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**Holocaust Survivor Care: Unique Needs and Best Practices
Guidance Recommendations Guide
The Jewish Federations of North America
August 11, 2016**

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Introduction

The following recommendations were created in response to the Notice published in the Federal Register on June 21, 2016 seeking comments on whether the U.S. Department of Health and Human Service's Administration for Community Living's (ACL) proposed Program Instruction guidance on serving Holocaust survivors living in the U.S. is sufficient for states to fully assess the needs of and develop plans for serving the Holocaust survivor population.

Following the 2016 reauthorization of the Older Americans Act (OAA), which included a new provision directing the Assistant Secretary for Aging to issue guidance for conducting outreach to and serving Holocaust survivors, The Jewish Federations of North America brought together 56 experts from secular and religious aging providers, national aging service organizations, and institutions specializing in services to survivors for three phone calls to review the Program Instructions and gather feedback and recommendations in response to the Notice. In addition, direct service providers to survivors were encouraged to submit in-depth recommendations through an online survey. We received recommendations from 24 communities in the following states: Arkansas, Arizona, California, Connecticut, Florida, Missouri, New Jersey, New York, Ohio, Pennsylvania, and Texas.

We commend ACL for including Holocaust survivors in its targeting guidance and acknowledging that being a Holocaust survivor can "limit the degree to which older adults experience full inclusion in society and are able to access available services and supports." However, as outlined in the companion letter to this guide, we are concerned that, without enforcement, states that have little experience with or education on Holocaust survivors and their unique needs are unlikely to effectively target resources in a way that enables Holocaust survivors to live their last years with dignity and safety. Therefore, it is our opinion that a Federal mandate requiring State Units on Aging (SUAs) to assess the needs of Holocaust survivors will ensure the maximum inclusion of this population in programs funded under the OAA.

Furthermore, service providers must be aware of Holocaust survivors' specialized needs as a result of the trauma they experienced under the Nazi regime. To successfully serve this population, service providers, as well as medical professionals and caregivers, require specific guidance and training to avoid re-traumatization. Consequently, we believe the brief guidance provided in ACL's Program Instructions to SUAs is insufficient.

After reviewing the existing research and the recommendations we received from our phone call series and service provider survey submissions, we have compiled this guide as a primer for SUAs that would like to begin learning about the complex issues associated with serving Holocaust survivors. However, this guide is not intended to be a training manual. For those interested in more comprehensive resources, we highly recommend starting with the Baycrest Health Sciences guide, "Caring for Aging Survivors of the Holocaust: A Practice Manual" (Baycrest). The JFNA Center for Advancing Holocaust Survivor Care is happy to provide further recommendations and can be contacted at HolocaustCenter@jewishfederations.org.

Definitions

As the following terms will be frequently used in this guide, please review the definitions below.

Triggers

A trigger is a stimulus that creates a reminder of past traumatizing events. A person might be triggered by a particular sight, smell, sound, holiday, or event. Encountering such triggers may cause one to feel uneasy or afraid (Handout Module 2).

For example, what seems like an ordinary request such as, “It’s time for you to take a shower,” can be anything but ordinary for a Holocaust survivor who knows that Nazi gas chambers were disguised to look like showers. Some common triggers are listed below (Frumer, 2015) – for an extensive list, we would recommend reviewing the Baycrest Manual’s “Potential Triggers for Holocaust Survivors.”

Common Triggers include:

- Lack of privacy
- Small spaces or crowded conditions
- Routines and schedules
- Harsh, strong, or unpleasant smells
- Taking a shower or bath
- Flashlights or bright lights
- Saying goodbye or staff changes
- Loud voices or foreign languages
- Dogs and other animals
- Jewish holidays or religious symbols
- Specific clothing items
- Registering

Once becoming aware of triggers, a social service provider might feel an impulse to “get rid of all the triggers” (Handout Module 2). Of course, providers should work to avoid violent images or angry tones in their speech and try to make environments calm (Handout Module 2). But there will always be trauma triggers that cannot be anticipated and cannot be avoided. Part of trauma-informed work is supporting survivors as they develop the skills to manage trauma responses.

Retraumatization

Retraumatization occurs when any situation, interaction, or environmental factor replicates events, sensations, or dynamics of prior traumas (i.e. triggers) and evokes feelings and reactions associated with the original traumatic experiences (Handout Module 2). Retraumatization may compound the impact of the original experience. For example, if a Holocaust survivor is brought to a hospital for a procedure, and it reminds them of a medical experiment performed by Nazi doctors, retraumatization can occur.

Person-Centered, Trauma-Informed (PCTI)

Person-centered, trauma-informed (PCTI) care is a holistic approach to service provision that recognizes the impact of trauma on a survivor’s life. Past or current trauma can affect physical, mental, and emotional health and can negatively impact a person’s ability to access services or pursue everyday activities. An organization that is person-centered and trauma-informed promotes the dignity, strength, and empowerment of trauma victims by incorporating knowledge about the role of trauma in victims’ lives into agency programs, policies, and procedures. For more information, please visit <http://www.samhsa.gov/ntic/trauma-interventions> and <http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf>. The Jewish Federations of North America’s Center for Advancing Holocaust Survivor Care, which aims to expand PCTI supportive services for Holocaust survivors, has more information on PCTI that can be found at www.HolocaustSurvivorCare.org.

Background

The Holocaust

The Holocaust and Nazi Persecution

The Holocaust was the state-sponsored persecution and murder of the Jewish people by the Nazi regime and its collaborators between 1933 and 1945 (USHMM). The systematic attempt to eradicate the Jewish people was referred to by some Nazis as the “Final Solution to the Jewish Question.” The brutality Jews experienced during the Holocaust was comprehensive, systematic, and multi-leveled. Jews were first dispossessed of their property and deprived of their livelihoods. Their homes, real estate, and businesses were seized, and their synagogues burned. Additionally, they were subject to beatings, humiliation, and public hangings (Yad Vashem).

As the Holocaust progressed, Jews began to be round up without notice, piled into cattle cars, and sent to sealed ghettos where poverty, starvation, and lack of sanitary systems took the lives of many. Those who experienced difficulties because of age, illness, or other vulnerabilities were shot; others died from the lack of food, water, and ventilation on overcrowded trains and in ghettos (Yad Vashem). Later on, many Jews were sent to concentration camps where they were victims of torture, starvation, and exposure to the elements. In some cases, physicians conducted experiments on Jews that included, but were not limited to, exposing them to hypothermia and mustard gas (USHMM).

To complete the “Final Solution,” Jews were murdered in fields in mass shootings and mobile killing squads, and, ultimately, in vast gas chambers designed to bring about the complete annihilation of the Jewish people (USHMM; Yad Vashem). In total, six million Jewish men, women, and children were killed – two-thirds of the Jewish population in Europe before World War II (USHMM).

Other Victims of Nazi Persecution

The Nazi regime was also responsible for the persecution and death of an additional five million non-Jewish victims. This group included lesbian and gay individuals, Jehovah’s Witnesses, Slavic people, people with disabilities, Roma and Sinti (“Gypsies”), Communists, and Socialists (USHMM). We believe that most non-Jewish victims of Nazi persecution remained in Europe or the FSU following the end of the War, and no research suggests that there have ever been sizable populations residing in the U.S. Therefore, the following information and recommendations were compiled specifically for Holocaust survivors residing in the U.S. today.

Holocaust Survivors

Demographics

More than 200,000 Jews found refuge in the U.S. during the Holocaust. Another 137,000 Jewish refugees settled in the United States from 1945 to 1952, and more came from Europe and the countries of the former Soviet Union (FSU) during the subsequent decades (USHMM). But time, age, and trauma have taken their toll, and it is estimated that between 100,000 to 130,000 Holocaust survivors remain in the U.S. today. The youngest are 71 years old, but most are much older. In New York City, home to the largest number of survivors, 53% are between the ages of 80 and 89, and over a quarter (27%) are between 90 and 99 (Kover, 2014).

While the size of the survivor population is decreasing, the number of survivors needing and seeking assistance is increasing. Several factors cause this trend. As survivors age and become frailer, many who

never needed assistance in the past now need help to get through their daily lives. The death of a spouse or caregiver creates a need to find alternate sources of care. Some communities have had an influx of Holocaust survivors moving to an area where social services are more prevalent. Many people who never identified as Holocaust survivors in the past are coming forward as survivors as programs to help survivors are publicized. The survivors from the FSU live in tight-knit communities and spread awareness of services by word of mouth.

The Conference on Jewish Material Claims Against Germany (Claims Conference), which is responsible for negotiating compensation and restitution for victims of Nazi persecution and their heirs and for administering funds to institutions that provide social welfare services to survivors, estimates that four out of five survivors live in New York, California, Florida, New Jersey, or Maryland. Most survivors in these states live in metropolitan areas. Because of high rent prices and unreliable transportation options in these areas, choices for affordable housing and dependable and accessible transportation are limited.

The German government, and by extension, the Claims Conference, has a specific definition of “Jewish Nazi Victim” that depends on an individual’s place of birth, date of birth, and wartime experience. The U.S. Administration on Aging does not define “Holocaust survivor.” In this guidance, the expectation is that the term would be interpreted broadly to include any victim of Nazi persecution, including someone who fled such persecution.

Financial Compensation for Holocaust Survivors

Some survivors receive financial compensation in the form of reparations or pensions from Germany or other European countries. Additionally, some Holocaust survivors receive social welfare support such as home care, food, or transportation from Jewish organizations with funding from the Claims Conference. Under U.S. law, financial compensation and pensions resulting from the Holocaust are excluded from calculations relating to federally funded or federally assisted benefits such as Medicaid, Supplemental Security Income, Federally subsidized housing or the Supplemental Nutrition Assistance Program (SNAP).

Poverty

It is estimated that approximately 25% of survivors live at or below the poverty line, although survivors from the FSU, as well as those living in New York City and Los Angeles, face poverty rates closer to 50% (Sherman, 2014; Kover, 2014; Samuels, 2014). These low-income survivors struggle to meet their basic needs for housing, food, and health care, and often rely on Supplemental Security Income (SSI), energy assistance programs, Meals on Wheels, and other programs in order to obtain the basic necessities of life (Samuels, 2014). Some providers that participated in our research report that poverty can be a triggering event for survivors for whom it reminds them of experiences of deprivation during the Holocaust.

Survivors from the Former Soviet Union (FSU)

The experiences of U.S. survivors from the FSU vastly differ from those of survivors from Western Europe. While Jewish communities from both regions experienced significant persecution and losses during the Holocaust, suffering did not end for survivors in the FSU. Many of these survivors, who were children when the War began, returned to Soviet towns and cities where the trauma they experienced during the Holocaust was compounded by struggles to survive under an authoritarian, communist regime and ongoing persecution and anti-Semitism.

The majority of Holocaust survivors from the FSU who emigrated to the U.S. came in the 1980s and 1990s and faced greater challenges assimilating. Language barriers have been an ongoing problem, with

many survivors from the FSU still unable to speak English. Moreover, survivors from the FSU are more likely to be low-income than other survivors – it is estimated that half of FSU survivors have annual incomes beneath the federal poverty threshold. While these Holocaust survivors are in critical need of services, providers participating in our research state that, as a result of experiences under communist governments, Holocaust survivors from the FSU are less likely to seek out services, particularly mental health care, and are distrustful of government benefits and programs.

Unique Needs of Survivors and Recommendations for Service Providers

Background: Trauma and Its Impact on Service Needs

For Holocaust survivors, physical, emotional, and cognitive challenges, outlined in more detail below, can be traced directly to trauma experienced during the Holocaust. Many survivors have common narratives of trauma from the Holocaust and immediately after that include the following (Hoffman, 2015):

- Constant threat of death
- Exposure to extreme violence
- Prolonged physical, mental, or medical abuse
- Extreme deprivation, thirst and hunger
- Dehumanizing treatment
- Exposure to unbearable weather
- Lethal hard labor
- Extermination of entire families and communities
- Guilt over surviving or inability to save others
- Immigration to new lands

These traumas are now being experienced through the lens of each survivor's own aging process. Danieli (1994) describes how "many survivors experience the normal phenomena of old age as a recapitulation of Holocaust experiences" (p.3, in Barak), and Bar-Cohen (2014) notes that Holocaust survivors and their families are now "coping with the much more exacerbated needs that have emerged as survivors age and their horrific histories come back to plague them once again" (Bar-Cohen, 2014). As this generation ages and peers pass away, each new loss stirs dormant grief and traumatic memories (Barak, 2013). These cumulative challenges and experiences greatly magnify the struggles of aging for survivors, "creating a group that ages differently and has more acute needs than do other older Americans" (Samuels, 2014).

Survivors may be particularly vulnerable to changes that are associated with the normal aging process because former coping strategies, such as hard work and taking care of the next generation, are no longer an option. Illness, dementia, frailty, dependency, isolation, and loneliness may disrupt daily activities, and traumatic memories and unresolved losses might become more dominant. Moreover, signs of illness or weakness may be triggers, as Holocaust victims who exhibited any sign of weakness were often executed during the Holocaust.

Public health experts agree that overall health outcomes for older adults who age in place are often better than for those in unnecessary or premature institutional care. However, the negative impacts of leaving one's home and entering a nursing home or other institutional care setting is further exacerbated for Holocaust survivors. For survivors, removal from one's home can result in a loss of autonomy, control, and independence, reminiscent of the loss of autonomy experienced during the Holocaust. This can trigger negative psychological impacts. Admission procedures, uniforms, medical personnel and procedures, showers, regimented schedules and routines, loud sounds and voices,

restrictions on movement, the lack of privacy, and even waiting in line for food can all trigger memories associated with the Holocaust (Daroff, 2014; Samuels, 2014; Sherman, 2014). For these reasons, enabling and empowering survivors to live safely in their own homes and communities for as long as possible is a fundamental goal of Holocaust survivor programs.

As one can see, the trauma experienced by Holocaust survivors has long-term impacts on their service needs that require specific attention in order to be adequately addressed. Thus, using the existing research and the information we received from participants in our expert calls and surveys, we have created a list of some of the unique needs of Holocaust survivors and recommendations for service providers on how best to address these needs. We have broken down these needs and recommendations into the following areas: mental health, physical health, nutrition, transportation, caregiving (paid), caregiving (family), other supportive services, and outreach and identification.

Mental Health

Unique Needs

Holocaust survivors can experience a host of mental health issues, which may or may not present until later in life. Researchers have found that survivors tend to report less satisfaction with their lives and perceive their life events as more stressful compared to a matched group of adults (Barak). In Israel, researchers state that half of survivors feel depressed and dissatisfied with life and have a sense of emptiness, and 40% feel very lonely, despite the presence of supportive social networks (Brodsky et al.). Survivors also have a high incidence of post-traumatic stress disorder (PTSD) and dissociative symptoms than non-survivors (Barak; Samuels). Anxiety and sleep disorders such as night terrors have been directly attributable to their experiences during the Holocaust (Kover, 2014). Survivors can also experience separation issues, an obsession with death, and excessive guilt. Additionally, as survivors lose spouses and the few friends and loved ones they have, they can quickly become isolated and lonely (Kover, 2014). The absence of social support can also contribute to a survivor's psychological well-being (Barak, 2013).

Respondents to our survey recounted that the survivors they serve are most likely to experience anxiety, depression, or PTSD. Survivors are not likely to seek out mental health services, either because of distrust of medical professional or because of fears related to stigma or institutionalization, all of which can make them hesitant to even accept help if offered (Kover, 2014). This was most frequently reported in our research by providers serving large populations of survivors from the FSU.

The risk of dementia may be even greater for Holocaust survivors than for the general population (Samuels, 2014). Dementia increases the need for medical care, adequate housing, advance planning, and protection from abuse and neglect (Samuels, 2014) and can keep survivors from accessing Holocaust reparations if their loss of mental capacity prevents them from describing their persecution with enough specificity to sustain a claim (Samuels, 2014). Survivors with dementia may experience frequent nightmares and flashbacks to the horrors they suffered during the Holocaust (Samuels, 2014). Many service providers reported dementia or short-term memory loss can cause survivors to re-experience old, painful memories, anxiety, and fear.

Recommendations for Service Providers

While the mental health needs of Holocaust survivors are complex, mental health professionals can therapeutically help survivors by understanding a number of established best practices. First, therapists and other mental health providers serving this population must receive training on the PCTI approach,

as well as on the Holocaust, Judaism, aging issues, and common triggers for survivors. Some providers also report that survivors tend to prefer individual therapy that is, when possible, provided in survivors' homes. Home based therapy helps to reduce possible triggers that may make a survivor more anxious or fearful.

Mental health professionals should also anticipate that it may take longer than usual to develop trust and openness with a survivor. Participants in our survey and phone calls report that speaking the same language as the survivor (most often Russian, but also German, Polish, Yiddish, or other Eastern European languages) frequently enables mental health professionals to build rapport faster. Furthermore, as survivors are often hesitant to express weakness, including mental health issues like depression or anxiety, providers should continue to monitor the mental health status of survivors, even if the survivor does not report any mental health issues.

Some survivors, especially those from the FSU, may never feel comfortable with traditional mental health services. These survivors may benefit from socialization programs that have therapeutic components. Even for survivors participating in traditional mental health services, socialization services are critical to maintaining supportive relationships and preventing the negative emotional and psychological health consequences associated with social isolation. These programs can include gatherings where survivors can meet in a safe environment and volunteer programs. If a survivor is unable to attend socialization programs, friendly visitors and companionship programs provided in the survivor's home can help reduce isolation.

Physical Health

Unique Needs

In addition to mental health complications, prolonged periods of deprivation, starvation, confinement, abuse, and other atrocities experienced during the Holocaust have placed an enormous burden on the physical health of survivors. Chronic health issues including heart conditions, foot problems, osteoporosis, insomnia, headaches, gastrointestinal issues, hearing loss, and painful dental problems are common. Many struggle to perform activities of daily living (ADLs) such as bathing and eating (Kover, 2014; Samuels, 2014; Van Pelt, 2013). Among respondents to the 2011 *Jewish Community Study of New York*, 73% of survivors described their health as poor or fair (SelfHelp). By 2020, it is estimated that 52% of all survivors may need disability-related assistance due to normal declines of aging combined with health problems associated with living under the Nazi regime (Miller, Beck, and Torr, 2009).

As described previously in this guide's *Background* section, a number of German doctors conducted "painful and often deadly experiments" on thousands of concentration camp prisoners without their consent (USHMM). Because of involvement with or knowledge of these experiments, providers participating in our research report that some survivors have a general distrust of most medical professionals. Furthermore, while all individuals who are unable to express consent or ask questions can experience anxiety and fear when undergoing medical procedures, these situations can be particularly traumatizing when the individual is also a Holocaust survivor.

Recommendations for Service Providers

The unique physical needs of Holocaust survivors can be best tackled by medical providers who are trained in PCTI care, have some background on the Holocaust, and an understanding of common triggers for this population, and who work hand-in-hand with case workers and other mental health professionals treating survivors. As with mental health providers, doctors must realize that Holocaust

survivors may take longer than an average patient to trust their medical providers and to openly discuss physical health issues. If possible, stress can be reduced by providing homecare and identifying doctors who speak the same language as the survivor. Some participants in our research recommend that skilled nursing staff, together with case workers, can make home visits to the survivor and relay information to doctors and the survivor's health care team to reduce the need for office visits for survivors who find these visits particularly traumatizing.

When beginning to work with survivors, it is critical that medical professionals collect thorough medical histories of physical ailments from before, during, and after the war, while being cognizant that asking for this history can trigger traumatic memories. Additionally, service providers contributing to our research strongly recommend that medical professionals establish a survivor's preferences and comfort levels for medical treatment as early as possible and to try to adhere to these preferences, as this can provide the survivor with a sense of empowerment over the medical process.

For any medical procedure, medical professionals should fully explain the survivor's choices, as well as the details of the procedure. They should also provide ample time for the survivor to ask questions and express concerns. Furthermore, doctors must keep in mind that admission to the hospital can be very traumatizing for some survivors, and hospitalization should be avoided unless a survivor cannot receive adequate care at home or at an outpatient facility. If a survivor must be admitted to the hospital, service providers should look for ways to reduce stress from potential triggers and consider offering temporary services such as a companionship service.

Nutrition

Unique Needs

Food holds a special significance for Holocaust survivors, who often faced hunger and starvation throughout the Holocaust. Whereas food security is important for all older adults, survivors have a complex emotional and psychological relationship with food. Participants in our research report that behaviors like hoarding or hiding of food in pockets or purses are common and are more frequently observed in survivors than in comparison to other older adults. They also note that survivors may experience panic when they begin to feel their low blood sugar or hunger pains. Some caregivers to survivors recount that survivors may ingest old or spoiled food as disposing of food can be triggering.

Food plays an important role within Judaism, both in terms of its preparation and its symbolism associated with Jewish holidays. Kashrut (may also be referred to as kosher practice) is the body of Jewish law addressing what foods traditional Jews can and cannot eat and how those foods must be prepared. Kashrut applies all year round. Many survivors keep kosher, meaning that they need both prepared foods and groceries to be kosher certified, which can often be expensive or difficult to find for nutrition service providers. Additionally, Jewish holidays can be particularly emotional for Holocaust survivors, who often have painful memories and few remaining family members. Subsequently, survivors may need or have a perceived need for more or specific foods during the Jewish holidays.

Unfortunately, the very process of procuring food can trigger survivors, reminding them of the painful experiences they underwent when deprived of food in ghettos, concentration camps, or the wilderness. As discussed throughout this guide, displays of weakness are often very difficult for survivors. Therefore, waiting in line to receive food, either in a cafeteria or food pantry, and signing up and receiving services like home delivered meals or SNAP benefits can be retraumatizing for survivors.

Recommendations for Service Providers

Service providers should take a thoughtful, person-centered approach to satisfy the nutrition needs of survivors. Volunteers and others involved in food delivery should receive training on PCTI care, common triggers, especially those related to food and the Jewish holidays, the Holocaust, and general Kashrut practices. Those working with individual survivors should establish whether each survivor keeps kosher and what considerations need to be made if they experience dental or gastrointestinal problems. Providers who deliver meals should also discuss whether the survivor prefers their food to be delivered prepared or in grocery form. Participants in our research reported that some survivors find preparing their own food to be more dignified and acceptable.

Furthermore, volunteers and others providing nutrition services should be aware of the reasons behind common survivor practices such as hoarding and hiding food and make efforts to allow this behavior to continue in a safe way if possible. Many respondents to our surveys mentioned that survivors are easily triggered if they are forced to stand in line for congregate meals or food pantries. Survivors also become easily embarrassed by having to express a need for food. To ameliorate this, providers recommend augmenting nutrition programs for survivors (e.g. providing an alternative schedule for survivors to come earlier than others for a food pantry). Other respondents strongly suggest that those cleaning up meals, in both congregate and home nutrition services, should never take a survivor's meal away before they have expressly stated they are finished and to not throw away food in front of a survivor. Additionally, at congregate meal settings, to-go containers should be widely available so that survivors can take home leftover food.

Individuals delivering meals should also receive sensitivity and confidentiality training, as many survivors may feel uncomfortable with others knowing they are in need of nutrition services. In this vein, participants in our research recommend that food should never be left outside of a survivor's door. Drivers and other staff should be cognizant that survivors may have feelings of abandonment associated with lateness and should try to keep a consistent schedule and to call if they will be late. While it is not always possible, some service providers report that drivers and volunteers delivering food can help lessen anxiety and isolation by staying with the survivor for a short amount of time after delivery if the survivor invites the provider into their home. Nutrition service providers should have frequent communication with case managers to report any behavioral or health changes.

Finally, because of the limited availability of affordable kosher options in both congregate and home delivered meals, providers may have to find alternative nutrition supports to enhance nutrition services for survivors. Providers could consider options such as food pantries, pre-paid grocery cards, or assistance with signing up for SNAP.

Transportation

Unique Needs

Like other older adults, Holocaust survivors rely on dependable, accessible, and safe transportation options to get to medical appointments, run errands, and enjoy socialization activities. However, for survivors, many modes of transportation present numerous triggers, which can cause survivors to relive traumatic memories of being transported to ghettos and concentration camps.

In response to our survey, providers report that many survivors experience anxiety or panic attacks when using public transportation. This reaction was also reported for some survivors who tried to use private transportation options like large buses or vans. Drivers of these forms of transportation may also

contribute to retraumatization, particularly if they are unaware of triggering word choices, such as asking survivors to line up, or if the driver does not speak the same language as the survivor.

Furthermore, while socialization programs are important for all older adults to avoid isolation and the various mental health complications that can stem from it, socialization is especially crucial for the well-being of survivors. Participants in our survey and calls remark that survivors' PTSD symptoms are often exacerbated by isolation, underlining the importance of reliable transportation options.

Recommendations for Service Providers

For survivors who depend on transportation services, a PCTI approach can help limit the number of possible triggers. For survivors who may be particularly proud of their independence and may be hesitant to ask for transportation assistance, a specially trained social worker can assist the survivor by telling them about the transportation program and explaining that the service and the driver are safe and reliable. Drivers can be trained to be sensitive to the needs of survivors and to know how to react if a survivor speaks about the Holocaust (Sherman, 2014). This training should also include information about common triggers, both verbal and physical, for survivors and methods to avoid them.

While respondents to our survey and calls mentioned that many survivors prefer private car service over larger institutional vehicles, some may prefer to travel in small groups. Therefore, establishing a survivor's transportation preferences early on can help prevent retraumatization. As outlined in the *Nutrition* section above, lateness can provoke feelings of anxiety and abandonment, so transportation providers who are serving survivors should attempt to maintain their schedule and contact survivors if they will be late. Moreover, many participants in our research report that survivors were often most comforted by a driver or volunteer in the vehicle who spoke the same language as them.

Caregiving (Paid)

Unique Needs

Paid caregivers provide invaluable services that allow many Holocaust survivors to age-in-place. However, because of the unique needs of survivors, it is paramount that these caregivers have adequate training to prevent the retraumatization of survivors that can easily occur without education.

In addition to the characteristics outlined above, many survivors exhibit some common characteristics that caregivers must understand. First, survivors may be distrustful of new caregivers, especially if the caregiver does not speak the same language as the survivor. If this trust is not established between the caregiver and the survivor, assistance with ADLs can lead to retraumatization. Additionally, because of the enormous amount of loss they have experienced, survivors are particularly vulnerable to feelings of abandonment if caregivers are tardy, inconsistent, or have high rates of turnover.

Resiliency and strength were key to survival during the Holocaust, leaving many survivors highly independent. Therefore, the need for a caregiver because of age, illness, or weakness can be demoralizing for many survivors, who are often uncomfortable receiving any type of assistance.

Recommendations for Service Providers

Paid caregivers are likely to spend a significant amount of time with survivors and can play a vital role in survivors' ongoing physical and mental health. Therefore, training on PCTI, the Holocaust, Judaism, and common triggers and behaviors of survivors is critical. Respondents to our survey also state that training on kosher practices can be helpful.

Participants in our research stress that providers should implement a process for careful selection of caregivers for Holocaust survivors. Many state that caregivers who speak the same language as the survivor are able to build a relationship with the survivor faster than those who do not, and they should be able to not take hurtful or distrustful actions personally. Finally, some providers mentioned experiences with caregivers who did not believe the Holocaust occurred, stating that they recommend a screening process for caregivers before they are placed with survivors.

As with all providers serving survivors, paid caregivers must use a person-centered approach to build trust with a survivor. One step caregivers can take early on is to establish the survivor's preferences, especially in relation to ADLs and other forms of care that require physical touch. Additionally, paid caregivers should be cognizant of how tardiness, as well as turnover, may cause anxiety and fear for a survivor and make plans on how to communicate if they will be late. Paid caregivers can also help limit the number of trips a survivor must take for medical visits by staying in communication with medical professionals and case managers.

Some participants in our research note that paid caregivers can develop secondary traumatic stress as a result of their work with survivors. Because of this, we believe that paid caregivers should be offered optional mental health services.

Caregiving (Family)

Unique Needs

Though most survivors have small extended families due to the Holocaust, the relationship between survivors and these family members can be complex, particularly when family members serve as caregivers. Participants in our research report that family caregivers who are aware of a survivor's experience during the Holocaust may experience secondary traumatic stress themselves. Family caregivers can be overprotective of the survivor and want to prevent any perceived or real discomfort. Others may feel that they are "not doing enough" no matter what they do. Some providers find that family caregivers avoid or refuse to have conversations related to advanced directives or end of life planning.

Additionally, a family caregiver can be overwhelmed by the unique needs of the survivor, like mental health issues, for which they may not be adequately prepared or trained. Some families may also have limited or perceived limited options because of language barriers that would prevent paid caregiving. Other providers participating in our research recount instances of survivors who were so distrustful of outside help that family caregivers felt they had no other options but to provide full time care themselves.

Because of the extent of trauma experienced by survivors, it is possible that survivors may not share all or even any of their experiences during the Holocaust with their family members. Consequently, family caregivers may be learning of a survivor's experience during the Holocaust for the first time. Others may never learn all of the details of a survivor's experience.

Recommendations for Service Providers

All family caregivers caring for older adults can benefit from family caregiver support services. However, because of the unique stresses placed on them, family caregivers of Holocaust survivors are much more likely to need family caregiver support services in order to promote comfort, skills, and confidence with

caregiving and to prevent the declines in caregiver health that have been associated with the eventual institutionalization of older adult care recipients (Daroff, 2014; Frumer, 2014; Kover, 2014; Sherman, 2014; Talley, 2007). These types of services should include both individual and group mental health counseling, training, and respite care.

Furthermore, case managers should identify family caregivers' awareness of survivors' Holocaust experiences. If caregivers are completely or partially unaware of a survivor's experience, providers recommend that agencies offer educational trainings or materials on the Holocaust and on common survivor behaviors and triggers. Caregivers should keep in mind that they may never learn the full extent of a survivor's experience and exercise sensitivity accordingly.

Other Supportive Services

Unique Needs

The majority of participants in our research report that Holocaust survivors require a host of other supportive services in addition to those outlined above, including case management, homemaker services, legal services, personal care, and chore services. Case management is especially important to responding to the many needs of survivors and coordinating care with various providers.

Legal services are also a unique need for Holocaust survivors as they can be intimidated by application processes associated with reparations, benefits, and services due to their fear of government agencies and authority figures. The need to fill out paperwork may be equated with the Holocaust-era fear of "not having one's papers in order." Moreover, survivors are often resistant to revealing their assets and savings. Applications for programs that require detailed explanations of one's Holocaust history can be particularly traumatizing for some survivors.

Recommendations for Service Providers

As with other services outlined in this guide, all supportive services should be provided in a PCTI approach. It is especially important that case management services be person-centered and tailored to each survivor's specific needs. Furthermore, having to tell and re-tell the story of an original trauma to different staff members in different settings can itself be traumatic, so trauma-informed agencies must keep accurate records of all trauma histories and screenings so that the survivor is not required to unnecessarily re-tell their trauma stories (Butler et al., 2011). For Holocaust survivors, who may not wish to revisit or disclose details about their past experiences, it is imperative that providers explain how personal information will be used and how it relates to the all of the services they will receive.

A number of participants in our research report that legal services are invaluable to survivors, many of whom may struggle to receive Holocaust-era reparations or sign up for government benefits. Those providing legal services should work hand-in-hand with case managers to understand various triggers and identify ways to advocate for the survivor's benefits in the least traumatic way possible (e.g. a social worker may go with a survivor to a government office to help with the benefit application process).

Outreach and Identification

Unique Needs

Throughout this guide, we have provided many examples of how agencies must accommodate survivors' discomfort with displaying weakness or asking for help. This behavior also means that survivors may be unlikely to seek out services in the first place, requiring agencies to undertake strategic outreach to

educate survivors on the various services available to them. Moreover, many survivors are suspicious of strangers and authority figures, which mean that while they may pursue services, they may not disclose their survivor status.

Recommendations for Service Providers

For agencies attempting to access the needs of and reach out to Holocaust survivors in their region, we would suggest that they work collaboratively with local Jewish organizations such as Jewish Family Service Agencies, synagogues, Chabad houses, Jewish Community Centers, Jewish Federations, and the Claims Conference. This collaboration could include creating referral mechanisms if an agency suspects they work with a survivor, creating promotional materials, and hosting joint events and trainings. It is also recommended that providers come to events with large amounts of promotional materials as providers in our research state that survivors frequently learn of their services through word of mouth from other survivors in their community.

Moreover, specific steps must be undertaken to reach FSU survivors. Participants in our survey recommend that, if possible, outreach and materials be prepared in Russian so that they are accessible to these survivors. Agencies should consider posting these materials in Russian speaking communities in places like restaurants, grocery stores, or doctors' offices. Providers may also consider putting advertisements in Russian newspapers.

As explained above, it may be difficult to discern if an older adult is a Holocaust survivor if they are unwilling to identify as one. First and foremost, a case worker should remember to provide ample time for a suspected survivor to ask questions and express concerns, and the case worker should continually reassure the individual of the confidentiality of communications and personal information. Moreover, a case worker may be able to gain a better idea of whether an individual is a survivor by gaining the individual's date of birth; country of origin; what year they immigrated to the U.S.; and potentially where they were during World War II. Furthermore, case workers should recognize that Holocaust survivors may not identify as Jewish, potentially because of trust issues related to anti-Semitism or because of conversion to other religions following the Holocaust. Those conducting intake are not encouraged to ask a survivor if they are Jewish as the question itself can be a trigger.

Conclusion and Topline Takeaways

In summary, agencies providing services to Holocaust survivors must have a thorough understanding of Holocaust survivors' unique experiences and needs and take a PCTI approach, which can be used for all traumatized populations, in all services to survivors in order to reduce triggers and prevent retraumatization.

To review, it is imperative that all agency affiliated individuals, staff and volunteers, interacting with Holocaust survivors have a base understanding of the following:

1. The Holocaust and Experience of Survivors
2. Trauma, Common Triggers for Survivors, and PCTI
3. Unique Mental Health Issues for Survivors
4. Unique Physical Health Issues for Survivors
5. Impact of Survivor and Survivor's Experience on Paid and Family Caregivers

Again, this manual is not a training guide and is meant to provide a brief overview. We highly encourage service providers that are interested in learning more to review the resources discussed in this guide and to partner with their local Jewish Family Service Agencies. The JFNA Center for Advancing Holocaust Survivor Care is also available to serve as a resource and can be reached at HolocaustCenter@jewishfederations.org.

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