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**TRAUMATIC MEMORIES REKINDLED BY LIFE STAGES**

**Key points**

* Trauma work should focus on the personal meaning and consequence of an individual’s life experiences, derived from psychological formulation;
* Difficulties in later life can be caused by an accumulation of experiences of the same theme, therefore, seemingly commonplace experiences that accompany ageing can contribute to extreme responses;
* Older life poses many opportunities for the rekindling of earlier difficulties;
* Relationships, and thoughtful interactions, that do not unwittingly re-enact old traumas give the potential for change.

**Trauma work**

Complex post-traumatic stress disorder (CPTSD) has been recognised by clinicians for many years (UK Psychological Trauma Society, UKPTS, 2017) but has only recently become a formal diagnosis (World Health Organization, 2018). Consequently, it has been difficult to publish literature and share frameworks of understanding or guidance for intervention with complex trauma presentations.

We often already have the tools for understanding and working therapeutically with individuals who have experienced trauma. As clinicians, we adopt a research-practitioner stance, and we form a conceptualisation of the difficulties that allows us to work therapeutically in our daily practice. We learn by listening to the experiences of the people we are working with; perhaps we learn even more by listening to the experiences of older people. Clinical Psychologists often have little difficulty with this assertion, having straddled the dual realities of diagnosis and formulation for decades; key tenets include the primacy of personal meaning and of people finding ways of coping or surviving that offer some reprieve from their pain (Johnstone & Boyle, 2018). We discuss why this is of particular interest to those working with older people below.

In line with the latest available guidelines for working with complex trauma (UKPTS, 2017), we view best practice as an approach of using formulation to understand and then address the concomitants of trauma, with importance placed on painful resonances throughout a person’s life. These are undercurrents of vulnerability that begin to accumulate. In our clinical work with older people, it is themes of traumatic experiences that have repeated throughout a person’s life that we observe to underlie emotional distress in later years. It seems that experiences from earlier times have been somewhat managed, the person has been able to move forward in time, but some experiences haven’t been resolved. Traumas across the lifespan then take their toll on a person’s holistic wellbeing (Krause, Shaw & Cairney, 2004). This means that we need to draw upon a range of therapeutic frameworks to understand the meaning of repeated and prolonged difficulties with emotions and relationships, within the context of a person’s life.

CPTSD comprises the symptoms of post-traumatic stress disorder (PTSD) plus a range of pervasive ‘disturbances in self-organisation’ that describe impairments in regulating emotional experience, in sustaining relationships, and in the sense of self (World Health Organization, 2018). The latter may include beliefs about oneself as being diminished, defeated or worthless (Maercker et al., 2013). Experiences that overlap with these vulnerabilities in self-organisation are common when people happen to become older. These themes in the impaired sense of self will likely be familiar to those working with older adults receiving support from mental health services.

The older people we work with are hugely adaptable and find ways to circumnavigate their memories and extreme negative emotion, and to not allow the same painful circumstances to happen again. They become skilled in avoiding the situations or relational interactions that might cause upset (Hepple & Sutton, 2004; Thorp, Sones & Cook, 2011). For example, they learn not to depend upon other people, they learn to insist upon their worth, which might be by becoming truculent. And life happens, ageing happens, and experiences of an uncannily similar and familiar theme may repeat.

**A brief case vignette**

*A lady sits within a communal area, noticing the coming and going of our caregivers (staff members, family members of other patients, workmen …), without interacting with them and without engaging in any activity to bring fulfilment. She is an intelligent and respected lady- or she once was. She values smart appearance, she worked hard in multiple career and family roles. And for some of the time now, she sits in this painful position of observing what she feel she doesn’t have – as well as sitting in a physically painful hunched over position, sometimes unclean, and sore. She has no interest in calling or looking at the photographs of her family who exist but who are not consistently available. She doesn’t display or reply to their cards or gifts. She often pushes away the staff members, swipes them away. We observe that she maintains her experience of feeling overlooked and forgotten about. We could imagine us withdrawing, saying ‘OK, fine, I’ll leave you’. Unintentionally, we have repeated an unhelpful pattern. Why can she not allow herself the moments of feeling cared for by others? Feeling hurt appears to become the meaning in her life, a grim re-experiencing of early traumatic experiences.*

**Rekindling**

In our experience, occasions of feeling completely disregarded and of ‘not mattering’ can be common and repeated for older people in Western cultures (Yalom, 1980). In addition, there is increased potential to experience loss, to face illness, for the body to fail, to feel lonely and without belonging, and to be dependent (Hepple & Sutton, 2004; Thorp et al. 2011; Ogle, Rubin & Siegler, 2014; Hannaford, Moore & Macleod, 2017). Dementia may be an additional and noteworthy concern; dementia can cause some individuals to feel strange, stranded, unsafe, powerless, without belonging, without being noticed, without a sense of self (Kitwood, 1997; Miesen, 2004; Davenhill, 2007; Petty et al. 2018a), whilst experiencing strong emotions without the necessary abilities to make sense of their emotions (Evans, 2008). These are conditions under which vulnerabilities for feeling unable to cope – which is of the highest importance in when understanding trauma – can reawaken. It is possible to develop CPTSD-related problems through repeated traumatic experiences in later life (Krause et al. 2004). In our experience, this is life’s rekindling of memories, raking the coals of a fire that seemed extinguished. Life shakes the grate and gives oxygen to the smouldering ember.

We approach therapeutic work by holding in mind the possibility that the person has experienced painful experiences that overwhelmed them in their earlier life, and they may not be fully aware of how hurt they felt and could feel again were circumstances to repeat. As an example, a child who learnt to sob to themselves without expecting a mother to provide comfort may now sob in (familiar) inconsolable distress when in a state of physical neglect, sore and unclean when they come to rely on other people to care for their daily care needs.

The potential to cover all relevant history at assessment could be equally overwhelming to the clinician. As a practical solution from practice, we have found that the “flags” to look for are repetitions. The resonance of the individual’s past difficulties will show themselves in the here and now; why is something seemingly not distressing from another’s perspective causing such an emotional response, such as being asked to complete a patient feedback form, interacting with a young and competent nurse, or feeling drowsy due to medication? Emotional vulnerabilities and their response patterns remain (Magai & Cohen, 1998; Davenhill, 2007), and they are likely being rekindled. This has been true for us when working with people presenting in seemingly bizarre and misunderstood ways.

Of course, this is not inevitable and does not happen for everybody. However, if we view a person’s present with an additional lens on their past, the seemingly bizarre can be easily understood for some, and differing levels of therapeutic intervention become apparent.

**Resolution and change**

Psychological formulation, drawing upon multiple theoretical models, is the approach to trauma work with older people at The Retreat. We place particular emphasis on the meaning of experiences to people, the impact on their sense of self and their place in the world (Petty et al. 2018a), and we are alert to what seemingly innocuous experiences might mean if they contribute to a particular repeated painful experience. Most often, we draw upon the structure provided by Cognitive Analytic Therapy (Ryle & Kerr, 2002; Hepple & Sutton, 2004) and the ideas of psychodynamic psychotherapy (Malan, 1995) and existentialism (Yalom, 1980). We aim to understand the meaning of compounding traumas over time, and their expression of emotional distress now (Davenhill, 2007; Ogle et al 2014). We find these approaches particularly helpful for working with older people and trauma presentations.

Of importance is the harm, and the potential for comfort and resolution, within relationships.

*and I was standing by the river and thinking now then, what do I do, do I go home, do I jump in the river or do I show my face in there and as it happened, someone was just walking by and he gave me a wave and I thought … go on then and I just went in and let it take over and I just cried and cried and cried for about three days, that’s all I did, and it was the biggest turning point in my life and they were very supportive and the, I really let them show myself, which I hadn’t done before, ever, and it was a real turning point* (Client reflection on trauma therapy at The Retreat)

Therapeutic environments, in which there are considered and respectful interactions between people informed by these therapy models, can provide an opportunity for painful memories and related avoidance to be revised. Primarily, relationships provide an environment where a traumatic experience is not repeated; which can take a surprising amount of understanding and work to achieve. Opportunities to make emotional contact, to understand, and to bear the upset (Waddell, 1998) are important. It is not necessary to avoid possible painful experiences, such as sitting in a wheelchair or waiting to be delivered lunch, but to understand these may cause upset and consider why. The work of the therapeutic interaction is to consciously resist the pull to re-enact the past (Malan, 1995; Ryle & Kerr, 2002; Hepple & Sutton, 2004); to not replay a side of the interaction that causes pain for the older person. Based on individual formulation, in the interaction we might notice and comment upon or apologise for their experience of feeling forgotten about or them tolerating waiting; we might sit with them; we might look to focus upon earlier experiences of being overlooked or needs not being met within therapy sessions.

*the abuse is just part of my life now, it is just part of my life now, it’s just something that happened and it feels that it has been worked through and it is not a big volcano ready to erupt any more and I never knew, never knew what the volcano ready to erupt was prior to The Retreat experience, but there was always something very big and firey there* (Client reflection on trauma therapy at The Retreat)

This is the importance of healing through relationships (Johnstone & Boyle, 2018) and consideration of the attachment system being influential ‘from the cradle to the grave’ (Bowlby 1969, p. 208).

**Conclusion**

Given the often limiting ways of understanding the emotional experiences of older people (Petty et al. 2018b), it is not surprising that the application of the latest understandings of trauma are also slower to reach older people. And yet, we might not need new frameworks of understanding, but rather the tools we already have that guide us to look to the person and their story. We suggest our general understanding of trauma might be enhanced by a greater appreciation of the long-term evolved consequences of earlier trauma for older people.

*The Retreat York provides psychological therapy for individuals and couples. The important recent context is the closure of the inpatient hospital services, which sadly included our specialist older people wards and therapeutic community. We have retained our tailored and thoughtful working with people of all ages within therapy, as is described here. Some services are commissioned by the NHS, some are funded by organisations or insurers and some are accessed privately.*

**References**

Bowlby, J. (1969). Attachment and loss: Vol. 1. Attachment. New York: Basic Books.

Davenhill, R. (2007). Looking into later life: a psychoanalytic approach to depression and dementia in old age. London: Karnac Books.

Evans, S. (2008). ‘Beyond forgetfulness’: How psychoanalytic ideas can help us to understand the experience of patients with dementia. Psychoanalytic Psychotherapy, 22(3), 155-176.

Hannaford, E., Moore, F., & Macleod, F. J. (2017). What a difference a year makes: comparing relationships between stressful life events, mood and life satisfaction among older adults, and their working-age counterparts. Aging & Mental Health, 1-8.

Hepple, J., & Sutton, L. (2004). Cognitive Analytic Therapy and Later Life: New Perspective on Old Age. Hove: Brunner-Routledge.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society.

Kitwood, T. (1997). The experience of dementia. Aging & Mental Health, 1(1), 13-22.

Krause, N., Shaw, B. A., & Cairney, J. (2004). A descriptive epidemiology of lifetime trauma and the physical health status of older adults. Psychology and Aging, 19(4), 637.

Maercker, A., Brewin, C. R., Bryant, R. A., Cloitre, M., van Ommeren, M., Jones, L. M., ... & Somasundaram, D. J. (2013). Diagnosis and classification of disorders specifically associated with stress: proposals for ICD‐11. World Psychiatry, 12(3), 198-206.

Magai, C., & Cohen, C. I. (1998). Attachment style and emotion regulation in dementia patients and their relation to caregiver burden. The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 53(3), P147-P154.

Malan, D. (1995). Individual psychotherapy and the science of psychodynamics. Florida: CRC Press.

Miesen, B. M. (2004). Towards a psychology of dementia care: awareness and intangible loss. In G. M. Jones & B. M. Miesen (Eds.) Care-giving in dementia: research and applications (Vol. 3) (p. 184). Hove: Psychology Press.

Ogle, C. M., Rubin, D. C., & Siegler, I. C. (2014). Cumulative exposure to traumatic events in older adults. Aging & Mental Health, 18(3), 316-325.

Petty, S., Harvey, K., Griffiths, A., Coleston, D. M., & Dening, T. (2018a). Emotional distress with dementia: a systematic review using corpus-based analysis and meta-ethnography. International Journal of Geriatric Psychiatry, 33(5), 679-687.

Petty, S., Dening, T., Coleston, D. M., & Griffiths, A. (2018b). Dementia: beyond disorders of mood. Aging & Mental Health, 1-4.

Ryle, A. & Kerr, I. B. (2002) Introducing Cognitive Analytic Therapy: Principles and Practice. Chichester: John Wiley & Sons.

Thorp, S, R., Sones, H. M., & Cook, J. M. (2011). Posttraumatic stress disorder among older adults. In: K. H. Sorocco and S. Lauderdale (Eds.) Cognitive Behavior Therapy With Older Adults: Innovations Across Care Settings (p. 189-217). New York: Springer.

UK Psychological Trauma Society (2017). UKPTS Guideline for the treatment and planning of services for complex post-traumatic stress disorder (cPTSD) in adults. Retrieved from http://www.ukpts.co.uk/guidance.html

Waddell, M. (1998). Inside Lives: Psychoanalysis and the Growth of the Personality. Duckworth: Tavistock Clinic Series.

World Health Organization. (2018). International classification of diseases for mortality and morbidity statistics (11th Revision). Retrieved from https://icd.who.int/browse11/l-m/en

Yalom, I. D. (1980). Existential psychotherapy. New York: Basic Books.