Posttraumatic Re-experiencing in Older People: Working through or Covering up?*

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This paper is about the therapeutic approach to older people who suffer from war trauma experienced at an earlier age. Special attention is paid to posttraumatic re-experiencing and its role in treatment. First, a few examples of posttraumatic re-experiencing are described. These examples will be used to briefly illustrate some interpretation models, before devoting particular attention to one of them: the psychodynamic interpretation model. Then principles of therapy are discussed.

INTRODUCTION

One of the major, often underestimated, consequences of war trauma, and many other kinds of trauma as well, is the forceful nocturnal re-experiencing long afterwards. The psychotraumatic events are relived again and again, and the frequency and intensity of this re-experiencing can increase in older age. In our daily practice, which concerns Dutch victims and veterans of World War II, we see that, even after more than forty years, intrusive re-experiencing, sometimes in a severe form, is still present or returns after years without symptoms. Examples were described by Lansky.[1] Manifestations are recurrent distressing dreams and intrusive frightening recollections, including images, thoughts or perceptions. In some cases, the original psychotraumatic event or part of it is relived in a dream. These instances of re-experiencing are often generally termed "nightmares." At any rate, re-experiencing is an intrusive phenomenon, one which produces anxiety in patients and those around them and which is more often than not misunderstood. For trauma victims, the easiest way to deal with the problem is to talk about it as little as possible. Sometimes the phenomenon is perceived as an indication of mental confusion.

There is much we can learn from the ways in which posttraumatic recollections and re-experiences manifest themselves. We can, for instance,

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gather information on the manner in which a person has processed his or her psychotraumatic experience. It can also provide us with a key to therapy.

GENERAL CONTEXT AND INDIVIDUAL PERCEPTION OF PSYCHOTRAUMATIC WAR EXPERIENCES

The general context in which traumatization occurs reveals similarities between various groups of individuals. The specific situation of the individual and the significance of the traumatic experiences in that person's life give the psychotrauma an individual character, reason to be cautious about making generalizations.

Not only is there a fundamental difference between the historic reality of, say, a German concentration camp and a Japanese internment camp; the experiences and perceptions of two survivors of exactly the same camp also have a strictly personal meaning. It is therefore advisable to draw a distinction between the general, often more concrete, characteristics of traumata, and their individual perception and significance. I will present a few general characteristics in order to illustrate what group of trauma victims I am talking about. The individual perception and meaning is relevant when we discuss a patient's treatment.

I consider the following aspects fundamental elements of war traumata: an abrupt disruption of one's existential continuity; a severe threat to one's physical and psychological integrity; a prolonged, extreme psychological and physical stress; the absence of the possibility to mourn a past loss, be it the loss of a significant other or of existential meaning; the individual's feelings of absolutely powerless to change the situation.

Two Examples of Posttraumatic Re-experiencing

Example 1

Ms. L., a fifty-five-year-old woman, has recurring nightmares about what she went through during the war. Sometimes her dreams are recreations of a situation from the war as it actually happened. Other times, real elements are intertwined with imaginary elements of a more symbolic nature. The following nightmare is an example of the latter case:

We are forced to stand in a long line. I am still a little girl. My mother and two brothers are standing next to me. We have lost our freedom—I can feel it. We are not free to do what we please. You have to get a ticket. Once we have got our ticket, we have to line up again. Suddenly I notice that we have been separated. I am separated from the others. I am standing in a different line and my mother and brothers are not there any more. I catch a glimpse of them in the distance, moving up in a different line. I am not allowed to go to

them. I am separated from the ones I love. We end up in different camps, they and I. An intense feeling of dread comes over me; I am afraid I will never see them again. I start crying and I wake up crying. I cannot find words to express the intensity of the fear.

This is a nightmare dreamt by Ms. L., who, with her mother, was sent to a Japanese internment camp when she was four years old. As far as Ms. L. can remember, she was never separated from her mother. But she was separated from her father, never to see him again. She lost a loved one. This nightmare has real elements—confinement and standing in line—mixed with symbolic ones—the loss of her father, which has been transformed into the loss of the persons she was with in her dream. It is very plausible that, in the dream, her mother has replaced her father. This could be because she has no lasting consistent image of her father in her memory, or because the father image has not yet been admitted to her dream-world.

Ms. L. says that often in her dreams she is in a situation as experienced in the war and comes close to death, always waking in the nick of time. Waking up saves her life, but the fear of dying remains a constant, almost unbearable, presence.

Example 2

Mr. N., sixty-one years old, says that he wakes from a nightmare a few nights a week. He does not exactly remember how long this has been going on, but knows that for the past year, at any rate, he has had the following experience two or three times a week:

He wakes up in the middle of the night shaking with fear. In his nightmare he re-experiences situations he had to face as a soldier in the former Dutch Indonesian colonies. Not only one, but four or five situations are re-created regularly in his dreams, one per night. These are exact re-enactments of actual experiences. In one scene, he is driving a jeep when he is caught in ambush fire. There are three passengers in the jeep. A soldier whom he has befriended, his mate, is sitting next to him. When the shooting starts, he leaps out of the jeep and crawls underneath it. He sees his mate and the other two passengers get hit and killed. There is nothing he can do and he stays down under the jeep. A night passes. The next day, a patrol squad finds him.

When he wakes up in the middle of the night, he is lying on the floor next to his bed, drenched in sweat and terrified. His heart is pounding. His wife is standing over him, speaking to him softly. After a while, he stands up, but is

still in a state of distress. He goes downstairs and his wife makes him a cup of warm milk. He gradually comes to his senses. His wife tries to get his mind off it by talking about something else. After about half an hour, they return to bed. He is scared to go back to sleep, but finally manages, after lying awake some time, he is not sure how long. In the morning, the alarm clock wakes him up. He is tired and unrested.

His wife describes it like this: In the middle of the night, my husband becomes extremely restless and starts kicking and sometimes thrashing his arms about. He usually gets tangled up in the sheets. He sits up, dives out of bed and lands on the floor next to the bed. By that time, I have tried to no avail to wake him up. Not until I have got out of bed and started talking to him does it dawn on him that it is me. He is petrified, sweating profusely and white as a sheet. I see mortal terror in his eyes. The first thing he says when he sees me is, 'Get down, you idiot!' After a minute, he gets up and goes downstairs. Only then can I get through to him. I try to calm him down. Once I have made him a cup of warm milk, I ask him what happened. He does not want to talk about it. I change the subject to take his mind off it. I am worried about his heart. I feel his pulse; his heart is beating wildly. After a while, it slows to a more regular pace. A half hour or so later, we go back to bed. In the morning, he does not always remember what happened the night before. He never wants to talk about it during the day either. It has been a frequent occurrence for the past few years. It used to only happen a few times a year. Some years it never happened at all. Once in a while, he gets out of bed and runs downstairs, yelling at me to find cover. One time he ended up in the cellar.

This example contains a few striking aspects. First of all, the memory is such a clear image with such a high-reality content that one gets the impression that the man is actually reliving the experience. His perception has a hallucinatory intensity, while his actual surroundings are distorted. His behavior seems to reflect his reaction to the situation as if he were experiencing it. He remains in this state for some time, even while his wife is trying to call him back to reality, which she eventually succeeds in doing.

The physical symptoms are also noteworthy. They are, on the one hand, a manifestation of fear: tachycardia, perspiration, high blood pressure, pupil dilation, reduced blood supply to the skin. On the other hand, there is hyperarousal, causing to be extremely alert within the bounds of the perceived situation, but to shut out impulses extraneous to the threatening situation. In this case, it is the actual situation that does not fit the perceived situation. Although the nocturnal events still cause the man's wife alarm, she

has, in a sense, learned to live with it and has an implicit understanding of what to do.

The case described is not an unusual one; this is a regular occurrence for many elderly people in their own homes, as well as in nursing and old age homes. The phenomenon is often misunderstood and it is not unusual to hear people speak of mental confusion.

The above examples illustrate two different phenomena: the posttraumatic nightmare and the posttraumatic re-enactment. To characterize both forms of dream activity, we will speak of *symbolization* in the case of the posttraumatic nightmare and of *replication* where it regards the posttraumatic re-enactment.

By drawing this distinction, we are afforded the possibility of correlating the findings of neurophysiological research with psychodynamic thought processes. The distinction makes it clear that we are dealing with different methods of processing the trauma, as well as different pathogeneses.

A fascinating article by Laub and Auerhahn[2] entitled "Knowing and not knowing: forms of traumatic memory" also explores the concept that different forms of posttraumatic memories provide insight into the manner in, and extent to, which patients come to terms with their experiences.

Let us take a closer look at the two phenomena.

The Posttraumatic Nightmare

Symbolization

Nightmares are described as repeated awakenings from the major sleep period or naps with detailed recall of extended and extremely frightening dreams, usually involving threats to survival, security, or self-esteem (criterion A of the Nightmare Disorder, 307.47; DSM-IV[3]). Nightmares may occur during any part of the night, in particular in the later one and they manifest themselves exclusively during REM sleep.[4] Posttraumatic nightmares occur frequently and the recollection of the dream content refers to the traumatic experience. Accounts of the dream content of posttraumatic nightmares agree with accounts of REM sleep dreams. The scenario corresponds with the traumatic experience, but the people featuring in the events, the scenes and the time sequence of the events are subject to condensation. For instance, people from the sleeper's present-day life may appear in a nightmare that refers to a psychotraumatic experience of long ago. Thus, a number of ideational and structural similarities can indeed be seen to exist between the dream and the original psychotraumatic event.

Ordinary nightmares tend to be repetitive. It is the kind of repetition in

which the contents may also repeat in a thematic way with symbolic distortions remaining present.

If we regard the nightmare in general as an expression of intrapsychic conflict, it is evident that anxiety plays an important role. Freud's second anxiety theory,[5] which is now widely accepted, assigns to anxiety the central role in intrapsyehic conflict. According to this theory, anxiety is produced by the ego when it perceives danger. This is to be called signal anxiety. The ego does this on the basis of remembered early traumatic instances of anxiety in which the ego was powerless in the face of internal or external danger. In the psychological development, early childhood anxieties precede the ability of the ego function of signal anxiety.

The extreme intensity of the anxiety in the nightmare not only ensues from conflicts the child or adult is experiencing at that point in time, but also from associated anxieties referring to an earlier period of development, all of which are reactivated under the regressive and isolated conditions of sleep.[6] Early childhood anxieties are intimately connected with an ego that is still immature and vulnerable. Overwhelmed by anxiety, the ego regresses to a state of infantile helplessness. The defensive ego functions are paralyzed, with the result that patterns of primitive, primary-process thinking prevail, characterized by projection, externalization, arid displacement. This explains why attempts have been made to link the nightmare with processes in which primary-process thinking prevails, such as psychosis.[4]

Although the actually experienced psychotrauma is present in the post-traumatic nightmare, it is not difficult to recognize the symbolic representation in these nightmares of the earliest and most deeply rooted anxieties and conflicts centering on existential threats: threat to life, threat of abandonment and death, and at a rather more advanced level, narcissistic wounding and loss of identity. It could therefore be said that the posttraumatic nightmare is about existential anxieties, the most fundamental of which are fear of annihilation, fear of loss of the object and fear of fusion. Their early, preverbal nature makes these fears difficult and complicated to describe.

These early childhood fears and anxieties play an equally important role in later life and old age, when anxieties and conflicts center on the same existential situation and are reactualized at the approach of death. For a traumatized individual, this can equally well be triggered by life-threatening situations he or she has experienced. The early childhood fears are associated with the following:

—the fear of annihilation with threat to life and destructive aggression;

—the fear of disintegration with loss of identity;

—the fear of being abandoned with loss and abandonment;

—the fear of fusion with loss of identity, paranoia, devouring and being devoured.

Because associations are formed in posttraumatic nightmares between these early anxieties, on the one hand, and the actually experienced psychotrauma, on the other, the latter also acquires symbolic meaning—only its power is far greater because the elusive anxieties of early ego-development have acquired a real basis through the feared actually having taken place, and the fact that the real psychotraumatic experience constitutes a repetition.

The Posttraumatic Re-enactment

Replication

The clinical manifestation of the posttraumatic nocturnal *re-enactment* clearly differs from that of the posttraumatic REM nightmare. This finds expression foremost in the description of the dream content. Wholly or partially absent are the processes of condensing that characterize the dream and occasion the incongruities in time, place, and persons. In its most explicit form, an exact replication of whatever happened during the posttraumatic experience is found. The people, the scene, and the sequence of the events in the dream content and those in the traumatic experience correspond perfectly. Moreover, the reality content is so high that one can indeed speak of a re-enactment.

Posttraumatic re-enactments can occur repeatedly with exactly the same contents without distortions. In replicational re-experiencing, the repetition is not symbolic, but adequately corresponds with the facts. The anxiety that is felt is felt within the re-experienced situation and is directly connected to the elements constituting the re-experienced situation. This could be termed a case of signal anxiety. The anxiety that occurred in the real psychotraumatic situation formed adequate protection against external threats. This signal anxiety is fixated.

The essence of this nocturnal mental activity—the replicational re-experiencing—is not an association with early anxieties or recent real-life conflicts. If early childhood anxieties are triggered here, or if there is a connection with actual triggers, that would be secondary.

Replicational re-experiencing occurs in isolation, without any connection to a person's own experience, though it is part of it, and without the context of a meaningful whole. The situation that is re-experienced has been given no place in the representational world other than as an isolated, encapsulated unit of meaning. In other words, the experience has not been processed, and neither does the re-experiencing have any significance, symbolic or other, for anxieties and conflicts in later life.

This is the case, however, for the nightmare. In nightmares, there is a link with the anxieties of early childhood, which correspond in some respects with those of later age. Thus, a meaningful context emerges, albeit of a predominantly symbolic nature.

Let it be clear that the distinction between posttraumatic nightmares and posttraumatic re-enactments entails entirely different psychotherapeutic approaches to the two phenomena. Where a symbolic association is concerned, a connection can be made with a wider meaning in relation to early childhood anxieties and possibly also current conflicts based on the same anxieties. Where replicational re-experiencing is concerned, it will generally not be possible to make this connection, let alone interpret it on an emotional level for the individual concerned.

THERAPEUTIC APPROACH

I will now limit myself to the role and significance of intrusive re-enactments. For an overview of the various therapeutic methods, I refer you to Shalev,[7] who describes a multidimensional treatment protocol based on the stratification of the posttraumatic stress disorder. As he points out, it is essential in this respect that "repeated intrusive dysphoric mental images stand in the way of exploratory psychotherapy, because they infiltrate much of the patients conscious and unconscious mental processes" (p. 167). For this reason, he uses desensitization in order to enable patients to have "a vivid image of the traumatic memory without experiencing psychologic arousal and distress." This is followed up by psychodynamic psychotherapy.

The notion that recurring memories have a disruptive effect on exploratory therapy appears to have found general acceptance. I would, however, like to qualify this overly broad concept. Posttraumatic re-enactments do indeed pose an obstacle given the isolated position they occupy in the patient's representational world. This is much less the case, however, for posttraumatic nightmares, which can even constitute a key component of psychodynamic or exploratory psychotherapy. The intensity of the arousal occasioned by nightmares is nowhere near that of re-enactments.

In a psychodynamic way of thinking, the meaning of posttraumatic nightmares could be compared with the meaning of normal dreams, i.e., a symbolization of inner conflict. In this sense, it could be a manifestation of working through psychotraumatic experiences in order to integrate them into one's own representational world.

In our clinical experience, a patient's shift towards integration is often accompanied by an alteration in the content of his or her posttraumatic nightmares, sometimes also by a decrease in their frequency. Post-

traumatic re-enactments are more resistant to psychodynamic psychotherapy and often do not show the alterations inherent in a process of integration. They seem to have a more "biological" origin.

The major themes and technical problems in the psychotherapeutic relationship with the traumatized elderly patient are: basic security has been damaged by the psychotraumatic experiences; early childhood anxieties with which the conflicts and concerns of later life are intimately related; separation and loss; memory and reconstruction; recent concerns and conflicts.

In a great many psychotraumatic situations, anxieties of early childhood are reactivated as the object and theme of anxiety in it are repeated. The object is the aggressor who does not respect the boundaries of the ego and the themes are those mentioned above.

Under duress, the bounds of the ego are overstepped and the individual is placed against his or her will in a situation where the ego is once again helpless, vulnerable, and boundaryless. The extreme helplessness evokes infantile feelings of complete dependence, but now the protective mother is not there. The psychotraumatic experience re-creates the state to which the early anxieties pertain. The feared becomes reality in the psychotraumatic experience, causing severe damage to the basic security at the root of psychological development.

The start of the therapeutic relationship is the establishment of trust between therapist and patient. This trust can develop if the patient has a sufficient sense of basic security. If this is not so, as in the case of the traumatized patient, it will take much longer, and require much more of the therapist, to build a therapeutic relationship of trust. An additional problem is that the main themes are, as we have seen, intimately connected with early, preverbal material. The result is that the early and preverbal (i.e., nonverbal) elements occupy a prominent position in the therapeutic relationship. In other words, the beginning of therapy is, to a large extent, determined by the damaged basic security, the influence of early existential anxieties, and the nonverbal aspects of communication.

The psychotherapist must be capable of creating an adequate feeling of basic security through a holding environment, while still managing to establish a therapeutic relationship in the absence of that basic security. Experience in treating early disorders such as schizophrenia and borderline schizophrenia is to the therapist's advantage, as is experience with elderly depressed and paranoid patients. The psychotherapeutic attitude of empathic listening has great practical value, but does not suffice. More than that, an approach is needed which Auerhahn, Laub and Peskin[8] describe as "the presente of a passionate listener". Besides the well-known techniques

of supportive-structuring psychotherapy,[9] it is necessary that psychotherapists not only display a real interest, but also have factual and historical knowledge of the psychotraumatic situation.

Once the psychotherapist manages to create a relationship of trust and a safe atmosphere, it will be possible to deal more specifically with the contextualization of the early anxieties. Lack of boundaries and the specific existential themes we have encountered are characteristic of the early anxieties. On a primitive level, destructive aggression does not mean damage, but rather total destruction. Abandonment means death. The all-or-none character is part of this phase of psychological development. A crucial point in this respect is that the psychotraumatic situation displays a comparable all-or-none character. The preverbal child has no cognitive distancing and no or only a limited inner frame of reference. We could also say that, at this stage, the representational world is shaped exclusively by primitive forces, primal violence not yet linked to representations of objects and self.

It appears to me that, on a fundamental level, the way in which early childhood anxieties are overcome during healthy psychological development can have a bearing on later age as well. In the first place, it is essential for the anxieties to be connected to identifiable objects, situations, and facts. The actual situation, no matter how grave, rarely has the charge and boundarylessness of the anxieties of early childhood. The threat is, after all, real.

By reconstructing the situation, it is stripped of its mystery and boundarylessness. Two things happen. Firstly, the object of anxiety becomes more real, with all the attendant consequences. After all, mystery does also offer some degree of protection. Reconstruction of the facts triggers a range of emotions that better correspond with a more mature ego and can be better worked through: humiliation, object-linked rage, guilt, etc. are felt and experienced. A torrent of emotions is unleashed.

Secondly, it becomes possible to speak about the traumatic experience in terms of facts, to name and contextualize those facts, or to face up to the realization that there simply is no context (concentration camps). Auerhahn et al.[8] stress that the psychotherapist must explicitly and actively help the patient to construct or reconstruct his or her own story. This is an extraordinarily difficult and confrontational process that should encouraged a little at a time. The (re)construction can only be successful if the patient and psychotherapist are prepared and driven to get to the bottom of whatever actually happened.

But the nature of the re-enactments is that they can occur at any moment, with or without prompting. The patient may become overwhelmed and, in

that state, reconstruction is not possible. This poses the main threat to therapy. Here, we are confronted with the distinct difference between nightmares and re-enactments.

From the outset, re-enactments will be present or can be triggered through therapy. Posttraumatic re-enactments will make it impossible to contextualize the early anxieties, because of the extreme arousal accompanying them. We cannot proceed until the re-enactments have been treated, for instance by means of systematic desensitization as described by Shalev.[7] If this is not or only partially successful, one should ask oneself whether exploratory treatment is possible in this patient's case.

Working through or Covering up Psychotraumatic Experiences

As we have seen, where posttraumatic nightmares are concerned, memories of psychotraumatic experiences are closely linked to early childhood anxieties that also have relevance to later stages of life, whereas, in the case of replicational re-enactment, an isolated event is concerned; the anxieties connected with that event are relived and seem not to have any symbolic or other connection with older age. Given the isolated character of posttraumatic re-enactment, it is less responsive to psychotherapy.

Here we are testing the limits of the therapeutic possibilities. After all, how can psychotraumatic experience take on meaning and be manipulated or processed if the experience itself has no meaning and is, in essence, the antithesis of any kind of meaning? Many psychotraumatic situations emerge for the precise reason that the aggressor is him/herself a victim of his/her own early anxieties and is left no choice but to act them out. The only *a posteriori* meaning that can be assigned to the life-threatening posttraumatic experiences is survival. Lidz[10] calls this a key motive for people to become preoccupied with earlier psychotraumatic experiences or unconsciously relive the experience at a later age. In fact, surviving is the same as overcoming early anxieties. In elderly people who are afraid of approaching death, this triumph over death is, the reasoning goes, reactivated. This is an example of the meaning that re-experiencing can have and which can be explored in psychotherapy. This places various demands on the therapist.

He or she must be able to create the safety needed by someone who regresses to the level of a small child. The therapist must have a reasonable understanding of the situation in which the psychotraumatic experience occurred and be able to hear the gruesome details of the real psychotraumatizing experience. He or she must be capable of bearing the fact that the nature of some psychotraumatic experiences render them nontreatable, as they are bereft of any contextual meaning. Finally, the therapist must be able

to bear, recognize and, if necessary, treat the transference evoked in and by elderly trauma patients in therapy.

SUMMARY

Posttraumatic re-experiencing is a key symptom of earlier psychotraumatic experiences. It is important to establish whether we are dealing with nightmares or re-enactments. Posttraumatic nightmares are an expression of intrapsychic concerns and conflicts and, in and of themselves, need not impede exploratory psychotherapy. The nightmare entails both regression to the perceptual level of a small child and reactivation of early childhood anxieties. Before it is possible to work through the psychotraumatic experiences, it is necessary to contextualize the early childhood anxieties that are so closely related to the themes and anxieties of later life. If this is not possible, it will have to be decided to resort to therapy that rather covers up the experience and explores the current significance of the posttraumatic complaints.

Posttraumatic re-enactments have an isolated position in the representational world and are accompanied by hyperarousal and intense vegetative symptoms, which is why they are considered an impediment to exploratory psychotherapy. Posttraumatic re-nactments require treatment of the symptoms before subsequent exploratory psychotherapy can be considered.

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