Berkshire Healthcare NHS
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Considering trauma when working with older people

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www.berkshirehealthcare.nhs.uk

Overview

- Trauma experiences of current generations of older people
- What can this look like for services
- Services avoiding re-traumatisation – practice of Trauma-Informed Care

Acknowledgements

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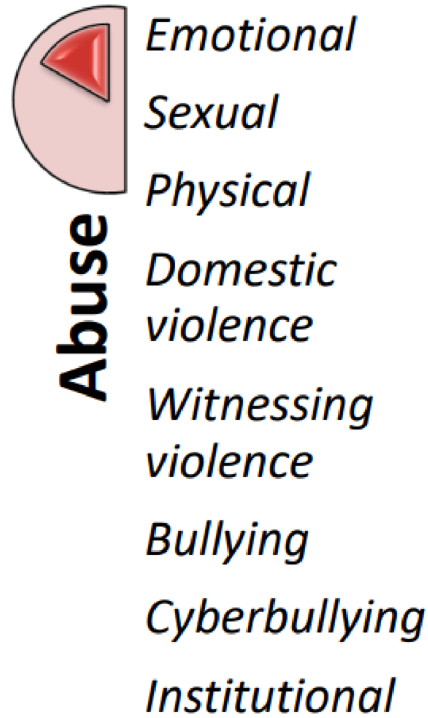
- Dr Anna Preston (Consultant Clinical Psychologist).
- Dr Louise Harriss (Consultant Clinical Psychologist).
- SAMHSA (2014).

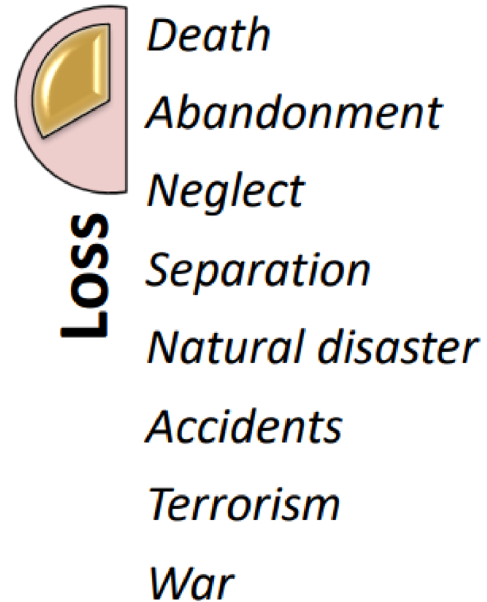
What do we mean by ‘trauma’?

“An inescapably stressful event that overwhelms people’s existing coping mechanisms”

(van der Kolk & Fisler 1995)

Possible traumatic events





SAMHSA
Substance Abuse and Mental Health Services Administration

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Trauma and older adults

Slide adapted from Dr Cate Bailey, Dr Katy Lee and Dr Kathy Martin

Realising the impact of trauma:

Specific to current generation of older adults:

- WWII evacuees and effect of war on parenting
- Holocaust survivors
- LGBTQ+ older adults' experiences
- Experiences of women (sexism)
- Windrush scandal eg: institutional racism
- Boarding school
- "Silent" generation & stoicism
- Negative experiences of parents with MH services – raises fear of the system

Trauma and older adults

Slide adapted from Dr Cate Bailey

Realising the impact of trauma:

Other challenges that may be faced with ageing:

- Death of partner/friends
- Physical illness
- Decreased physical or cognitive function
- Loss of meaningful roles
- Relocation
- Loneliness
- Dementia (most feared condition in later life; experience of confusion; buried trauma resurfacing)

Trauma and older people

Recognising those who have experienced trauma: How might trauma affect interactions with services?

- Frequent attending or calls for help
- Making demands or complaints
- Never attending
- Attending only as an emergency
- Missing important screening appointments
- Medically unexplained symptoms
- Poorly managed chronic conditions
- Multimorbidity and dual diagnoses
- Refusals of treatment and self-neglect
- Accepting care and then refusing (initial deference to power base)

(Slide adapted from Dr Cate Bailey)

Trauma and older people

Recognising signs of attachment insecurity

It may not always be possible to gather a trauma history (e.g. with moderate-severe dementia) and we may need to rely on current patterns of behaviour to draw inferences:

- *How does the person relate to others?*
- *Any signs of distress when staff finish their shift, leave their job or take absences from work? Preferences/ dislikes for a particular care giver?*
- *How does the person respond to reassurance offered when being in an unfamiliar situation/ task they dislike?*
- *How does the person seek support from others at times of distress?*

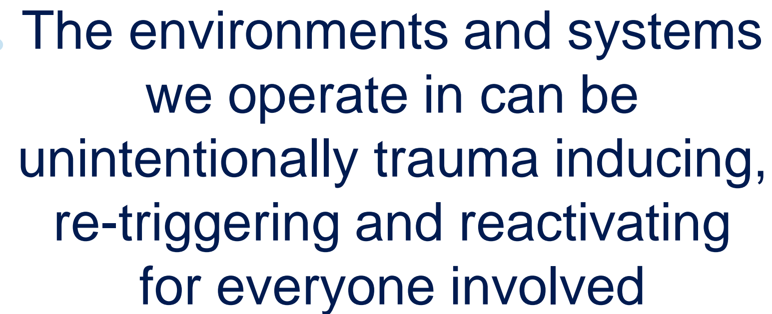
British Psychological Society (2017)

What is re-traumatisation?

- The person experiences something in the present that is reminiscent of a past traumatic event.
- Current events or triggers can evoke similar emotional & physiological responses associated to past trauma events.
- We need to **avoid re-traumatisation**: in the way services are delivered, the way we form a connection and the way in which sensitive disclosures or endings are managed.
- Staff need support and supervision to maintain trauma focus lens.

Trauma and older adults

Resisting re-traumatisation



The environments and systems we operate in can be unintentionally trauma inducing, re-triggering and reactivating for everyone involved

Trauma and older adults

Resisting re-traumatisation

- Loss of independence and requiring help with activities of daily living (especially personal care): “becoming dependent again”.
- Care delivered may involve restraint and a lack of privacy/sensitivity (e.g. commode in hospital bay; doors left open while assisted to dress in a care home).
- As we age, subjected to more invasive medical care/procedures (loss of dignity).
- Delirium/infections more common: Embarrassment and shame about disinhibited behaviours (memories may be fragmented).

Trauma and older adults

Resisting re-traumatisation

- Interventions may be “done to” person with poor **consent** practices.
- **Diagnostic overshadowing** (ascribing everything to age/dementia) and excluding people from conversations/decisions.
- Transitions to care homes (forced relocation).
- **Themes of loss of control, helplessness and vulnerability,** triggering the ‘threat’ system and attachment-related behaviours.

Trauma informed guidelines

Sweeney et al. (2021)- some key points…

- Assessments can be intrusive and painful: need a sensitive approach for taking a personal history as trauma is common.
- People may feel obliged to make disclosures and then subsequently experience complex emotions such as shame.
- Being declined, redirected or discharged can be triggering.
- Repeated assessments can re-traumatise.
- Importance of the environment: privacy (not overheard or 'on display' through doors/windows), lighting, seating, not too clinical etc to promote a sense of safety.

Trauma-informed services

NOT trauma-informed	**Trauma-informed**
Lack of awareness or training about the links between trauma and mental health (traumatic life events not explored or discussed).	Recognise the impact of trauma on MH difficulties and feel skilled to sensitively explore this
Over-emphasis on diagnoses or descriptive labels *("What's wrong with you?")*	Curious, formulation-led approach for understanding the person's presentation *("What's happened to you?")*
Power differentials exist in how services and interventions are delivered *("Doing to")*	Collaboration in relationships and attempts to reduce unhelpful power dynamics to empower people *("Doing with")*
Staff and clients are categorised as **"them and us"**	Staff and clients are viewed as human beings who all experience challenges, adversity and suffering
Staff feel unsafe in their work environment or work relationships (lack of agency or voice)	Staff are supported to work within safe environments and feel able to challenge ideas or raise concerns (psychological safety)

Questions