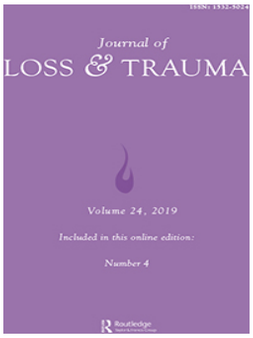

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Stronger Than My Ghosts: Narrative Exposure Therapy and Cognitive Recovery in Later Life

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ABSTRACT

Background: To explore cognitive recovery during and after Narrative Exposure Therapy from the patient's perspective, autobiographical material and interview responses were qualitatively analyzed. *Method*: Using a framework of cognitive development, patient-reported outcomes from four senior Dutch citizens (57–81 years of age) were examined. All participants reported multiple traumatic experiences, including adverse childhood experiences. *Results*: During and after treatment, the participants reported gradual changes in posttraumatic feelings, cognitions, and treatment-related perceptions toward increased self-awareness and self-esteem. *Conclusions*: A framework of cognitive development provides a comprehensive understanding of how older adults deal with childhood trauma and its consequences.

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PTSD; trauma; narrative exposure therapy; older adults; qualitative research

Traumatic events, either experiencing or closely witnessing them, exert a tremendous impact on someone's assumptions about oneself, others, and the world (Janoff-Bulman, 1989). Processing those experiences and gaining control over symptoms go hand-in-hand with the struggle for new meanings and perspectives (Tedeschi & Calhoun, 2004).

If specific posttraumatic stress symptoms, seriously disturbing an individual's functioning in life, last longer than four weeks after the traumatic event, they are qualified as posttraumatic stress disorder or PTSD (American Psychiatric Association [APA], 2013). This disorder can be activated at every stage of life. Consistent with the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5; 2013), the core symptoms of PTSD include involuntary reexperiencing of the event, hyperarousal, avoidance of stimuli reminding of the event, and finally negative alterations in thought and mood. PTSD in older adult patients is frequently associated with comorbid depression (Van Zelst, De Beurs, Beekman, Deeg, & Van Dyck, 2003), cardiovascular disease (Edmondson & Cohen, 2013),

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and dementia (Lohr et al., 2015). In addition, PTSD in later life is associated with serious impairments in daily life (Kessler, Kruse, & Wahl, 2014). Those findings lend additional urgency to treatment research regarding PTSD in older adults.

Risk factors for PTSD include adverse childhood events or ACEs (Van Zelst et al., 2003). In high-income countries, child maltreatment by parents or caregivers has been found to be related to injuries of varying severity and long-term consequences affecting the children into early and late adulthood (Gilbert et al., 2009).

Practice guidelines for PTSD treatment (e.g., National Institute for Health and Care Excellence [NICE], 2018) recommend cognitive behavioral therapy (CBT) focusing on trauma exposure. However, the guidelines have not yet specified whether their recommendations for adults can be generalized to older adults. In order to explore the cognitive changes that appear to be at the core of CBT, this qualitative study was conducted.

Posttraumatic changes in thoughts and meanings play an important role in adaptation and recovery, as has been stated in various cognitive perspectives on trauma (Foa, Tolin, Ehlers, Clark, & Orsillo, 1999; Janoff-Bulman, 1989). In this cognitive framework, emotions and cognitions are closely connected. Distressing emotions and conflicting cognitions may result in distrust and symptom increase (Janoff-Bulman, 1989), thus complicating adaptation and recovery. Traumatic events, therefore, can remain highly central in a person's identity and life story (Berntsen & Rubin, 2006). In contrast, individuals exposed to traumatic events can also develop growth and resilience (Tedeschi & Calhoun, 2004).

Persisting burdening cognitions, such as shame or self-blaming, may interfere with age-specific psychosocial tasks in childhood, adolescence, early and later adulthood. For later years, those tasks are described as growing toward self-acceptance or ego-integration (Erikson & Erikson, 1998). From a perspective of lifespan cognitive development, patients' reported cognitions and feelings may be considered to be indicative of past developments and of current recovery.

In order to understand the older patients' coping and recovery reported in their own words, a qualitative analysis of patient-reported material (autobiographies and interview responses) was conducted. In this study, three questions were investigated. First, which posttraumatic cognitions, related to past life stages, could be identified in the autobiographies of older PTSD patients recovering with the help of trauma-focused exposure therapy? Second, to what extent did cognitions change during the treatment process? Negative cognitions about oneself, others, and the world were expected to be associated with traumatic episodes and to reflect distressing convictions and emotions. During therapy, a differentiation toward more

well-being was expected to happen, due to advances in the treatment process, when patients have better learned to tolerate sensitive memories. Third, how did patients perceive their treatment process? During and after therapy, a noticeable change in perceptions in a positive direction was expected.

Method

Trial registration

The trial was registered in the Netherlands Trial Register (NTR), number 3987, and NARCIS (Dutch National Academic Research and Collaborations Information System), OND1352440.

Procedures, participants, and interventions

This study is based on data from an RCT comparing Narrative Exposure Therapy (NET; Schauer, Neuner, & Elbert, 2011) with Present Centered Therapy (PCT; Frost, Laska, & Wampold, 2014) in older adult PTSD patients. NET has been found to be a safe and effective intervention for older adults (Bichescu, Neuner, Schauer, & Elbert, 2007). The present study describes a small cohort of participants from the NET condition. In the participants' past, adverse events occurred both in childhood and later in life.

After medical ethics committee approval (protocol number P13.009), participants were recruited from two specialized Dutch centers for research and treatment of psychological trauma between April 2013 and April 2016. These civilian trauma survivors were aged 55 years and over, meeting DSM-IV criteria for PTSD (APA, 2000). Exclusion criteria included severe cognitive impairment, current high risk for suicide, active psychosis or bipolar disorder and nonfulfillment of all DSM-IV criteria for PTSD, current diagnosis of substance disorders, and concurrent psychosocial treatment for PTSD during the study. After receiving a complete description of the study, potential participants gave their written informed consent. All participants were interviewed pretreatment, posttreatment, and at follow-up; the NET participants completed an autobiography, from birth to the present.

Trauma narratives

NET addresses individual effects of traumatic events by simultaneously reconstructing autobiographic memory and providing imaginal exposure. In NET, the therapist and patient collaboratively develop a chronological

narrative of the patient's life, highlighting memories of trauma and perceived support. Developing and revising this narrative allows the patient to reexperience avoided traumatic events in prolonged exposure. NET was carried out according to the manual (Schauer et al., 2011) by therapists from both trial sites. The treatment included 11 sessions, each lasting 90 min. In the last session, the participants signed and received their documented narration.

Interviews

At all assessments, master students in clinical psychology with theoretical and practical interview training conducted semistructured interviews face-to-face. The assessors had signed a declaration of confidentiality. The duration of each interview was approximately 20 min. Most interviews took place at the research sites, two of them at a participant's home. After having completed all assessments, including the interviews, the participants received a gift voucher to thank them for their time and efforts.

The first questions dealt with perceived health, expressed in the patient's own words. The next questions referred to ascribed explanations of the traumatic events ("What was for you the most important reason for your problems?"). In addition, participants could evaluate the contact with their therapist and the treatment process. Finally, using a developmental perspective (Erikson & Erikson, 1998), participants could report potential lessons learned ("What have you learned about yourself during treatment?"), and reflect on a metaphor or title for their life story, and their perceived future ("If you would write a memoir, which title would you choose for it?").

Data analysis

All transcribed narratives and interviews were entered into MAXQDA[10] (VERBI, 2007), to provide consistency to the coding process and to enable thematic analysis. The data analysis was based on a three-step process derived from the Grounded Theory formulation (Glaser & Strauss, 1967). First, the material was open-coded. The transcripts were closely read and coded line-by-line. The codes were primarily derived from the Posttraumatic Cognitions Inventory (Foa et al., 1999), to reflect the framework of cognitive adaptation. Additional codes, involving feelings, reported resilience, and life stages, were added.

The first author (psychotherapist) and a research assistant (psychologist) independently coded all narratives; differences were discussed until consensus was reached. The second author (psychotherapist) then reviewed the codes, to maximize intersubjectivity in interpretation. Consistent with the

theoretical framework, the main groups involved posttraumatic cognitions, developmental impact, and responses from the interviews, the latter indicated as treatment-related perceptions. The narratives served to explore the posttraumatic cognitions; the interviews mainly provided information on how patients perceived their treatment process and cognitive changes.

Results

Participants

In order to obtain a sample of NET-participants with a maximum of cultural and clinical homogeneity, only biographies from Dutch civilians, born in the Netherlands, were analyzed. The present sample consisted of those four participants: one woman and three men, aged 57–81 ($M = 64.40$ years; $SD = 9.69$). All participants lived or had lived in stable relationships; all of them had children and some of them also grandchildren. After secondary education, they had held various professions; currently, however, they were unemployed or retired. All participants reported multiple childhood trauma (traumatic memories reaching back from around 5–12 years of age) and subsequent adverse life events; the number of events during adulthood ranging from two to five, ($M = 3.3$). In total, the participants reported four to nine ($M = 6.5$) traumatic events, as indicated on the Life Events Checklist in the CAPS. The reported ACEs ranged from surviving bombardments during World War II, to physical or sexual abuse or domestic violence. Two patients reported recurrent sexual harassment by a relative or parent. The reported traumatic events are presented in Table 1.

All participants were currently diagnosed with symptoms of PTSD and comorbid depression. Additionally, three of them reported chronic somatic problems. All participants started NET in outpatient treatment. For two of them, however, continuing treatment (with NET) in an inpatient setting was needed due to severe dissociation.

Posttraumatic emotions and cognitions

Several themes emerged from the narratives: feelings and cognitions reflecting distress or well-being related to oneself or to others. When talking about their traumatic childhood experiences, participants mentioned not only anxiety or panic, but also anger, confusion, estrangement, and inadequacy. In the case of sexual harassment, they reported disgust and self-blame, as well as anticipation anxiety. “I felt sick; it smelled like rotten food,” and, “The feeling that something terrible is going to happen and that you can’t stop it.” The anger was mixed with helplessness, resulting in a perceived inadequacy: “I should have done something.”

Table 1. Traumatic events and additional burdens of participants.

Type of event	Event	Life stage
Warfare	Bombardments during World War II	Childhood
Violence	Father's beatings	Childhood
	Witnessing father beating up mother	Childhood
	Being bullied at school	Childhood
Exaggerated demands	Being forced to listen to father's wartime stories	Childhood
	Father imposing excessive Labor	Childhood
Sexual abuse	Relative's sexual abuse	Childhood
	Father's sexual abuse	Childhood
Violence to pets	Father killing pet cat	Childhood
	Relative killing pet dog	Childhood
Isolation	Extended hospital stay	Childhood
Triggering event	Food droppings after flood	Adolescence
Loss	Partner dying in car accident	Adulthood
	Life partner's death	Adulthood
	Son's death	Adulthood
	Son converting to radical Islam	Adulthood
	Bankruptcy of own business	Late adulthood
	Being threatened during work in public service	Late adulthood
	Unemployment	Late adulthood
Comorbidity	Chronic disease	Late adulthood
	Depression	Varying
	Dissociation symptoms	Varying
Triggers in late adulthood	Playing chess in hospital	Late adulthood
	Extended stay in isolation unit	Late adulthood
	Crisis in somatic disease	Late adulthood
	Sudden change in medication	Late adulthood

Sexual harassment was associated with a perceived lack of protection and consolation from the (other) parent(s), resulting in confusion and inability to explain what was going on: "I didn't understand anymore. I felt alone." And, when trying to tell one's parent what was going on: "You don't understand anything at all. I don't exaggerate." The inability to share one's feelings was repeatedly expressed: "There was no way I could express my feelings and I got locked up inside myself, fretting." All participants mentioned the themes of cognitive ruminating, social isolation, and desperation, expressed as: "My life is useless; everything feels worn and heavy." For all participants, the reported events were highly central in their identity and life story. This centrality could be inferred from the reported permanent change caused by the adverse events and from persisting self-blame and feelings of shame. In contrast to the reported negative cognitions, positive emotions related to attachment figures, such as an older sister, a grandfather, or the favorite pet, were reported as well.

Coping mechanisms

During childhood, reported coping mechanisms ranged from submission to the circumstances, retreating from interaction into dissociation, to finding consolation (serving as self-regulation) with a favorite pet, such as a rabbit or a dog. Perceived permanent change was reported as well: "On the night

Jackie (the dog) was killed, my life changed forever." On the other hand, participating in creative activities, such as a musical performance, brought on the feeling of being admired, resulting in shared pride and joy. Social support and connectedness were described as important. Belonging to one's family, however difficult the situation, was sometimes a life-saving necessity. "Whatever you want to do, in the end something pulls you back." The perceived lack of support or social alienation was described as extremely difficult to bear, for example, "She (Mum) never stood up for me," and, "I lived locked up in my own world." This alienation was described mainly for childhood trauma; in later life, however, it easily returned when experiencing new hardships.

Lifespan perspective

From school age, new experiences and risks were reported. Both being bullied at school and feeling inadequate by the inability to set limits to the abuse resulted in sharply perceived inferiority. Patients reported that adolescence offered new possibilities, such as learning a profession, having more control by attracting sexual attention among peers, or being able to limit the domestic violence. In young adulthood, all participants managed to find work, commit to a partner, and start a family. All participants succeeded in forming stable romantic relationships. New competences, such as giving birth or curbing undesirable events, caused pride and resilience. Professional skills could evoke similar responses. Those achievements, however, could be shattered by sudden losses. For those participants who had suffered from domestic violence, the death of the perpetrator was a highly ambivalent experience: relief intermingled with anger and regret that no reconciliation had taken place: "I have to make it up all by myself, I can't make it up with him anymore."

Remarkably, from middle adulthood, the smallest amount of information was available. From late adulthood, all participants reported a reactivation or a first onset of posttraumatic symptoms, triggered by somatic illness, dismissal, or serious surgery. Unexpectedly, old nightmares returned after a sudden change in medication or an innocent game of chess. "My relative always wanted to play chess; afterwards, he abused me." In hindsight, feelings of anger were more accessible. "I was angry, deliberately angry. I thought: I am going to leave and will never come back." Feelings of disgust returned in full force. "Disgust is what I feel; in my throat, my stomach aching, my head aching." For one participant, persisting feelings of guilt led to suicidal ideations. In treatment, several lessons from the events were recounted, such as "I will do it differently myself. I never want to be like

my father"; or, "I am still here, you didn't bring me to my knees. I am stronger than my ghosts (memories)."

Treatment-related perceptions

In the interviews, all participants described deteriorating health as the factor requiring treatment. They ascribed their problems to increased symptoms, the adverse experiences in their youth, or "too much stress." In the course of treatment and follow-up, the explanatory models showed little change, except for one participant who initially ascribed his problems to "anxiety." At follow-up, however, he acknowledged them to be caused by "the abuse, as was the case at the beginning." After treatment, mental health was reported as improved, although not all problems were solved. When feelings of guilt persisted, symptom severity did not decrease.

Notwithstanding experiencing problems in trusting others, the participants highly valued the therapeutic relationship and treatment process. At follow-up, one participant expressed some criticism on the treatment logistics, which might be valued as an act of self-assertion. Somatic problems and current domestic stressors were mentioned as factors interfering with treatment. Regarding lessons learned, participants indicated having "learned to talk about it," or "to show emotions," or being aware that "although I am not to blame, I feel guilty." Characterizing their life, participants moved from "the big fight" or "no childhood, a lost childhood," to "we will manage." Perceived future ranged from "I don't have a clue" to "I hope that we can stay together for a long time."

Improvements in mental health were perceived as most notable. Doubts and disappointments were reported as well. "Although I feel better in my mind, my physical strength is deteriorating." No adverse effects on somatic problems were reported. Interfering complications included dissociation and suicidal ideations. Although this led to the treatment lasting longer, all participants succeeded in completing the full NET module.

Discussion

Main findings

Biographies and interviews were analyzed in order to reveal which post-traumatic cognitions of older PTSD patients, related to past life stages, could be identified, to what extent existing cognitions changed during the treatment process, and finally, how the treatment process was perceived.

In the biographies, strong and centralized self-oriented cognitions were found in terms of self-blame, persisting shame, alienation, anger, and permanent change. In addition, positive cognitions showing attachment and

resilience were reported. In the interviews, treatment-related perceptions reflected gradual change in longstanding cognitions, such as a growing acceptance of anger, self-esteem, and growing confidence. The treatment process was reported to be emotionally validating and in majority leading to a clinically meaningful symptom reduction.

Regarding cognitively and emotionally processing the adverse events, this study illustrates some of the steps required on this path of change. The steps include being able to better tolerate sensitive memories, while learning to cope with feelings of anger or shame. In this way, traumatic memories may lose some centrality, allowing for a more balanced self-image. Rather than radically changing cognitions, participants reported a gradual shift from mainly pessimistic self-oriented cognitions to more self-disclosure and self-assertion. This wider range of responses allowed for a more comprehensive self-image, including not only vulnerabilities, but also resilience and endurance. At follow-up, one participant described the benefit of the treatment as: "Getting to know myself better. Fewer appearances. Standing up for myself; more self-esteem."

Lifespan perspective

The framework of a lifespan cognitive development offered a comprehensive understanding of the way in which older adults deal with childhood trauma and its consequences. Thematic content illustrated that the participants not only suffered from the traumatic events, but also from the long aftermath. When reaching adolescence and adulthood, the participants had managed to control the dreaded behavior, form new attachments, and acquire an adult identity in society. To form those new attachments, sufficient personal resources appeared to be available. Changing the context of one's life seemed to support the use of available resources. Persisting feelings of self-blame or perceived injustice, however, restricted those developments.

Crises and health problems in later adulthood, however, disrupted the balance achieved, (re)activating or exacerbating symptoms. As expected, negative cognitions were associated with traumatic episodes; more differentiated feelings and cognitions were associated with later life stages, including treatment time. Differentiation involved the emergence of more self-asserting cognitions alongside persisting self-defeating ones.

The present study confirmed the central role of feelings and cognitions in processing adverse events. The childhood experiences retained high centrality in the participants' life story (Berntsen & Rubin, 2006), compared to other life events. Notably, the expressed feelings and cognitions predominantly involved the self. Other-directed feelings, such as anger, seemed more

difficult to express. This might be explained by the loyalty to one's parents, in spite of their behavior. Besides this loyalty, justice could be clearly at stake: "If only he would have said, 'Sorry'—if only once!"

The relatively few reported cognitions from middle adulthood may be explained by the high centrality of childhood memories. In addition, memories from adolescence and young adulthood reflect the importance and frequency of transitions in these life phases and result in a "reminiscence bump" (Berntsen & Rubin, 2002). Recent adverse events frequently served as triggers reactivating symptoms, resulting in heightened attention as well. Cognitions involving the world at large were not apparent, perhaps because of the child's small world, in which the adverse events took place. Remarkably, the participants perceived their future *not* as foreshortened, neither due to pessimism, nor to feeling prematurely old.

Next to the themes included in the open coding, other ones emerged. The self-regulation found in cuddling a beloved pet illustrated the impact on a child when the animal was tortured or killed. Such an event could trigger perceived permanent change. Participants also described anticipation anxiety as especially troubling. Central in the participants' cognitive world were lack of trust, confusion, and the difficulty to express feelings. On the other hand, new attachments, resilience, and pride emerged. As for developmental stages, the care for new generations in middle adulthood can be inferred from the reported stable marital and family relationships.

Cognitive processing

The reported feelings, cognitions, and perceptions reveal lifelong trajectories of cognitively processing the adverse childhood experiences. These trajectories, underlying the separate feelings and cognitions, show new starts, achievements, setbacks, and sometimes relapses. During treatment, processing appears to be intensified; patients report both stable and changing emotions and cognitions. The framework of a lifelong cognitive development was found to offer a comprehensive understanding of the way in which older adults deal with childhood trauma and its consequences.

Strengths and limitations

One of this study's virtues lies in the fact that that semistructured interviews allowed the participants to present their views and treatment-related perceptions in their own words. Even in this small sample, common characteristics across different types of childhood trauma could be identified, as well as ways to deal with it. Using patient-reported material, this qualitative analysis offered a unique insight in treatment process and treatment

response. In addition, the data were repeatedly analyzed and discussed within the team of researchers, thereby maximizing inter-subjectivity.

Some limitations merit to be discussed as well. Regarding the sample, the reported achievements in adult life (being employed, having a family and even grandchildren) may suggest a risk of selection or survival bias. This bias occurs if those who suffer less from health risks than others are more likely to enter a study. As a consequence of this bias and of the small sample size, generalizability of the findings of this study to Dutch ACE victims in later life is limited. A larger sample and older participants would have been helpful to improve generalizability. Generalizability, however, is not the main objective of this study. The aim of this study rather lies in understanding the patients' perspective and the patients' cognitive and emotional changes during and after treatment, indicating signs of recovery, and leads to further research. Future research with larger samples and older adults would strengthen the evidence. The next limitation refers to therapists and interviewers. Differences in documentation style might have caused some risk of confound. Finally, the interviews took place at the end of the assessments, which might have influenced the participants' attention span.

Clinical implications

The findings of this study highlight some of the changes that may occur when processing adverse events. These findings suggest that NET may effectively address the long-term aftermath of ACEs by embedding childhood trauma and its consequences in a lifespan perspective. In order to optimize treatment planning, routinely assessing ACEs in intake procedures would be recommended for patients of both sexes. Even if patients initially deny having experienced ACEs, they will understand that discussing them is allowed in a clinical setting. Later, they may be able to open up on this issue. By early recognizing ACEs in the patient's history, treatment can be adjusted to the patient's needs (e.g., preferred gender of therapist). During treatment and in assessments, cognitions may provide useful insights for subsequent treatment, such as schema therapy, which is found to be safe and effective with older adults (Videler, Rossi, Schoevaars, Van der Feltz-Cornelis, & Van Alphen, 2014).

In this study's participants, validating the emotional impact of the experiences appeared to be the first gain. An observation such as, "I could tell him everything," reflects this validation. During treatment, feelings of distrust and shame required patience and acknowledgment of the need for safety and keeping control. If necessary, dissociation was addressed appropriately. Potential complications called for the availability of inpatient treatment and necessitated emergency plans. Overall, NET improved cognitive

coherence by completing the autobiographic narrative. The focus on coping and recovery appeared to be an essential strategy for older adults trying to regain resilience and hope, even if residual symptoms persisted. This study suggested that NET has the potential to release the energy previously consumed by dealing with traumatic memories. During and after treatment, renewed personal growth was found to be within reach for older adults, just as for younger patients.

In conclusion

Consistent with previous research (Bichescu et al., 2007), NET might be a suitable and age-specific intervention for older adults suffering from multiple traumatization. Gradual changes in posttraumatic feelings, cognitions, and treatment-related perceptions indicated increased self-awareness and self-esteem. In future research, attention for the lifespan content of the narratives could provide additional information on dealing with adverse events during the life course.

The findings of the present study advocate a wider perspective on coping with adverse events, transcending the current focus on PTSD symptoms (Mooren & Kleber, 2013). They show that recovery after trauma, however distant the memories, is not limited to PTSD symptoms, but includes feelings, cognitions, and treatment-related perceptions, which can be considered indicative of processing the adverse events.

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