causal relationships of their own character changes.

Another type of lifelong personality change with different characteristics may develop in persons who were exposed to catastrophic trauma during early childhood, while still in an early developmental stage. In these cases as well, adult child survivors of the Holocaust may not be aware of the extent of their psychological problems after early exposure to trauma and consequently do not tend to turn for help or claim compensation until many years later when new symptoms appear, or when prior subclinical symptoms are aggravated under the impact of later stress or factors related to ageing.

5) The special status of H.S. as compared to non-Jewish. non-genocide P. T. survivors of the WWII era:

Historically, the PTSD concept was inspired by the plight of combatants and soldiers, mainly after Vietnam. Although wider applications were found for this concept, it basically describes the fate of young males in POW camps, members of the Resistance in occupied countries after incarceration

in concentration camps, and late sequels of seamen in danger, as well as victims of natural disasters, rape and child abuse.

Contrary to the above instances, H.S. were victims of massive genocide perpetrated on a passive civilian population. The length of exposure to a series of many different and cumulative traumata was unusually long. The entire multigenerational family was endangered and often annihilated, including children (unlike in the cases of combatants, etc.). Property, existences at home and ties to their country of origin were irretrievably damaged. H.S. were passive civilians not in the service of organisations, military or otherwise, and did not return as veterans.

After Liberation, additional traumatic events occurred in most instances. In addition to the traumatic events of the type mentioned above under Criterion A of DSM IV, the massive losses and endless mourning were another insult. Children were caught by the genocide during their early development with adult after-effects.

The German forensic psychosomatic expert W. Schueffel et al (1996) proposed a classification of traumatic stress on a gradient of severity; overwhelming stress which demands total mobilisation of human coping-resources is "catastrophic," whereas Holocaust is the ultimate measure of traumatic stress beyond even catastrophe.

Holocaust includes:
- Concentration camps, the extreme stress criteria of which were defined by W. Niederland (1983); Ghetto and forced labour;
- Flight in total illegality for evading deportation and murder.

In conclusion, in Schueffel's opinion, the Jews were exposed to the most extreme stress on the gradient of catastrophes.

6) P.T. reactions specific to H.S. until and after 1969:[***]

Post-traumatic reactions in H.S. were diagnosed long before the substantiation of the PTSD concept, such as the post-concentration camp syndrome defined by Scandinavian investigators (Leo Eitinger, 1980) pertaining first to Norwegian non-Jewish survivors, and later applied also to H.S. It usually appeared after a delay of a few years after seemingly initial readaptation and a subclinical latent interval.

[***] 1969 was the final date for submitting compensation – claims according to the W. German laws.

In other European countries, K.Z. syndrome was a common diagnosis (i.e., Bastiaans, in the Netherlands, 1974). The French psychiatrists devised their own set of diagnostic terms. In Germany, Venzlaff (1954), von Bayer (1964), and Matussek (1971) defined severe post-traumatic states after exposure to Nazi persecution as follows (resp.)

- Erlebniss reaktiever Persoenlichkeitswandel,
- Psychoreaktive Umstrukturierung

and a syndrome consisting of four main factors:

1. Hopelessness and resignation
2. Apathy and inhibition
3. Aggressive irritated moods, and
4. Mistrust

All describe P. T. symptoms as well as permanent personality changes. In most expertises (primarily German), the diagnoses of insomnia and neurovegetative instability (or dystonia) are used, as well as chronic reactive depression, anxiety, neuroses. Hoppe (1984) found "reactive aggression" as a main post-traumatic state in H.S. and other concentration camp survivors. H. Grauer (1999), a Canadian expert, commented on the similarities of these post-traumatic diagnoses with singular DSM IV criteria of PTSD of our time.

In the 50s in Israel, Levinger (1962) found that Holocaust survivors suffer from exhaustion and irritability, and used the term [post concentration camp] neurasthenia. In the files of non-psychiatric general physicians in Israel, I found a wide variety of post-traumatic somatoform reactions described by many different diagnostic labels, mainly so-called "functional" symptoms.

In the 60s, W. Niederland (1964) in the U.S. established the concept of survivor syndrome based on exactly defined diagnostic criteria. He also pointed out that this is a form of delayed P.T. reaction appearing in acute incapacitating form after a free or subclinical interval of 15-20 years following initial adaptation and coping with the stresses of emigration to the U.S.

All the above-mentioned diagnostic concepts were in use before 1969 and continue to be used today. I wish to emphasize that post-traumatic reactions after the Holocaust often do not resemble

the post-traumatic reactions of (ex-) combatants, although the basic DMS IV criteria can be dissected out of the wider syndromal context. Nor do adult or ageing child survivors' post-traumatic states resemble the adult PTSD. Yet there is more than PTSD involved with H.S. (see similar opinions of Prof. Lauter from Munich, 1997, and Engelsman, a Dutch expert, 1987).

7) Variations in life-course of PTSD and the notions of delayed onset, free interval and subclinical latency:

W. Op den Velde, an expert on PTSD and delayed PTSD among WWII victims, including H.S., suggests a classification of lifetime courses of PTSD. Based on his classification, I propose the following courses of PTSD and its variants and equivalents:

A. Acute and subacute PTSD (and equivalent P.T. reactions), which gradually develop into a chronic condition. Late aggravation may, and indeed, does often occur ("Verschlimmerung").

B. A delayed form of PTSD (and equivalent P. T. reactions) in which the first incapacitating clinical symptoms develop after a symptom-free latency of at least five years, or any time after that until advanced age.

C. A mixed condition with early (sub-) acute PTSD or other P.T. complaints during up to five years after liberation, followed by a symptom-free interval of decades (Op den Velde suggests 15-30 years), after which PTSD breaks out, often in advanced age.

D. Delayed or postponed PTSD (or equivalent P. T. reactions) following a sub-clinical latency of covert, hidden, negated, warded-off or walled-off, not recognized, misdiagnosed, neglected or denied symptoms and defended against (through persistent avoidance, Criterion C) with outwardly preserved coping abilities and earning capacity (i.e., the absence of Criterion F above).

The present expertise, therefore, deals with the likelihood of delayed onset PTSD and its variants and equivalents as enumerated above (see sections 3 and 6) at advanced age after one of the following possible courses:

a) Following a symptom-free latency without clinical antecedents, or

b) After a symptom-free interval of decades, following a (sub-) acute P. T. reaction up to five years after liberation, or

c) After a subclinical latency (with subliminal antecedents).

8) Remarks on invalidism:

According to Criterion F of the DSM IV definition of diagnostic criteria, the PTSD symptoms should cause distress to a degree that is of clinical significance, or impairment in social and occupational functioning, or in other areas of functioning. Subclinical symptoms in the absence of at least marginal dysfunction (that is, in the absence of Criterion F) would not fulfill the diagnostic criteria; at most, they indicate the possibility of future delayed outbreak of full-fledged PTSD cum invalidism under the impact of new or additional releasing factors.

9) A critique on the juridical limitations of the use of formal diagnoses:

Ernst Weller, Judge in the "Oberlandesgericht" in Koblenz (in Kisker and Bischof: Koblenzer Handbuch fuer Entschaediaunasrecht, 1996), is of the opinion that restitution for health damage should be granted not merely or mainly on the basis of a medical or psychiatric diagnosis, but rather for, or in the presence of, a "complex of pain and suffering, complaints and reduced ability to function property." The diagnosis is less important than the degree of suffering.

Prof. K.P. Kisker, a foremost psychiatric expert in the field, in the same Handbook volume quoted above (p. 110), is of the opinion that the main weight should be given to the psychiatric expert's detailed description of the daily life of the claimant and of the day-by-day relationships with the family and/or other close persons. Also, a detailed description of the limitations in carrying out his or her work or vocational activity would be required. The description of the daily routine and limitations counts more than the diagnosis.

Prof. H. Lauter (p. 173, in the same volume, above), a psychiatric expert on restitution claims, is of the opinion that it is not the type or even the intensity of a definable disorder that counts, nor the exact diagnosis, but only the extent and the intensity of the functional deficit, and whether the claimant is able to take care of his/her domestic life, family relations and social life.

The German experts of the 90s, after four decades of experience with H.S., seem to retreat from the over-riding importance of formal diagnosis in post-traumatic claimants for restitution. They emphasize a phenomenological-descriptive approach of clinical evaluation of P.T.

In this context, i.e., the complex of suffering and pain rather than formal diagnosis, H. Krystal (1997) notes that, "as a result of the impediments to effective grieving, they [i.e., the elderly Holocaust survivors] continue to suffer from perpetual mourning." This gives rise to incapacitating late symptoms not mentioned as PTSD criteria or used for other official criteria of post-traumatic diagnoses, namely: Alexithymia, anhedonia, survivor's guilt, the dread of being abandoned [again], and the "fear of total aloneness" and social isolation. The "complex of pain and suffering" exceeds the confines of diagnostic labels.

The formal diagnosis is of limited use in juridical decisions from the descriptive-phenomenological. humanistic perspective, as propounded by recent senior professors of German psychiatry and "Guttachter" psychiatry .

III. P .T .Reactions in Ageing H.S. and other survivors of the WWII era

1) Prof. V. Sadavoy, a renowned gero-psychiatrist from Mt. Sinai Hospital in Toronto, Canada, in Survivors: A Review of Late-Life Effects of Prior Psvchological Trauma (1997) reviews data from ageing WWII H.S., combat veterans from the Korean and Vietnam conflicts. Lifelong, persistent P. T. reactions are often aggravated in old age, or may become clinically manifest only after a long delay beyond mid-Iife or later. Two convincing case reports on late onset in H.S. and in a VVWII Polish member of the Resistance are presented. According to Sadavoy, published research on P.T. reactions among the elderly is "exceedingly sparse," considering the public health implications of P.T. disorder in this age group.

2) Prof. H. Stoffels, formerly in Prof. Kisker's department in Hannover, and now a professor in Berlin, found in 1994 that, in contrast to formerlv prevailing opinions, old-age is itself a risk factor for frequent retraumatization in elderly H.S. "Aktualisierung" of the forgotten or repressed earlier responses to, or memories of, post-traumatic events occurs. Stoffels did not specifically mention persistent P.T. reactions, late aggravation or late onset, but acknowledges that the latter is common.

3) Dr. Ch. Joffe (1999) from Sydney (Australia having the world's second-largest population of H.S. -about 30,000 -after Israel), in a recent comparative study of 100 randomly-selected community-based, non-help-seeking elderly H.S. (i.e., not samples from clinical lists), found a

prevalence for PTSD of 39%, compared to 12% resp. 4% prevalence of PTSD in prewar European Jewish refugees and other Jews of British origin living in Sydney. There was also found a high prevalence for depressive reactions, insomnia, use of tranquilizing or somniferic medications were remarkably and significantly higher among ageing H.S. as compared to both control groups.
Joffe emphasizes that there is no difference in prevalence of P.T. morbidity between concentration camp H.S. and others who survived using illegal papers and in hiding. Joffe did not inquire on the courses of illnesses, whether persistent or late onset.
4) H. Bower (1994) in Australia, researching a community sample of ageing H.S., found a prevalence of 85% of one or more of the following: anxiety states, chronic depression, somatic complaints, memory disturbances, and/or contact disturbances.

5) Prof. R. Yehuda (1995) from Mt. Sinai Hospital in New York, in a local community-based random sample of elderly H.S., found that 55% suffered from PTSD (using DSM-IV criteria).

6) In another study several years later (1997), Yehuda et al, in a community-based sample in New York of 90 elderly H.S., consisting of 50 concentration camp survivors and 40 survivors of hiding or illegality, found a high prevalence of PTSD as well as depressive reactions; "emotional detachment" (Criterion C) was more frequent in the higher age group than in the younger pre-gerontic age group. The latter showed increased rates of hyper-vigilance (Criterion D). There were no differences of prevalences between camp survivors and hiding survivors. Yehuda did not differentiate between persistent, aggravating or late-onset PTSD in this study.

7) Favora et al, in Italy (1999) investigated elderly Nazi concentration camp survivors (at a mean age of 71.5 years), and former members of the Resistance, and found a life incidence of 35.3% and present prevalence of 25% for PTSD. For depression (major depression), the percentages were (resp.): incidence -45%, prevalence- 33.3%, 7-8 times more than for non-persecuted subjects of the same age.

8) S. Robinson et al (1994) in Israel, in a community-based sample of 130, mostly retired H.S. (mean age of 68.3 years), found that 60% suffered from symptoms of "survivor syndrome". 70% claim that they continue to suffer from late P. T. sequels of Nazi persecution.

For survivors of extermination camps, the percentages were higher than for survivors from forced labour camps and hiding. Robinson did not inquire about time of onset of their "survivor syndrome", but mentions that they had acute P. T. reactions soon after liberation.

9) Kuch and Cox (1992) in Canada, studying a community dwelling sample of H.S., found an incidence of 65% PTSD among tattooed Auschwitz survivors, and 20% among other H.S. Even the rate of the latter group is 3 to 4 times higher, compared to the population at large. Rates for different lifetime courses or late-onset are not given.

10) R. Landau et al (2000), in studying 194 old H.S. (ages 75-92 years) found increased physical and mental morbidity with a prevalence for PTSD of 24% (compared to 4.6% among controls). Male H.S. tend more to PTSD than female H.S, while the latter have more health-related difficulties as compared to non-H.S. older females.

11) M.K. Potts, et at (1994), found a prevalence rate of 15% for PTSD (DSM-IV criteria) among survivors of Japanese internment camps for civilians of the (former) colonial powers. These camps were infamous for their severe deprivations, but boys were placed with their fathers and girls with their mothers, which softened the impact of the total alienation.

I mention these percentages for the sake of comparison with Jewish H.S. from Europe.

12) Bergher et al (1997) review seven research publications on prevalence of PTSD (and equivalent P.T. reactions) in former POWs, 40,45 and 50 years after WWII. The prevalence rates among elderly, former POWs varied between 29-70%, with an average of about 44%.

The death rate in Japanese POW camps was about 40%, and in German POW camps, about 10% for combatants of Western powers. The prevalence of PTSD among these elderly POW survivors was distributed accordingly, i.e., higher for the crueler Japanese camp survivors. No late-onset rates were given for PTSD in elderly, former POWs.

I mention these statistics for comparison with those of elderly H.S. POWs were generally young males in army service, whereas the genocidal Holocaust (literally meaning 'sacrificing all') must be seen as exposure to a much more severe degree of traumatic stress, as compared to even the Japanese POW camps.

13) Sociological studies of H.S. by B. Kahana et al (1988, 1989) and Harel et al (1993) found that community-based H.S. in Israel and the U.S., compared to pre-WWII refugees from similar cultural and ethnic backgrounds, are lonelier (41% vs. 12%) and suffer more from insomnia (56% vs. 26%) and other significant health differences not repeated here.

Their studies on late subjective effects of the Holocaust trauma in H.S. not sampled from lists of restitution claimants or from clinics are considered of high scientific quality.

In another study on 275 elderly H.S., Kahana et al found that 48 years after WWII, 64% of H.S. were preoccupied daily by their Holocaust experiences (Criterion B); and 92% claimed that they suffered from damaged psychic health as a result of their Holocaust experiences. However, 77% never used mental health or psychiatric services.

Summary: Recent representative research and reviews on P.T. reactions and PTSD, at advanced age in H.S. and survivors from the WWII era, show that 40-50 years after traumatic exposure:

(1) Prevalence of PTSD in H.S. is 39-65%.

(2) Prevalence of P. T. complaints and symptoms on single PTSD criteria or survivor syndrome or equivalents is 60-85%.

(3) Prevalences of H.S. from camps and from illegal hiding do not differ when based on strict PTSD criteria, whereas other studies do show differences.

(4) Tattooed Auschwitz survivors or survivors from other extermination camps show the highest prevalence of PTSD: 65% in advanced age.

(5) Non-Jewish elderly survivors of Nazi concentration camps, WWII POW camps, and Japanese civilian camps show high prevalences of PTSD 40-50 years after their incarceration, but not as high as prevalences in elderly H.S.

In the above-reviewed publications, no attention was given to various life courses of PTSD, although late-onset PTSD has been mentioned as a possibility and is thus acknowledged.

IV. Late-Onset Post-Traumatic Reactions

Under this subheading, WWII P.T. cases, also other than H.S., with late-onset will also be considered for comparison.

1) Already as early as 1967, Prof. Z.H. Winnik in Jerusalem, in his study of 72 H.S. aged 60 years and over, concluded that after the war they had shown a relatively painless social and vocational

adjustment. The acute and then progressive breakdown occurred after a successful career, stable economic states and good integration into society. H.S. differed from a control group of other new-immigrant patients by poorer prospects of their total remission.

2) Prof. L. Eitinger (1980), reviewing his studies of the concentration camp syndrome (including H.S. and non-Jewish survivors), observed "relatively long periods of latency." In the Norwegian study, the delayed breakdowns following a symptom-free, apparently successful readaptation, were already discovered before 1969.

3) W. Niederland (1964, 1968) in the U.S. mentions a latency period preceding the delayed onset of the survivor syndrome of H.S.

4) Prof. M. Assael et a! (1982, 1984) reported on 39 aged H.S. with late depression and belated chronic mourning, often following repeated losses, even over four generations: Parents and siblings and/or spouses in the Third Reich, and children, even grandchildren, in the Israeli wars.

5) J.A.M. Meerlo (1968), also in the U.S., described delayed mourning reactions in H.S.; also H. Krystal (1997) and Fisch (1989), with concomittant late and incapacitating depression.

6) M. Rosenbloom (1985) in "The Holocaust survivor in later life," states that in the early post-war years, clinical intervention was not readily sought by H.S. Many suffered in silence by denying their pain, and it was not until many years later that depressive moods, excessive guilt, nightmares and flashbacks appeared (Criterion B of DSM IV criteria).

7) In 1987, at a psychiatric conference organized by ICODO (a Dutch foundation for WWII victims, including H.S.), the central theme was: "Can invalidating P.T. reactions appear 45 years later?"

A. Engelsman's (1989) statement summarizes the consensus of Dutch clinicians: The common clinical experience shows that survivors, having been active in society over several decades, indeed, often decompensate, but even then **they remain reluctant to turn for psychiatric help** because of shame, guilt and avoidance of the early trauma.

Moreover, the medical doctors themselves had to cope with their own post-traumatic problems after liberation, and thus disregarded their patients' P.T. complaints and symptoms. The medical profession, including psychiatrists, and those in Israel as well, participated in this kind of massive

social denial of the plight of survivors, as reviewed by Judith Stern (2000). She refers to an overview by H. Dasberg (1999) on the problems of Israeli psychiatrists who unknowingly conspired with their patients in avoiding acknowledging P .T. by ignoring the true nature of their post-traumatic complaints.

8) Prof. M. Kuilman et al (1989) reported on 100 WWII survivors (including H.S.) who reacted with late onset or worsening symptoms during mid-Iife and ageing. Before that, they had been outgoing and hyperactive, and had successful careers.

9) Prof. R. Krell (1996) in Canada reports that during the last decade survivors who were children during the war broke down for the first time with depressive P. T. reactions only after 40 years.

10) In examining claimants for compensation, H. Bower found (1994) depression and anxiety reactions, contact disturbances and excessive aggression or irritability after 30 or more years of latency.

11) Prof. B. Schreuder (1997) noted, "It is repeatedly demonstrated to us that even after 40 years, intrusive re-experiencing is still present or has returned after years without symptoms." He mentions latencies of up to 40 years.

On the basis of the clinical observations and expert opinions of the above experts, the concept of late-onset of P.T. reactions after an extended latency period has been substantiated as a common clinical course in H.S.

Below will be reviewed retrospective inquiries concerning late-onset PTSD in ageing veterans. From military organisations and navies from the WWII era; the APA's DSM-IIIR (or IV) were the sole formal diagnoses for these studies.
12) Prof. W. Op den Verde et al (1993, 2000) investigated 147 ageing male veterans of the Dutch Resistance. In one-third of them, the first symptom of PTSD occurred between 1971 and 1985, that is, between 26 and 40 years after the end of the war. No details for the years after 1985 were given.

Delayed-onset PTSD occurred between 1951-1985 i n 68.3% of the time.
Combining their two types of statistical information, I estimated that in approximately 39% of the total sample, a full-blown late-onset (delayed) PTSD began between the years 1971-1985. The

authors state that in several cases, the delayed onset came as late as 35 years after the period of symptom-free latency.

No differences were found among veterans with or without concentration camp imprisonment.o The authors refer to two Israeli H.S. studies confirming this lack of differences between concentration camp and illegal hiding survivors decades later.

Traumatization does not preclude good or even excellent social and vocational functioning over the course of decades. A "paradox" was a term proposed by these authors, i.e., good functioning after early traumatization and late breakdown. Late P.T. reactors are prone to complications of coronary artery disease, and other psychosomatic afflictions during the latency (pre-Iate-onset) period more than non-P.T. controls.

13) Similar observations of 30-year latencies and late-onset PTSD (DSM IIIR criteria) were made by Weisaeth et al (1993) in Norwegian and Danish war sailors from WWII, and

14) French WWII ex-combatants even after 50 years of latency with good prior "paradoxical" adjustments were seen (L. Crocque, 1997).

15) H. Spiro et al (1997) mention "numerous" case reports on delayed PTSD among POWs and ex-soldiers, even after 50 years. Relating to the particulars in some of these cases, the authors wonder if it is not often a question of delayed recognition of PTSD symptoms, because the patients deny, hide or avoid confrontation with the past (Criterion C).

This study also refers to six previously published case reports in the medical literature on late-onset PTSD among veterans and POWs (p. 98). They introduce the concept of partial PTSD in cases of heavy re-experiencing (Criterion B) and hyper-arousal (Criterion D) in the absence of numbing and reduced emotional reactivity (Criterion C). In cases of this partial PTSD, patients tend to numb themselves with drugs, sleeping pills or alcohol. This latter observation is relevant for ageing H.S. who, by chronic use of tranquilizing or somniferic medications, keep their latent, subclinical and often non-diagnosed P.T. reactions in a latent state a little longer.

The authors also mention physiological vulnerability for heart disease, thyroid dysfunction, obesity and other psychosomatic illnesses during the latent symptom-free period (that is, free from overt PTSD symptoms). The added risk or propensity towards the psychosomatic disorders is statistically

verified by Op den Velde et al for Dutch elderly Resistance veterans, and discussed in cases of Holocaust survivors by Freyberger et al (1996) in Germany.

Summing Up to This Point:

(1) Although late-onset after latency in ageing H.S. was not foreseen by post-war German psychiatrists and lawmakers, first reports on delayed P.T. reactions appeared even before 1969 in Norway, the U.S. and among aged H.S. in Israel.

(2) In the years after 1969, clinical reports and publications on delayed P.T. reactions in ageing H.S. appeared with increasing frequency.

(3) Strict criteria-based PTSD diagnosis was used in epidemiological surveys on late-onset PTSD among WWII veterans only as recently as the last decade.

(4) Late-onset (or delayed, postponed, all almost synonyms) -P.T. reactions among ageing and aged H.S. is a firmly substantiated concept.

One Further Remark:

There is nothing as convincing as the detailed clinical description of the individual patient's case history. Indeed, detailed clinical case presentations of late-onset after latency among the ageing and aged H.S. are published throughout the clinical literature, but cannot be presented in detail in my present expertise.

In my own psychiatric practice, I repeatedly saw H.S. patients with late-onset P.T. reaction. Some of the most striking cases were published in publications of the Hebrew University of Jerusalem, Bar-Ilan University in Ramat-Gan and Tel Aviv University (H. Dasberg, 1988, 1992 and 1993).

V. Releasing Factors ("Triggers") and Life Events Preceding Late-Onset P .T . Illness

Elderly H.S. react with PTSD symptoms as a response to cumulative lifetime stress and added recent stress as was shown in a controlled, comparative study by R. Yehuda et al (1995). Added stress acts as a *trigger* for late aggravation and also for releasing late-onset PTSD and equivalent P. T. reactions.

These releasing factors can be subdivided into categories for convenience as follows:

- Personal factors
- Outside threats
- Health problems
- Development factors related to transition from mid-Iife to ageing.

Personal Factors

Retirement is a major trigger. With it comes loss of status, loss of a daily routine, fear of abandonment and a surplus of spare time to reminisce. The change of status and social identity may be a burden for many ageing people, but in the case of H.S. it brings back warded-off memories, survivor guilt and mistrust.

Disengagement is a critical psychosocial process for most ageing people, taking place at the point of transition to the ageing phase of life, as gerontologists have described it. It is compensated by remembering, reminiscing, reviewing and gradually reintegrating their earlier life. This is an age-specific developmental task which, however, is often too heavy for previously-traumatized H.S., some of whom had to live in a precarious psychological equilibrium during many years of their adult lives.

Common upsetting life events for H.S. at the time of transition to old age include: Relocating to new apartments or old-age or nursing homes (K.B. Adams et at, 1994), hospitalization (E. Edelstein, 1982; F. Zilberfein et al, 1992), or institutionalization (E. Bachar et al, 1995).

Furthermore: Loneliness and faltering social support (Harel et al, 1993), demoralization (Fenig et al, 1991), and decline of income are common triggers. Other triggers of an emotional nature include nostalgia and re-experiencing of homesickness for the pre-Holocaust home (Hertz, 1990), and grieving over old and, often at the same time, new personal losses.

The common events of ageing derive their traumatic significance from the early traumatic disruptions. The memories from the past are revitalized as if occurring in the present, even after very long intervening delays. It is a common observation that the returning memory becomes traumatic in the face of new losses and new threats (0. de Levita, 1997).

Outside Threats

Other triggers include new threats of war, such as the Persian Gulf Crisis (Z. Solomon et al, 1992). Robinson et a! (1990) reported on exacerbation of Survivor Syndrome after scud missiles damaged homes. Nazi war-crimes trials like the Demjanjuk trial (H. Dasberg et al, 1991) and testimonies given in those trials (J. Stern, 1990) stirred up old memories, as did rising anti-Semitism and street riots (Eaton et al, 1982).

A recent trigger I have personally observed among H.S. patients was the tension related to discussions dealing with the return of stolen Jewish property from pre-WWII Jewish families. The processing of new claims with its ensuing bureaucratic, administrative and clinical work-up revived memories and aggravated early memories as well as triggered off late-onset P.T. reactions.

Health Factors

Cancer in ageing H.S. triggers P.T. reactions as well (L. Baider et al, 1992; Peretz et al, 1994), as shown in carefully planned comparative studies. Heart surgery , with its ensuing renewed awareness of death (L. Crocque, 1997), as well as cognitive changes in early stages of dementia - by itself not necessarily trauma-related -accentuate past memories and reduce the coping ability and cover up recent concerns and recent memories (B.M.L. Miesen, et al, 1997).

The interaction of insidiously developing old-age dementia with late P.T. reactions is a special problem in itself. The two conditions interact and mutually influence one another. First symptoms of late-onset in previously functioning ageing individuals are becoming manifest (in L. Hunt et al, 1997).

The fear of becoming dependent on others in the wake of declining health, and the fear of declining income are perceived as major threats among ageing H.S. Shmotkin (1998), referring to L.Y. Steinitz (1982) and H. Dasberg (1987) and others, concluded that "evidence of increased vulnerability of H.S. that reach old age is also provided by accumulating clinical experience." (p. 143).

Development factors related to transition from mid-life to aging

P. Aarts and w. Op den Velde et al (2000) developed a plausible theory for explaining the late-onset at ageing. The psychological process of reintegrating traumatic memories and reintegrating one's past life as a natural process of ageing (whether or not retirement has officially taken place)

are in essence similar demands or "developmental tasks," and interfere with each other. Other releasing factors playa secondary role in late reactions according to Aarts et al. The transition to old age after mid-Iife is a phase of human development characterized by unavoidable psychological processes of retrieval of the past and its attempted reintegration and disengagement from the preoccupations with the present. It is at this stage of life that many H.S.'s defensive armor of avoiding the truth behind their subclinical latency traces breaks down.

Summing Up to This Point:

Releasing factors (triggers) are recent events that induce feelings of helplessness, fear of being forced into a passive role which undermines the H.S.'s habitual defensive stance of apparent mastery and supposed outward adaptation. Triggers reactivate the "re-sensitization" of old traumas in the face of ageing problems (D. Shmotkin et al, 1998, p. 151).

The releasing factors enumerated above, as well as others not mentioned here, trigger and revitalize the "warded off" (W. Op den Velde's terminology, 1993) and "walled off" (H. Krystal's terminology, 1998) memories of the original traumatic events of exposure to death, threatened murder or serious injury, and revive the traumatic disruption that took place under the impact of the genocidal persecution 'as if' it is returning or actually occurring in the present.

The ageing H.S. tends to respond anew with intense fear, helplessness and re-experiencing of the horrors of the past (Criterion A) in its original intensity or, belatedly, for the first time in his/her life, in a modified form with added feature of belated grief and mourning resulting in P. T. depression.

VI. The Dynamic Equilibrium of the Latency Period

The crucial question to be answered remains this: What keeps the post-traumatic reactions at bay during the latency period of the free interval between exposure to the original traumatic event and the late P.T. reaction at an advanced age?

There are at work here personal, interpersonal and societal factors that cover up and hold off the outbreak of the P.T. reaction during the period of "incubation." (Crocque's tenn). Various psychic defenses will be discussed here.

The DSM IV definition of PTSD (Criterion C) mentions "numbing" of general responsiveness and avoidance of stressful stimuli reminiscent of the traumatic situation; this leads to (involuntary unconscious) denial of associative connections of current stress with the past stress events. R.J. Lifton, who originally added the tenn "numbing" to the vocabulary of P.T. descriptions, speaks of psychic "closing off" which makes adaptation possible, temporarily and even for many years. A new dynamic equilibrium is restored for a while. The latent trauma, however, is always present, a state of affairs called "paradoxical" by post-trauma experts.

L. Tas (1995) speaks of "Blocked Mourning," on referring to postponed reactions. Schmitt and Stoffels (1991) also discuss late-onset cases in terms of "blocking off' until the return of the persecution-trauma upon ageing. They present a convincing case of Mrs. N. The late-onset P.T. patients-to-be are free to reintegrate socially, for the time being. They may develop an outer 'hardness,' i.e., they cope with daily demands, but remain anhedonic, rigid, sad, pessimistic, and suffer from somato-form symptoms.

The phenomenon of "hardening" among H.S. was first described by J. Shuval (1957) in one of the first comparative studies of H.S. with matched non-H.S. controls. The concept is discussed by H. Dasberg (1987) as well. Prof. Hass (1995), an expert on H.S.'s late reactions, says that during the initial 40 years of their post-war life, "most survivors escaped the brunt of their past calamities by working, doing, not thinking, not feeling," i.e., they close off, negate and use denial as a psychic defense. (In DSM language: they ~). Others speak of "Arbeits-neurose" in relation to this neurotic post-traumatic behaviour.

Kleber and Brom (1992), in Copinq with Trauma, are of the opinion that basically there is ~ central defense against the inner onslaught of traumatic repercussions, and that is: Denial. An international symposium on denial of traumatic and post-traumatic stress as a central psychic defense has been published by an Israeli researcher (The Denial of Stress -S. Breznitz, 1983). Denial takes various forms such as: repression, suppression, rationalization, and so on, enabling outward apparent adjustment, often excellent adjustment, for the duration of the latency period. The price paid is: Cognitive constriction, hardening, constricted personalities and increasing risk for future decompensation. However, in many instances, the patients, and often their physicians as well, do not understand the connections. This, indeed, is post-traumatic avoidance (Criterion C), perpetrated in a "conspiracy of silence" in the service of psychic defense.

Y. Sadavoy (1997), in his paper on elderly survivors, speaks of the traumatically-induced "false self' which is an "armour to meet the world," providing the conditions are not too unfavorable. The

traumatic inner "true self' remains hidden, waiting to be released by later triggers. From this psychoanalytic perspective, survivors with hidden post-traumatic problems essentially suffer from identity disorders, diagnosable post-factum, after the late-onset has occurred. They act "as if' it were not true. This "dormant, sub-clinical coverage" (Krystal, 1981), held up by "splitting" of the personality has to come to an end, at a time when the natural urge for reminiscing and reintegration of old memories take over in old age or after reaching mid-Iife. Until then, the "dormant" problems continue to be "walled off' (H. Krystal's term). As was said, the avoidance, detachment, constriction and blotting out of awareness, and blocking off during the subclinical latency period, fulfill Criterion C (of the DSM definition of PTSD, above).

Pre-Iate-onset complaints during latency could not be related or could not be connected to trauma, or were minimized. The H.S. unwittingly perpetrate on themselves the defense of "knowing and not knowing," as described in relation to H.S. by Laub and Auerhahn (1993). Non-recognition of links to trauma is the rule during the latency period. Misdiagnosis of complaints is common and often treated by G.P.'s or in Sick Fund clinics in a strictly focal manner by the medical subspecialties.

In the past, the German experts, in cases of late claims, demanded evidence for so-called "Bruecken" symptoms; it seems that they have receded from this viewpoint. However, bridging symptoms can often be found if the specialist knows how to elicit a post-traumatic anamnesis. In practice, however, many doctors, lacking the proper ability for empathy, elicit instead the examinee's (post-traumatic) response of closing of and mistrust. Doctors mistrust the victims, and the victims mistrust society, as Matussek put it. After decades, post-traumatic amnesia may lift in some P. T. victims, and they present a striking reversal from lifelong dissociation and forgetting. 0. van der Hart and D. Brom (2000) discuss 14 cases of this type of unexpected or late-onset.

I recently saw a 76-year-old female patient who, after a visit with her grandchildren to present-day Auschwitz, had a dramatic re-experience of dissociated memories; however, following an initial relief, she developed an intractable post-traumatic late-onset depression later at home. This has been a recurring course of events in my own practice. One of my own case-descriptions of late-Iife lifting of P.T. amnesia and dissociation was cited in full in the Koblenzer Handbuch des Entschaedigunasrechts (1996, p. 155).

Not all P.T. victims can react with the bliss of denial, repression or dissociation. J. Mittelbach, attending the Arnoldsheim symposium on post-persecution trauma, presented a case study of a victim with post-traumatic syndrome who refused to submit a claim for health damage because he

had desecrated Jewish corpses by pulling out their teeth. Consequently, his suffering -so he claimed -is what he deserved, to never forget his "sin." It was not recognized that his masochistic self-punishment and guilt were, of themselves, severe post-traumatic handicaps.

Thus, silent, latent, supposedly symptomless, pre--Iate-onset dynamic equilibrium, as well as subjects with post-catastrophic personality changes, of which the victim may not even be aware, exhibit subclinical or unacknowledged traces of the post-trauma. Sometimes a minor later stress may give the suppressed traumatic memory (or "traces") its full significance and belated PTSD breaks out after many years (as described in cases presented by D. de Levita, 1997, and by many other authors).

Theoretical Conceptualizations of the Clinical Course of Latencv/Late-Onset

J. Bastiaans (1974), a renowned post-trauma psychiatrist and psychotherapist, leaning on Selye's theories on stress reaction (from a period preceding the invention of the modern PTSD concept), discerns three stages:

1) An acute P.T. stage, often lasting a few years, of intense psychophysiological arousal, tension, insomnia, frightening nightmares and perpetual post-stress fatigue, the latter is a clinical phenomenon diagnosed as post-concentration camp neurasthenia by Levinger in Jerusalem in the 50s.

2) A latency stage of apparent recuperation, even over many decades, characterized by repression and denial, outward adaptation with hyperactivity ("Arbeits neurose"), or in, Y. Danieli's words, "over-coping," and psychosomatic complaints. [All of which may not be connected by patient or doctor to the hidden past trauma.]

3) Finally, after many years, exhaustion sets in with the breakdown of defenses and the return of the impact of the original trauma. In present-day language, return of Criteria B- and D- symptoms after years of laboring under the sway of Criterion C phenomena.

P. Aarts et al (2000) developed a plausible, theoretical concept for understanding the sequence: Latency --> Late onset, based on combined gerontological and psychotraumatic observations, already mentioned on p. 16 above.

The Role of the Medical Profession and Society At Large

Medical professionals also play a role in the dynamics of holding at bay and warding off. They misdiagnose, minimize, do not recognize and unknowingly conspire with the patient's avoidance. Moreover, professionals may have been traumatized themselves or were otherwise involved in, or affected by, the catastrophic societal upheavals of the Nazi or post-WVVII period (see above, IV/parag. 7, p. 11).

Society at large puts up demanding norms of negation and normalcy. This also interferes with the proper examination and diagnostic process during a post-catastrophic or post-war era. (H. Dasberg, "Society Facing Trauma: Psychotherapists Facing Survivors" (Hebrew), 1987; z. Solomon, 1995, and J. Stem, 2000, both referring to Dasberg's 1987 observations; and H. Dasberg, "Myths and Taboos Among Israeli First- and Second-Generation Psychiatrists in Regard to the Holocaust," 2000).

Jucovy (1992), a renowned investigator of traumatic sequels in H.S. in the U.S., states: "Powerful defenses employed by survivors themselves and by the world about *them* lead to a latency period with delayed investigation of the late sequels." Kuch and Cox (1992) in Canada: "Most H.S. had not received psychiatric care." Misdiagnosis was also common in ageing WWII veterans (Clipp and Elder, 1996).

Y. Danieli (1997), speaking of "unmasking latent PTSD," states that external attainments represent adaptive achievements and, therefore, "clinicians can easily miss intra-psychic problems."

Souget, at a conference on late P.T. effects among H.S. sponsored by ICODO in Holland (1987), discussing the late outbreak of PTSD and of postponed mourning in a H.S. after a case of fatal cancer was diagnosed, reaches the conclusion that early diagnosis of post-Holocaust reactions would have been possible if clinicians had been able to identify with persons in terminal stages, as indeed many K.Z. inmates were, for reasons other than cancer

Schmitt and Stoffels (1991) in Germany state that the medical expert is obliged to listen to anamneses of horror and at the same time must arrive at medically- and scientifically-sound conclusions. Clinicians, especially if their own WWII or Holocaust-related trauma has not properly been worked through, may

themselves close off and shy away. Schmitt et al. quote Dasberg (1987): "As if those who returned from death were tainted by the stigma of death and the world at home retreats from them."

Psychiatrists may react with uncontrollable countertransference in relation to the victims. especially when the latter fled into "pathological health and unwittingly misled the diagnosticians." (Meerlo, 1968).

F. Haenel, a German medical "Guttachter," recently (2000) discussed a "Iate-onset" case from WWII as follows: Experts sometimes react with mistrust and react to the examinees' hostility; the latter then retreats into shame and guilt. The 62-year-old woman under consideration following traumatizing experiences during WWII, although she had worked until retirement, had been anhedonic all her life, had suffered from contact disturbances. and had repeatedly been treated, over the years, for gastric complains, premenstrual tension, muscle- and headaches, and unspecified "neuroses." Her doctors had been unable to empathize with her plight, never suspecting a latent, post-traumatic reaction, until it came out after retirement, when the patient's, as well as the doctor's, denial broke down.

The Jewish-Polish psychiatrist, Prof. Maria Orwid, a renowned specialist on post-Holocaust sequels at Jagellonian University in Krakow, states in a recent paper (2000), "I know I had many problems [as a child survivor of the ghetto], but I am not sure whether I had identified those problems with the Holocaust, because there was a period of 'conspiracy of silence.' Later [before beginning in-depth research on Holocaust trauma], I had to come to terms with it myself." This frank disclosure shows the conflict of many medical experts, not only in Poland, but also in Germany, Israel, the U.S. and elsewhere, as indicated in the above-quoted literature.

Summing Up So Far:

It was deemed necessary for this expertise on late-onset P.T. reactions among H.S. to add the description of the dynamic equilibrium of the pre-Iate-onset phase, which, in many cases, is extended over the entire life span from 1945, until reaching mid-Iife or the (pre-) gerontic phase. Post-traumatic reactions in victimized, trauma-exposed WWII survivors in general, but in Jewish H.S. in particular, are common at advanced age with high incidence and prevalence rates (see Section III of this expertise). Late-onset of delayed P.T. reactions is a firmly-substantiated clinical concept already described in large samples of H.S. before 1969 (in European countries, the U.S. and Israel), but is also very common beyond mid-Iife and at advanced age, occurring after 1969 until the present (see Section IV).

Delayed late-onset P. T. reactions are characterized by a complex of pain, suffering and dysfunction in various areas of daily life and can become chronically incapacitating. An initial post-war malaise, stress reaction, "neurasthenia," period of hyper-arousal or post-war acute or subacute remitting P.T. reactions have been reported to occur soon after the war, prior to the latent symptom-free phase of relatively successful readaptation.

However, as a rule, there is no report of early post-war P. T. reactions preceding the re-adaptation to post-war social life, which indeed can be remarkable and even excellent over many years, until after the peak of active life has been reached at mid-Iife, or on approaching the transitional phase of ageing and old age, when delayed (late-onset) P. T. reactions may appear. The latency phase can be symptom-free, or with subclinical traces, or with fluctuating, remitting symptoms not interfering with social re-adaptation. Releasing factors or triggers have been described (Section V), but may be merely accessory causes, hastening the underlying incubatory subclinical process towards its overt late-onset manifestation. The pre-Iate-onset latency is here described as a state of dynamic equilibrium, of an interplay of (manifest) adaptational and (underlying) traumatogenic processes.

Psychic defenses which keep the traumatic process at bay during latency are abundantly described by clinical observers of many schools. Proposed were descriptive, metaphoric or psychodynamic terms such as avoidance, numbing, closing off, blocking of, blotting out of awareness, "knowing and not knowing," dissociation, masochistic self-punishing defenses, denial, negation or repression, all in relation to the latent post-traumatic pre-Iate-onset delay.

Readaptation to social life during the delay is described post-factum as paradoxical, neurotic-hyperactive, as "overcoping" or overcompensating for the losses.

Post-traumatic personality characteristics of H.S. during sometimes long years of free interval are: hardening, hyperactivity, constriction of personality, split identity with inner traumatized and trauma-prone core and outer armor of facing the world, and so on, as mentioned above in detail.

The underlying dormant P.T. state has been described as dormant, latent, "in-incubation," subclinical, silent.

Fluctuating and remitting P. T. symptoms, if appearing during the latency phase are described as minimized, present as traces, focal or displaced to psychosomatic foci of clinical attention; whereas

at the same time, P. T. changes of personality disorders, if not interfering too much with social adaptation do not draw attention as clinical problems over extended periods.

Doctor-patient relationships in the form of uncontrollable counter-transferences, subconscious or unwitting "conspiracy of silence," mutual distrust, lack of empathy, result in frequent non-recognition or misdiagnosis.

The overriding influence of social norms, directed to post-war rebuilding and post-traumatic avoidance in and by the post-Holocaust world, also influence doctor-patient relationships (as expounded in Section VI above).

Theoretical models for the sequence: "Long-lasting symptom-free latency period" -----> "Delayed late-onset at advanced age" have been developed by clinicians, based on stress theory , gerontological theories and/or psychodynamic theories. All of them are briefly presented in this expertise for the sake of the solid substantiation of the concepts under consideration.

VII. Added Remarks on Child Survivors of the Holocaust

In addition to the exposure to the cumulative and traumatic events of the Holocaust years, as well as:

- deprivations suffered in illegal hiding or camps, and
- massive loss of families, including one or both parents, the children sustained the additional traumatic impact of:
- interrupted normal development.

The persecuted children, as a rule (abruptly and without preparation in most instances) were separated from their mothers and from the rest of their family at an early age.

The developmental trauma characteristic to children is not the type of trauma that breaks into the life of already formed, stable and more or less matured adult personalities. To be a child means to be dependent on the familiar adults, mainly the mother. Developmentally-damaged children did not have the benefit of a pre-traumatic peacetime upbringing, and consequently cannot look back or lean back on an antecedent, not-yet-damaged personality, as is the case with adults who sustained traumatic damage after their childhood development was already more or less complete.

Child survivors (ch.s.) have no insight into or awareness of the fact that they are damaged or disordered. These children, as a rule, also later as adult persons, attempt to succeed in life, but there is often a price to be paid -namely, frequent "character-neurotic" development, by former continental diagnostic standards. In the final quarter of the last century, this terminology shifted to "Personality Disorder" which is defined as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment." (DSM IV, 4th edition, p. 629).

These disordered states include social inhibition, feelings of inadequacy, hypersensitivity to negative evaluation, and in adult, socially-successful child survivors, also a fear of failure (M. Cohen, et al, 2000) and a relentless urge to prove their worth in the eyes of others, distrust of others, and often instability. 'ln interpersonal relationships and disturbed intimacy, excessive submissiveness (and as a variant of the latter, often "excessive altruism" has also been described in adult child survivors). These disturbed ways of life are egosyntonic, that is, not considered problematic by the individual. They do not know why they suffer from these socio-communicative, interpersonal problems, and only supplementary information from another person close to them makes a diagnosis possible.

Post-Holocaust personality disorders in child survivors were described in the 60s and 70s by German forensic psychiatrists of children who had submitted claims during the allotted period (i.e., before 1969). It was predicted that, notwithstanding their innate developmental powers of progressive development, which are characteristic for their young age, they would be prone to psychiatric decompensation at an advanced age (H. Paul, et al, 1967; R. Lempp, 1979, 1992).

Adult child survivors often show difficult work relationships or problems in their marriage. Lempp points out that deprived childhood is reflected in the adult as problematic interhuman contact, identity problems and depressive moods, notwithstanding their occasional social successes in adult life.

H. Keilson, 30 years after the liberation, personally interviewed (and collected systematic information by questionnaire) a randomly-assembled research sample of 204 adult child survivors from a list of 2,041 Holocaust orphans with no known clinical backgrounds. The investigation was !1Q! intended to deal with reparation claims. These adult child survivors were described as suffering from a "complex" of:

1) Divided loyalty between war-time foster families (in the case of hidden children), post-war foster families, and their own original biological families,

2) Mourning and survival fantasies, i.e., the nagging pre-occupation with the unrealistic expectation of the return of their parents,

3) Problems of interrupted schooling and "socio-communicative" disturbances, and

4) Identity disorders or problems.

The younger adult ch.s. (i.e., age of separation from the mother was up to 10 years of age) 30 years later showed primarily "character-neurotic" development. In 1975, a prevalence of 30.4% for the then-adult ch.s. who were 10 years of age or younger upon separation from the mother. Whereas the pre-adolescents at time of separation tend to exhibit anxiety neurosis (according to the terminology of 1975), while those who were adolescents on separation tend to exhibit depressive reactions. (In 1975, pooled anxiety and depressive reactions for those over 10 years of age on separation: 44.8%).

Keilson included in depressive reactions also "restricted personality" which is !}Q! what today is subsumed under the concept of depression. He meant, rather, inhibition of activity and initiative and emotional detachment, mindful of the "constricted" post-traumatic personality of Kardiner. This in fact was PTSD the symptomology of the numbing, avoidance and emotional detachment subsumed under Criterion C of the DSM IV definition.

Keilson presents 40 detailed case histories. The age of onset of post-traumatic anxiety and/or P. T. depression was !!Q! a focus of this research. However, it is apparent, upon careful reading of these case histories, that in many cases these reactions that were recorded 30 years later, were of recent origin, in 1975.

It can be safely assumed that similar late reactions would still appear in future years as Paul, et al, and Lempp had predicted in Germany. The characterological handicaps, anxiety and depressive reactions, were the late outcome from losses and too-early separations in childhood and from mal-development.

Victimized former children, as adults, were trying to live up to their post-war challenges and in many instances reacted with hyperactivity and overwork in an attempt to fulfil the expectations of

new educators, always fearful of being confronted with new losses. These young victims had the benefit of their innate powers for progressive development as retrospectively described by later clinicians in Dutch Annual of Psychoanalysis. 1995-1996 on "Traumatization and War."

Later research on ageing child survivors has been reviewed by me in: "An adult child-survivor syndrome: On Deprived Childhoods of Ageing Holocaust Survivors: A Contribution to the Substantiation of a Concept" (H. Dasberg, published in 2001). Included there are recent clinical-descriptive research as well as recent epidemiological-statistical comparisons of ageing child survivors with matched control groups (for instance, by M. Cohen et al, 2000). The conclusions of that review describe the main deprivations as follows:

(1) the lack of functioning parents or adult caretakers, who are initially filled with fear and worry, then either disappear, die or may even return, although as changed persons, after the liberation, and,

(2) being at the mercy of strangers in the Holocaust world and afterwards. The child survivors are gravely deprived children, yet, at the same time, traumatized children.
After re-entry into post-war society and after an initial malaise of a variety of acute psychic symptoms and social disabilities and conflicts, ch.s. are able to take advantage of the innate, vital powers of progressive development characteristic to their young age, and they, seemingly, adapt. In most instances they set aside or are forced to set aside by adult educators and society, temporarily, the hurts and impact of losses and traumatic memories.

In the typical case, what remains as an overt feature is their relentless striving to belong, to succeed, to be accepted, not to disappoint their caretakers, and not to fail. This, after all, is the most important lesson they all learned during the period when their lives were threatened. The price paid is lifelong symptoms in different combinations, intensities and courses over time, as follows:

Subjectively pervasive feelings of loneliness and estrangement; insecurity; lack of self-esteem; being deficient; anhedonia, i.e. not enjoying life or their own achievements without undue guilt and doubts; guilt and suppressed grief and recurrent bouts of grief; amnesia often of periods of childhood; and a perpetual feeling of loss and lack of intimacy.

Observed **objective** phenomena are low threshold for anxiety; bouts of depression; withheld rage with unexpected emotional outbursts, combined with, at other times, emotional detachment and difficulty in expressing emotion and difficulty in making inter-human contacts; dysregulation of aggression; authority conflicts; marriage conflicts; anxiety states; identity problems, and late

identity disorder; and, on the childhood level: Developmental disturbances and emotional retardation, and frequent lifelong personality disorders.

The characteristic feature of adult ch.s. personalities is the SPLIT. In the early years it was a split of loyalty between dead parents and new caretakers, between returning parents and wartime caretakers, or between the reality into which they had grown up and what became their new post-war reality. This split is basically a feature of incomplete mourning and postponed mourning, and also between a traumatized inner core and outward adaptedness. During their adult lives, there characteristically seems to exist a split between the outer shell of psychosocial adaptation, often excellent, and the inner core of infantile, not matured child features. Experts in different times and countries, and using various descriptive methods, are all in consensus regarding the child survivors' (psychologically) split personalities. As a consequence, ch.s. were able to disregard the manifestations of their adult child survivor syndrome over long periods of time.

Upon reaching mid-Iife, the post-Holocaust malaise -seemingly successfully postponed -now comes out into the open. There is a broad consensus on this. **New** psychosocial and clinical needs are now existent. It is only recently that the younger child survivors have entered their ageing period. It was, therefore, only during recent years that the massive recurrence of the consequences of childhood deprivation became apparent.

Summing up:

Adult child survivors suffered from personality disorders due to early maldevelopment after traumatic separation from their mothers up to age 10, and from anxiety and depressive reactions.

As a rule, child survivors as adults were not motivated to accept the self-image of disadvantaged, mentally-crippled children. For these reasons they were probably not ready to submit claims for mental health damage in the early years. This is especially true for persons with personality disorders in the wake of persecution-related mal-development. Their readaptive efforts often break down on ageing, as was indeed predicted by earlier clinical observers of child survivors. Moreover, personality-disordered persons are rarely aware of the extent of their invalidism or its sources.
The intervening years between childhood and later life are characterized by one of the following life courses:

1) Lack of overt symptoms

2) Latent or dormant or subclinical symptoms

3) Temporary symptomatic setbacks: anxiety reactions, depressive reactions

4) Personality disorders, not easily diagnosable as clinical disorders, but "only" as socio-communicative or behavioral problems

5) Psychosomatic disorders (this problem would of itself necessitate a separate expertise)

These adult ch.s. as a rule could not be free (for the sake of continuing adaptation and preservation of self-image) for submission of restitution claims. This would have been disastrous for maintaining a remnant of psychic equilibrium. However, on approaching the ageing phase of life, they are prone to full-fledged late-onset P.T. reactions for the first time in their lives, as is the case for ageing H.S. in general, and indeed for other ageing trauma victims from the WWII era.

VIII. Conclusions

Looking back at 50 years of medical-psychiatric observation, delayed late-onset post-traumatic reactions (P.T.R.) in Holocaust survivors (H.S.) beyond mid-Iife and at advanced age, seems to occur with increasing frequency, and more often than initially conceived during the first decades following WWII.

Ageing and transition to old age are life stages that have been more closely studied and researched in recent years than 30-50 years ago when psychogerontic and psychogeriatric knowledge was scarcer.

Following a latent, symptom-free interval, often lasting up to 4-5 decades -early exposure to traumatic events notwithstanding -the new stresses, threats and/or transitional crises of ageing may reactivate and release dormant, subclinical reactions not previously recognized or diagnosed.

Ample epidemiological and clinical evidence is available from H.S. studies, as well as from other non-Jewish WWII victims, for substantiation of the concept of late-onset P. T.R. in ageing H.S.

Incapacitating late-onset P.T.R. are likely to occur at advanced age, even though not found at earlier medical or psychiatric examinations.

IX. Recommendations

Based on the above material and the conclusions reached, it is now possible to make clear recommendations pertaining to further research on late-onset P.T.R. as well as

prevention, intervention, rehabilitation and compensation.
As to the latter, which was the sole purpose of the present expertise, the recommendation is to aim for a correction of the outmoded laws from before 1969, which at present preclude submission of claims for late-onset post-traumatic reactions and suffering at a time when it is most urgently needed.

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