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Commentary: the impact of past trauma in later life†

The author sees her suicidal ideas and overdose as resting squarely on traumatic experience unresolved for 50 years, an immutable pathogenic secret ('traumatic' memory) only now surfacing as 'late onset post-traumatic stress disorder' (PTSD) (see Ong & Carter, pp. 435–436, this issue). I suggest this risks an overly pathologising approach to her predicament, and discounts the biological, social and existential forces that all shape life over time; not least for those near the end of their natural span.

Consider some of the potential variables. First, a serious or life-threatening illness commonly throws up a crisis around personal values and the meaning of life in the patient. This may revitalise memories of war or other emotive events from the past. For example, I encountered an ex-serviceman survivor of the Japanese death camps of World War Two, who began to talk obsessively of these experiences – which his wife had never heard about before – in the aftermath of a near fatal cerebrovascular accident.

So too in the psychiatric domain. A person with depression has depressed thoughts: shocking or sad memories of personal significance might quite understandably assume renewed prominence at such a time. It does not follow that these past events are directly causative, as the PTSD model asserts. Indeed, no mental state phenomenology has causation inscribed on it, a fundamental point. In the present case it is obviously important to decide whether her low mood, sleep disturbance, etc. amounted to a potentially treatable depressive illness. The author does not seem to think so.

Second, situational stressors – bereavement, economic hardship, loneliness as friends die off – may act as cues for recollections of the past: there is nothing pathological in this. More specific cues may also arise out of public events, as with commemoration ceremonies marking anniversaries of the end of World War Two and the Holocaust, accompanied by replaying of old film footage and interviews with survivors. Indeed, the Holocaust continues to play an active part in European consciousness, through direct reminders but also indirectly when political issues like racism, refugee policies, medical ethics and Israel's treatment of Palestinians are discussed. The more public debate and exposure, the more such survivors will remember by day and in sleep. Many of these survivors might describe their memories as painful, and some – like this woman – prefer not to talk about them or to follow media coverage of the subject. Again, these are not the 're-experiencing' or 'avoidance' of PTSD and are generally variations of normality. Such memories may retain their capacity to distress for a lifetime – and as moral signifiers perhaps they should: they attest to the human values that transcend the man-made demolition of worlds.

†See pp. 435–436 and p. 437, this issue.

Third, the aging process puts pressure on physiological and psychological resources, and thus on the adjustments and philosophies that have long characterised a person. This is a time of diminishing roles and duties; the past may be more vivid than the present and an old person looks back as a preparation for death. Past extreme experiences, and the existential questions that these invoked, may loom larger than for many years. In this case, not knowing what exactly had happened to her parents or brother, and realising that neither she nor anybody else would ever know, might naturally loom large in thoughts and dreams as she neared the end of her life.

Elsewhere I have discussed at length how PTSD arose as much from socio-political ideas as from medical ones, and why its claims to supposedly distinct disease status are problematic on both conceptual and clinical grounds (Summerfield, 2001). Late onset PTSD seems a pseudocondition, I am afraid, and indeed overrides the fact that the patient did not attribute her mental state to the Holocaust. PTSD is but a recent facet of the medicalisation of life (including, as here, past life), a cultural trend that has gathered pace in this century. Not just undoubtedly extreme events, but also more common ones are now held capable of causing lifelong psychological effects. It is likely that the author carried assumptions of this kind – which in general are social values, not medicopsychological facts – into this assessment, perhaps influenced by the narrow determinism of much of the Holocaust trauma literature (Summerfield, 1996).

Attaching a psychiatric diagnosis to this woman implies that she is not of sound mind, yet the dilemma for the authors is that on clinical grounds she did not seem like this. Moreover, she certainly seems to have maintained a coherent philosophical position: she said she has had a long and fulfilling life, she feared dependency and decrepitude, she was an atheist, a long-standing member of EXIT and had written a living will. Her anger at being handled as a psychiatric case seems understandable and on the evidence presented, well founded. This case demonstrates the limitations of a static, pathology-bound biopsychomedical paradigm in capturing the complexity and ambiguity of human experience.

References

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