The Psychology of Trauma and Aging

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Medical Concept of Trauma

- Term long used in medicine and surgery
- Comes from Greek word meaning “wound,” or “to pierce”
- Medical practice: refers to any injury where the skin is broken from external violence AND to the effects of such an injury on the body and mind
The Psychoanalytic View

- Borrows analogous concepts from medicine & applies them to the mind:
  - The idea of a violent shock
  - The idea of a wound
  - The idea of long-lasting consequences affecting the whole somatic and intrapsychic organization
Freud’s view of trauma: The economics of mental energy

• “We apply it [trauma] to an experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way, and this must result in permanent disturbances of the manner in which the energy operates”
Freud’s view of trauma: The economics of mental energy (cont.’d)

• The person is then incapable of discharging the excitation or emotional disturbance all at once without psychologically catastrophic consequences

• The event [or accumulation of events] constitutes a radical threat to the psychological integrity of the person
Freud’s view of trauma: The economics of mental energy (cont.’d)

• The task of the “mental apparatus” is now to immobilize the inflowing quantities of excitation, then allow for their release in a measured manner and progressively restore normal function.

• This incremental discharge of excitations Freud termed abreaction, and forms the basis of treatments involving stepwise desensitization to stimuli, allowing the person to release the toxic memories gradually.
Missing from Freud:

- The fact that traumatic events are often multiple *in two ways*
  - 1) more than one kind of event
  - 2) repeated over time

- Taking elder abuse as an example, traumas can be multiple in both ways:
  - 1) Different kinds of abuse, e.g,
    - Psychological (e.g., fear)
    - Physical
    - Financial exploitation
  - 2) Elder abuse often extends over long periods of time
Traumatic events, even when single, can have multiple & life-changing consequences

Natural disasters, e.g. Hurricane Dorian involve:

• psychological injury (the terror of fearing for one’s life, being homeless, loss of one’s familiar surroundings, loss of aspects of personal identity)
• personal loss (sudden & unexpected death of loved ones; “ambiguous loss” of not knowing who is alive or dead)
• financial loss (destruction of property & loss of livelihood)
Trauma affects people as they are

• Again citing elder abuse as an example, traumas can affect people who have been previously traumatized, so post-traumatic symptoms may be complex and difficult to decipher...and

• Efforts at healing will need to address residual effects of earlier traumas as well as what is going on now
Beyond Freud: Newer definitions of psychological trauma

- Child psychiatrist Dr. Lenore Terr:

  “Psychic trauma occurs when a sudden, unexpected, overwhelming intense emotional blow or series of blows assaults the person from outside. Traumatic events are external but they quickly become incorporated into the mind”
More definitions...

- Psychiatrist Dr. Bessel van der Kolk:
  - “Traumatization occurs when both internal and external resources are inadequate to cope with the external threat”

- Note: both the Terr and van der Kolk definitions imply that psychological damage is done not only by the trauma itself, but by the individual’s inability to manage ongoing reactions
More definitions...

• SAMHSA (Substance Abuse and Mental Health Administration):

  “Individual trauma results from “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social emotional or spiritual well-being”

• Note: Both the Terr and SAMHSA definitions emphasize that trauma often results from multiple events. This could mean different events or repeats (series) of the same event.
One more definition...

- DSM-5’s PTSD:
  - Among many possible triggers are included: exposure to actual or threatened death; serious injury, intentional or accidental; and sexual violation (new for DSM-5)
  - The individual experiences or witnesses the event in person (vs media)
  - If not in person, the individual learns that it occurred to a family member or close friend
  - Has first-hand repeated exposure
DSM-5 PTSD, cont’d.

Symptoms must include one of the following:

- Upsetting dreams
- Dissociation (flashbacks that make one feel as if re-experiencing the traumatic event, even if details are not explicitly recalled)
- Distress or strong bodily reaction at exposure to cues
- Self-blame
- Feelings of detachment, irritability, sadness, difficulty concentrating, sleep problems, [increased suicidal risk]
Also, there is increasing interest in the psychobiology of trauma exposure and PTSD:

- There may also be changes in blood pressure, heart rate, nervous activation and increases in stress hormones like cortisol
- These physiological changes are acute but if repeated over time may have adverse long-term health consequences
- There appears to be an “endorphin high,” not only in inflicting traumatic abuse but also in experiencing it. This may contribute to the tendency to repeat the traumatic sequence
One more definition...

• Trauma-informed approach:

• Defined by SAMHSA as an approach that responds to signs & symptoms of trauma in clients, families, staff

• Natural synergism between the field of elder abuse and a trauma-informed approach (examples from EMDTs; films)

• Basic terms and concepts of trauma-informed approach affect our work in elder abuse:
Coping with trauma: Learned helplessness vs. mastery and empowerment

- Learned helplessness (Dr. Sandra Bloom) occurs when a victim is attached to or dependent upon an abuser AND perceives that there is nothing he or she can to affect the outcome of what is happening.

- The abuse and/or neglect are normalized.

- To overcome learned helplessness, mastery and empowerment require recognizing the how, when and why of the abuse—at whatever level the client is able to grasp it.
Fear, amnesia, dissociation, emotional memory, and the engraving of trauma

• Fear may cause the loss of ability to describe trauma in words
• There may be amnesia, partial or complete, for the actual events, but not for the emotions
• Dissociation: split between conscious memory and emotional reaction (either the conscious memory is blocked but the powerful emotions persist as in classic PTSD—
• OR the memory is consciously available but the emotions are muted)
• The persistence of strong feelings and sensations without explicit memory has been called emotional memory, or the engraving of trauma
Flashbacks & dissociation are the core of PTSD

- Flashbacks are dissociative phenomena; occur when unverbalized emotional memories re-emerge episodically in a sudden, unwanted, intrusive way, often in response to a trigger or cue.

- Flashbacks are not necessarily “memories,” but a re-living of the emotions of the experience separated from the actual memories.

- At the time of the flashback, people become overwhelmed by the same emotions they felt when the trauma occurred.

- To avoid the pain of flashbacks, people can become withdrawn, alienated from friends & family, avoidant & depressed. Functioning declines. They often lead diminished lives.
Flashbacks, cont’d.

OR, instead of becoming withdrawn, less frequently:

• Trauma sufferers can become aggressive and re-enact their psychological injury by bullying or inflicting trauma or abuse on others

• Some of the abusers we see in EMDTs have been abused in the past by their victims. The present abuse is partly vengeful but may also be a kind of flashback, i.e., a re-enactment of their own emotional memories of past abuse
Back to Freud for a moment:

• Flashbacks entail a kind of abreaction, an intermittent release of intense emotions

However:

• Unless the person can explicitly remember what happened, verbalize and understand it, that is, give it a meaningful narrative, the painful flashbacks may continue unabated

• There needs to be a bridge between verbal expression and emotional memory, a process of re-integration
Treatment implications

- “Give sorrow words” (terror, too)

- Dr. JoAnn Difede’s treatment program for veterans of Iraq and Afghanistan wars

- Combines realistic exposure with GPS goggles, e.g., visualizing scenes of house-to-house combat in Falluja on the same street in which the person had fought, and measured release of emotion WITH de-briefing and discussion of what actually happened

- Reliving small segments of reality but at full emotional intensity...
Treatment implications

- Also from Dr. Difede’s approach:
  - Program is comprehensive, also using emotional support & ancillary activities (“therapeutic sanctuary”)
  - Feeling safe is critical for healing efforts to go forward
  - While re-integration of memory and emotion is the heart of PTSD treatment, depression and anxiety may need to be treated separately if they rise to clinically significant levels
Trauma-bonding and repetition-compulsion

2 additional aspects of the psychology of trauma relevant to older people and elder abuse victims in particular

- Trauma-bonding refers to tendency of repeatedly traumatized persons to create new relationships based upon the same power dynamics as in the original abusive relationship, also called traumatophilia (Fenichel).

- Previously or repeatedly traumatized persons may see themselves as unable to make their own decisions (learned helplessness) and cede control to caregivers, allowing abusive relationships to develop.

- Separation from an abuser may not be the end of the story!
Trauma-bonding and repetition-compulsion

• Repetition-compulsion is an extreme version of the human tendency to repeat emotional experiences, positive or negative. We’ve already seen how this might work:
  • 1) In classic PTSD, there is often a push to repeat or re-enact (although not explicitly remember) the trauma
  • 2) In PTSD, esp. in an elder abuse context, there is a tendency to re-establish the same power dynamic in new relationships (contribute to trauma-bonding)*

• *in addition to the fear of retaliation, guilt and shame that contribute to the perpetuation of abuser-victim relationships in elder abuse
Trauma-informed interviewing for elder abuse & neglect

A few principles:

• Recognize the scope of what has happened
• Understand that the person may deny, fail to recall details, or give fragmented accounts
• Recognize & adjust to victim’s current state: e.g., fearful or mistrustful, distracted, weak/malnourished, or fatigued. Take into account educational status and cognitive functioning
Trauma-informed interviewing for elder abuse & neglect

• Try to find a quiet, private space
• Ask permission to broach the subject. “No” means “no”
• Be gentle. Let the person speak in long uninterrupted segments. This can be helpful even if it does not clarify matters
• Maintain emotional warmth (facial expression, tone of voice) and technical neutrality (use client’s words, make no assumptions, be careful about “bashing” the abuser to whom the victim is connected)
• Try to avoid saying “I understand”
Trauma-informed interviewing for elder abuse & neglect

• Avoid using the word “victim” unless the person so identifies himself or herself. “Survivor” may be no better, especially if the person is denying the import of what has happened

• If the person becomes upset, stop inquiring and attend to his or her comfort. Unless you are doing therapy like the Difede program, you are not trying to elicit emotion for its own sake!

• Don’t press elders to do what they cannot—recall, acknowledge, resist further abuse, etc.
Interviewing aging trauma survivors: the Holocaust experience

- Dr. Irit Felsen:

- Old age itself can be re-traumatizing. Much of what we know about relationships between trauma and age-related stressors comes from this demographically aging group of Holocaust survivors. Many now-living survivors were children at the time.

- With aging, clients’ usual ways of coping with traumatic memories, e.g., the distractions of work or raising children, no longer obtain. After years of not thinking much about Holocaust experiences, memories may return in old age.

- The physical & emotional pain suffered decades earlier by Holocaust survivors re-emerges or becomes exacerbated with aging.
Interviewing aging trauma survivors: the Holocaust experience

• Example: The loss of friends and relatives, universal for aging persons, proves to be an especially big blow to those who have lost so many others in the past

• Example: The need to be in assisted-living or other facility calls to mind for some the loss of home, possessions & autonomy during the Holocaust
Interviewing aging trauma survivors & the Holocaust experience: Relationships with health-care providers

• Health in concentration camps meant survival, and so physical weakness has ominous implications and is often hidden

• There may be a deep mistrust of doctors, who held decisive positions of life or death in the extermination camps of Eastern Europe
Dr. Felsen’s points about the interview itself:

- Interviewer must strike the right note for emotional engagement:
  1) be empathic and caring but not insincerely sweet. If so, clients will forgive errors
  2) be neutral (don’t insert your own interpretation or values) but not so neutral as to appear remote
  3) be warm but not falsely cheerful; especially avoid condescending “elder talk”
Interviewing aging trauma survivors: The Holocaust experience

• 4) do homework in advance—consider the person’s age, exact circumstances, location during the Holocaust

• 5) Dr. Felsen: “Try to create a visual image of the person as a vibrant young adult.”
Critical incident Stress Debriefing (CISD) (Mitchell & Everly)

- CISD developed for interviewing traumatized individuals after an acute disaster, including emergency workers
- Goal is early intervention; interview may be at site of the disaster
- Events, feelings, coping strategies & termination in single interview
- Idea is that immediate verbalization & catharsis may prevent or attenuate PTSD-type picture
- Applied to emergency rescue crews at the Murrah Bldg. bombing in Oklahoma City in 1995
- Approach generally helpful but criticized for its exclusive focus on the individual and neglect of peer (workers), family and social support [film]
Ambiguous loss (and dementia): Dr. Pauline Boss

- Ambiguous loss is experienced when there is a partial loss—a death with no body, as in:
  - 1) Intergenerational estrangement: parents who are permanently estranged from their adult children
  - 2) Those lost or missing but not confirmed dead in war, terrorism or natural disasters
  - 3) Those paralyzed or become unable to communicate after a sudden accident (Christopher Reeve, Dr. Carolyn Feigelsen)
4) Those who have suffered from an illness that changes them dramatically and irrevocably—sharply violates the sense of reality in those around them (e.g., ALS)

This last group also includes patients with dementia. Here changes in personality and affect are often more disturbing than the intellectual losses, because what is now different is that which previously made us unique as individuals.
Ambiguous loss (and dementia): Dr. Pauline Boss

• In the ambiguous loss of dementia, there is a rending of human bonds, not abrupt as in an accident, but still profound.

• Dr. Boss: “The absent quality of a person who is still physically present distresses even healthy and resilient family members.”

• The connection with elder abuse: Some caregivers or family members cannot tolerate the partial loss of a person with dementia; they may become angry, ungrounded. This is a potentially toxic stew for the abuse of vulnerable elders.

• Even well-intentioned caregivers often accuse their charges of “faking it.”
Trauma and dementia

The problem:

• Healing from post-traumatic syndromes has everything to do with re-integrating dissociated feelings and verbally expressed memories
• But how are dementia patients to do this?
• When dementia patients have flashbacks, they are “remembering” in the same way that all significantly traumatized individuals do, because that kind of remembering takes place in emotional centers of the brain distinct from those controlling memory and language
• So, in a way, dementia may involve a permanent state of dissociation from traumatic memories
Two films: “This shaking keeps me steady” and “Father and daughter”

- In the field of elder abuse and neglect, there are 2 categories of trauma—that of the workers as well as the victims—represented by these two films
- In “This shaking...” , emergency workers struggle to maintain distance, or boundaries, because they are constantly exposed to terrible scenes
- The feelings emerge in dreams, and the one constant emotion: “The sadness is always there”
- In “Father and daughter” a young girl’s separation from her father impacts her entire life course, into old age
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Trauma in Older Adulthood – Prevalence and Populations Affected

- Literature tends to focus on veterans and survivors of war
  - Accessibility
  - Control
  - Large database
- Gender gap in elder adult trauma research
- Effect of climate change on populations experiencing trauma
  - Severe weather events
  - Displacement (war, natural disasters, gentrification, eviction)
“The vast majority of the patients we saw on the psychiatry service were young, recently discharged Vietnam veterans, while the corridors and elevators that led to the medical departments were filled by old men... The vast majority of them scored positively for PTSD, but their treatment focused on medical rather than psychiatric complaints. These vets communicated their distress via stomach cramps and chest pains rather than with nightmares and rage, from which, my research showed, they also suffered.”

- Dr. Bessel Van Der Kolk, The Body Keeps Score
Trauma in Older Adulthood

- Elders with diagnosed PTSD report the most distressing traumatic events to include:
  - intimate partner violence
  - sexual trauma
  - death or injury of a loved one
  - serious illness or injury
  - Fall History
- Hospitalizations associated with PTSD (Jakel, 2018)
- Older adults reportedly experience significantly fewer traumatic experiences in older adulthood than younger age groups
  - Shift in focus to cumulative trauma
Trauma in Older Adulthood – Cumulative Trauma

• What is Cumulative Trauma?
• How do repeated trauma experiences affect elders?
  • Inoculation Hypothesis – exposure to trauma at different points in time is protective against the effects of subsequent traumas. (Jakel, 2018)
  • Vulnerability Hypothesis – cumulative traumatic experiences predisposes an individual to acute stress and PTSD, and can increase PTSD symptomatic severity. (Jakel, 2018)
  • Crisis Resolution Hypothesis – the effect of cumulative trauma on the psyche is determined by the perceived resolution of the experience. (Lapp, 2011)
How Trauma Effects Memory
Trauma and Dementia in Older Adults

- Increased exposure to violence in life associated with a decrease in cognitive ability and short-term memory, but only among individuals actively recalling emotional states linked with those experiences. (Bogliacino, 2017)
- Reported frequent stress linked to increased risk of dementia and Alzheimer’s Disease. (Greenberg, 2014)
PTSD and Dementia in Older Adults

• **Short-term memory deficits associated with PTSD.** (Bogliacino, 2017)
• **Non-causal link between PTSD and dementia in veterans.** (Jakel, 2018)
  • Prisoners of war (POWs)
• **Onset of cognitive deficits results in worsening of PTSD symptoms.** (Jakel, 2018)
  • Trauma severity predictive of PTSD progression
  • PTSD symptom severity linked to increased risk of developing dementia in later life. (Wang, 2016)
Trauma and Aging – Treatment Approaches

• Psychotherapy
• Eye Movement Desensitization and Reprocessing (EMDR) Technique
• Psychoanalytic Interview
• Bodywork Techniques
  • Dancing
  • Yoga
• “Collective Ceremonies”
  • Theater/Improv
“How can doctors, police officers, or social workers recognize that someone is suffering from traumatic stress as long as he reenacts rather than remembers? How can patients themselves identify the source of their behavior? If their history is not know, they are likely to be labeled as crazy or punished as criminals rather than helped to integrate the past.”

- Dr. Bessel Van Der Kolk, The Body Keeps Score
References


Thank you for your time

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