



## special articles

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### Grand rounds: 'I'll knock elsewhere' – the impact of past trauma in later life<sup>†</sup>

"And when life has no more meaning in old age, the will to meaning is lost; when life no longer seems to be worth living, some people who have experienced disasters and are unable to cope, may throw their lives away." (Wilson *et al*, 1988)

There continues to be a great deal of interest among psychiatrists, psychologists and sociologists about post traumatic stress disorder (PTSD) related to war crimes and experiences. Twentieth century studies of Holocaust victims and Far East prisoners of war, Korean and Vietnam veterans and the recent experiences of people in Bosnia have honed the diagnosis and increased awareness of the gradations of these disorders. Almost every conceivable variable has been examined in attempts to explore the motivating and resulting behaviours. Initially most studies dealt with the immediate impact of the event, but more recently articles have focused on the longer-term effects on relatives and the next generations of the earlier events (Sigal, 1998). Time has allowed this. The passage of time has also established that post-traumatic stress symptoms can be reactivated as much as half a century after the original trauma (Krasucki *et al*, 1995). Reactivation of events from 40 or 50 years previously may occur via current stressors such as social isolation and upheaval. Equally perceived helplessness precipitated by the somatic process of ageing could reactivate previous feelings and a delayed onset or exacerbation of clinical PTSD may emerge during the process of ageing. Institutionalisation itself could re-awaken feelings associated with incarceration or victimisation (Aarts & Op den Velde, 1996; Sadavoy, 1997). Late-life PTSD is more often associated with sleep disturbance, nightmares, intrusive ideation and avoidance of reminders of the original events (Kuch & Cox, 1992).

This case highlights many important issues confronting clinicians working with elderly patients. The current cohort of the older population has significant war experiences. It introduces too the controversial ethical issue of the right of elderly patients to choose death as a solution of dealing with 'unfinished business'. To remember is too painful, while to forget denigrates the importance of the events. This debate continues with terminally physically ill patients at a high intensity.

#### Case history

Mrs E. L. is an 83-year-old widow. She came to the attention of the psychogeriatric services in July 1999 after a referral from her general practitioner (GP) for auditory hallucinations that disappeared when her urinary tract infection was treated. At the time of the domiciliary assessment, it became apparent there was suicidal intent that needed prompt attention and she was referred to the day hospital.

In her family and personal history, her earliest memories were of the poverty prevalent in Germany at the time. Her father was fighting on the Russian front and she clearly remembers visiting relatives with her mother to get food and being among crowds of children chasing lorries in the hope food might fall off the back. The home situation improved after her father's return from war because he worked as an accountant. Her elder brother suffered from cerebral palsy, with marked impairment of gait and speech. There is no other family medical or psychiatric history of note.

When Hitler came to power in 1933 her parents recognised the potential threat and Mrs E. L. and her sister were sent to Switzerland. No country was prepared to accept a disabled person and her parents had no option but to stay in Germany with her brother. In 1941 she came to England and started working as a translator. Her parents and brother were at some point killed in a concentration camp, which she found out through the media. She was not formally notified. This lack of information remains an intrusive memory. Her dream content has centred around images of this trauma.

An assignment for her husband, a war crime investigator, took them to Dachau, West Germany, where she reported feelings of panic, fear and anger at the scale of the operation. It confirmed her atheism; if there is a God he must be an extreme and cruel figure. It cemented the couple's belief that this is no world in which they wished to raise a family. They continued to enjoy their life well into retirement when her husband was diagnosed with Parkinson's disease. Over the following 10 years the illness progressed, he became bed-bound and barely able to communicate. Mrs E. L. nursed him at home until his

<sup>†</sup>See p. 437 and p. 438, this issue.

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last 3 months, when he was cared for in hospital. He died in 1979.

In 1981 Mrs E. L. joined EXIT, a euthanasia society. At the same time she signed a living will, witnessed by her bank manager. By her account she had adequately grieved the loss of her husband. No corollary of this is available.

At the time of her initial assessment by a community psychiatric nurse, her presenting complaints focused on her thoughts of old age as a curse and she dreaded the prospect of dependency and frailty, which would isolate her from her large circle of friends drawn from all ages and backgrounds. She felt that she had lived a long and fulfilling life and could see no point in continuing. There were frequent references to her wartime experiences and the impact it had on her life. She avoided any programmes on television of the Holocaust, yet admitted to its intrusive ideation. In her presenting mental state there was evidence of a low mood associated with sleep disturbance and recurrent nightmares of her war experiences. There was clear suicidal intent. There were no phenomena of psychoses elicitable and her cognitive functions were fully intact. This continued to be her presentation throughout her time at the day hospital, which caused a great deal of concern within the multi-disciplinary team because some members were ambivalent to treating her as being mentally ill, yet all felt a suicide attempt was probably inevitable and there were conflicting views of her right to make this decision. The preferred diagnosis was of late onset PTSD.

For several months she was treated with anti-depressants and individual psychotherapeutic sessions. An important therapeutic intervention was her understanding of the significance of her unpublished memoirs *I'll Knock Elsewhere* as her need to produce a narrative as part of the healing process. The title was aptly chosen from Shakespeare's *Comedy of Errors*, act III, scene I, "I'll knock elsewhere – to see if they disdain me", which held poignancy in view of the rejection of her brother.

Unfortunately, she subsequently took a life-threatening overdose and was found with the living will placed beside her. She was admitted as an in-patient to the psychiatric unit for older people.

## Discussion

There is no doubt this patient had a mental illness in accordance with the definitions in ICD-10 (World Health Organization, 1992) and DSM-IV (American Psychiatric Association, 1994) of PTSD. Late onset PTSD is now well recognised and conceptualising her as such was of some benefit to most members of the multi-disciplinary team.

Did it benefit her? Her capacity to make an informed choice was not impaired owing to a mental illness and her cognitive functions were fully intact. Her wish to choose death as a resolution was seen by her as her right and based on her unique life experiences. Condoning this choice still presents an ethical, medical and legal conundrum. Should we assume that everyone who expresses a wish to die is mentally ill? Does a trial of treatment adequately differentiate 'irrational/mentally ill' suicide from so-called 'rational' suicide? Is the role of the psychiatrist to prevent death at all costs, or is there a point at which psychiatry can stop trying? There is controversy over when living wills should be respected, especially when there is a question as to the mental state exerting an influence on the decision-making process. A recent editorial in the *BMJ* (Smith, 2000) deals with the principles the health service should aim for to ensure a patient can die with dignity. Especially when a patient no longer feels, as with this patient, that he or she has what he or she perceives as 'quality of life'.

The management outcome was a nursing home placement with this patient's reluctant agreement as she became aware of her increasing dependency on 24 hour care and a grudging acknowledgement of having to continue with her natural life span. Her parting angry comment to the multi-disciplinary team was of us acting like Nazis in exerting control over who should live and die. Have we inadvertently behaved so in the management of this patient?

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