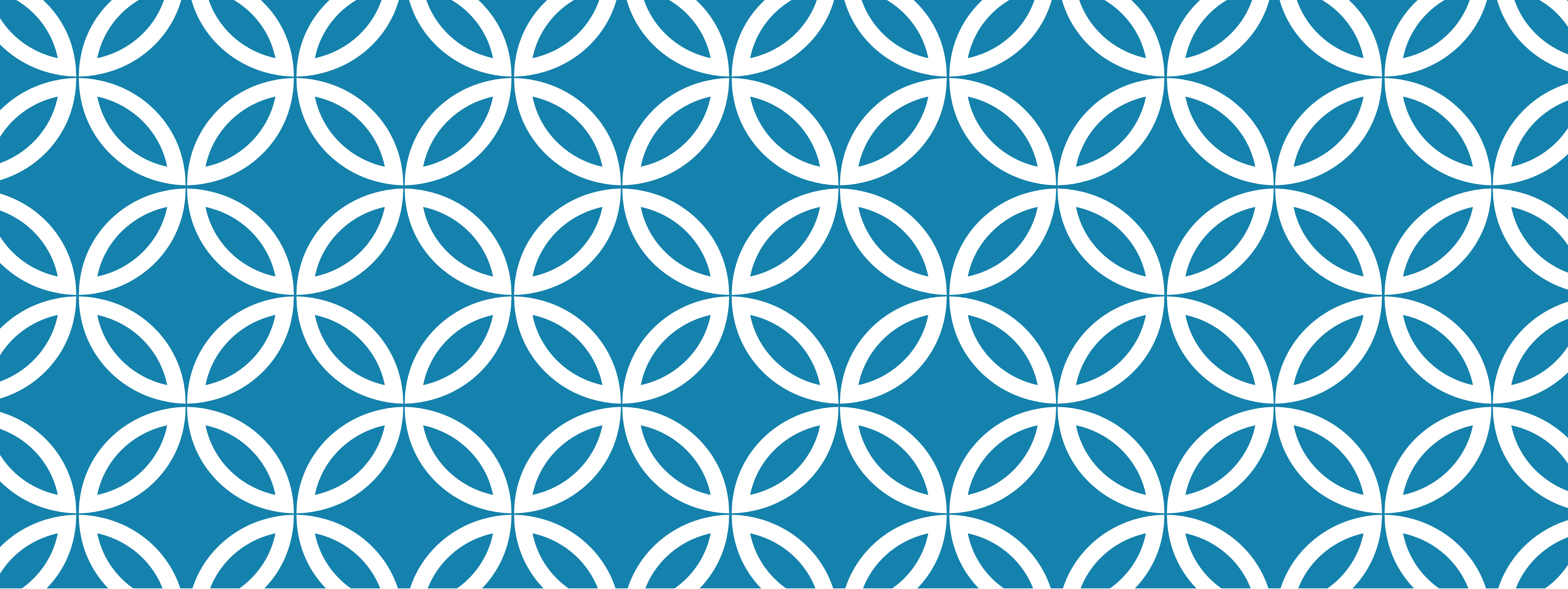

TRAUMA-INFORMED COUNSELING FOR OLDER ADULTS

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TODAY'S PRESENTATION

Understand the specificity of challenges faced in late life using a biopsychosocial model that requires an interdisciplinary or multidisciplinary focus

Appreciate the cumulative impact of trauma on adult development and coping strategies

Understand the network of aging services available to provide active assistance when necessary

Learn the importance of building rapport to help facilitate mental health treatment and engagement in services

Understand the ethical tensions of autonomy and beneficence

CHALLENGES IN LATE LIFE

Older adults seeking help are struggling with problems that threatens psychological homeostasis such as:

- Chronic illness
- Disability
- Loss of loved ones to death
- Prolonged caregiving for family members with severe cognitive or physical impairments

Many people who have struggled with depression, anxiety, substance abuse, or psychosis throughout their lifetime become older adults and continue to struggle with those problems.

DEBUNKING MYTHS OF AGING

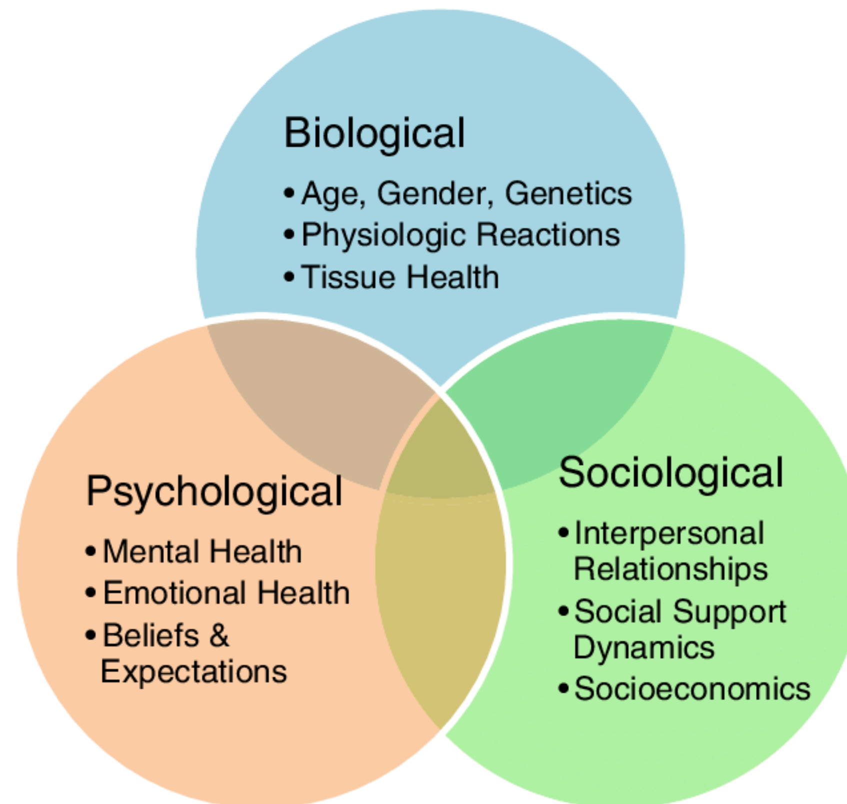
It is not uncommon to implicitly assume that problems facing older adults are due to *advanced age* rather than to an underlying illness, psychological disorder, or severe life stress.

- "I feel unheard and hopeless when my physician says, 'it's common for someone of your age to experience hearing loss and depression."

There is a tendency to equate the old-old years with illness, frailty, and disability.

The belief that aging and frailty are identical cause many problems for older adults

BIOPSYCHOSOCIAL MODEL



THE STORY OF MRS. MARTINEZ

Mrs. Martinez is an 83-year-old Hispanic woman whose husband died from a sudden heart attack one year ago. She has an 8th grade education and raised 4 children with her husband. Since her husband's death, her youngest son was released from jail after serving 2 years for a domestic violence offense and has moved in with her "to get back on his feet."

Mrs. Martinez lives on a fixed income of $860 per month. She owns her home. She manages her type II diabetes and was recently diagnosed with macular degeneration which resulted in her decision to cease driving. She and her son made an informal agreement that she would provide him with a place to live if he would drive her to her doctor's appointments, the store, and to church.

Adult Protective Services (APS) was called by her primary care provider who reported that she had not attended the last 2 doctor's visits and was worried about her diabetes management. APS later learned the Mrs. Martinez took a taxi to the emergency department because she had run out of her insulin and her son had not been home for 5 days.

WHAT ARE THE KEY ISSUES USING THE BIOPSYCHOSOCIAL MODEL?

Bio:

- Medical co-morbidities – Type II diabetes mellitus; Macular degeneration

Psycho:

- Adjustment to widowhood
- Recent move-in by son (what do we need to know about son's mental health associated with incarceration and history of domestic violence?)

Social:

- Increased dependence on son for transportation and social engagement (i.e., church)
- Limited access to care given transportation dependency/need

TRAUMA AS AN ADDED LAYER

What is trauma?

Individual trauma results from an **event**, series of events, or set of circumstances **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

PREVALENCE OF TRAUMA: POTENTIAL TRAUMATIC EVENTS

Abuse

- *Emotional*
- *Sexual*
- *Physical*
- *Domestic violence*
- *Witnessing violence*
- *Bullying*
- *Cyberbullying*
- *Institutional*

Loss

- *Death*
- *Abandonment*
- *Neglect*
- *Separation*
- *Natural disaster*
- *Accidents*
- *Terrorism*
- *War*

Chronic Stressors

- *Poverty*
- *Racism*
- *Invasive medical procedure*
- *Community trauma*
- *Historical trauma*
- *Family member with substance use disorder*

PREVALENCE OF TRAUMA

Exposure to trauma is ubiquitous: seven out of ten respondents worldwide and nine out of ten adults in the USA report experiencing one or more lifetime traumas.

Fink, Galea, 2015

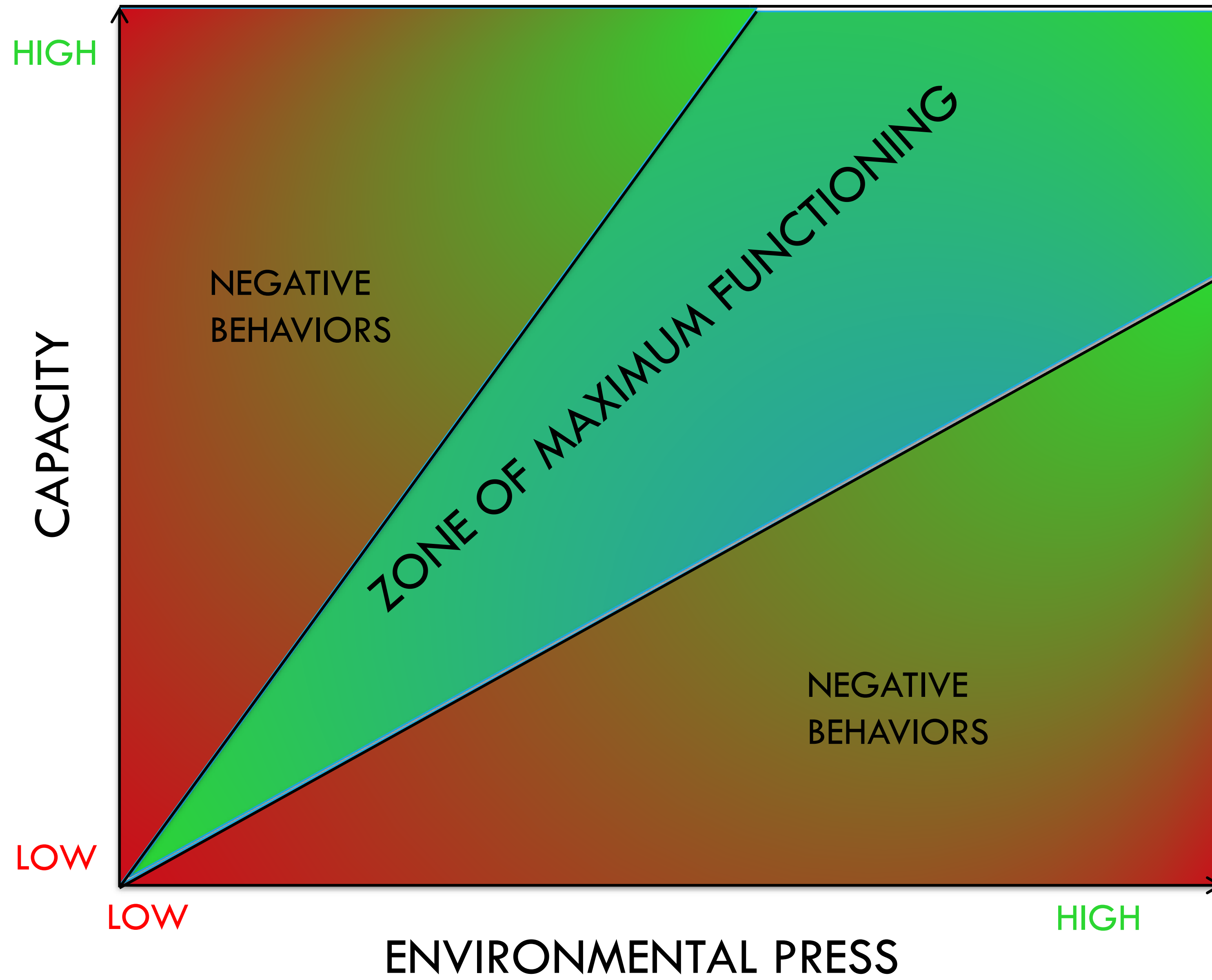
IMPACT OF TRAUMA:
PROBLEMS OR ADAPTATIONS?

Fight	"Non-compliant, combative" OR Struggling to regain or hold onto personal power
Flight	"Treatment resistant, uncooperative" OR Disengaging, withdrawing
Freeze	"Passive, unmotivated" OR Giving in to those in power

IMPACT OF TRAUMA: SIGNS OF TRAUMA RESPONSES

Additional Signs

- Flashbacks or frequent nightmares
- Sensitivity to noise or to being touched
- Always expecting something bad to happen
- Not remembering periods of one’s life
- Feeling emotionally numb
- Lack of concentration
- Irritability
- Excessive watchfulness, anxiety, anger, shame or sadness


HIGH
NEGATIVE BEHAVIORS
ZONE OF MAXIMUM FUNCTIONING
CAPACITY
NEGATIVE BEHAVIORS
LOW
LOW
HIGH
ENVIRONMENTAL PRESS

TRAUMA BRAIN = DYSREGULATED BEHAVIOR

As client's anxiety increases, their "thinking" brains become less engaged and behavior becomes more dysregulated.

YOU can develop skills to help clients regulate and related by becoming calmer and more connected.

This is achieved by:

- Warmth
- Validation
- Flexibility
- Structure
- Hope for the future
- Humor
- Being part of a connected community

PURSUING ACTIVE ASSISTANCE FOR AN OLDER ADULT

Each community has a somewhat different network of services. Important services to look for in any local context are as follows:

- Physicians who are knowledgeable about and comfortable treating older adults;
- Various types of residences available to older adults, including independent living, assisted living, residential care, skilled nursing communities;
- Geriatric case-management services;
- Specialized services for older adults with dementia;
- Specialized services for caregivers;
- Congregate meal sites and home-delivered meal programs;
- Senior recreation and day centers for older adults;
- Transportation services;
- Income assistance programs;
- Legal services;
- Home health services;
- Emergency services to help buy food, pay utility bills;
- Mental health services for older adults.

IT TAKES A VILLAGE

Working with older adults requires us to view the person in context – and it's often a complicated picture that requires community collaboration.

Know your "virtual team" – who can you call to help with any given situation or circumstance to offer support or remedy a problem?

Service systems for older adults are often complex, with various rules about eligibility, and can be misleading to some degree about what services are actually provided.

- Example: Transportation services

MENTAL HEALTH SERVICES FOR OLDER ADULTS

Therapy is generally oriented toward increasing a client's independence by empowering him or her to solve their own problems

Therapists who specialize in aging or older adults often toggle between being a caseworker and therapist:

- Example: A client is referred to therapy because they are so depressed that they haven't eaten well in weeks. The therapist might immediately refer then to home-delivered meal services and then starting therapy after a few days of good meals.

Myth busting moment: Older adults are less likely to seek professional psychological help then younger adults. *NOT TRUE!*

TRAUMA INFORMED VS. TRAUMA-SPECIFIC TREATMENT

Trauma Informed Care

Takes into account knowledge about trauma in all aspects of service delivery

It is not specifically designed to treat symptoms or syndromes related to trauma.

Is a philosophy of providing care that recognizes and takes into account possibility of trauma in a client's history.

Trauma Specific Treatment

Evidence-based and best practice treatment models that have been proven to facilitate recovery from trauma.

Directly addresses the impact of trauma on an individual's life and facilitate trauma recovery- they are designed to treat the actual consequences of trauma.

Trauma Informed Care, Alameda County
alamedacountytraumainformedcare.org

YOU CAN BE THERAPEUTIC WITHOUT BEING A THERAPIST

Building rapport is essential in working with older adults or responding to a traumatic situation;

You can develop skills to help de-escalate a dysregulated client while communicating empathy.

ELEVEN THINGS NEVER TO SAY TO ANYONE

1. Come here.
2. You wouldn’t understand.
3. Because those are the rules.
4. It’s none of your business.
5. What do you want me to do about it?
6. Calm down.
7. What’s your problem?
8. You never (or) you always.
9. I’m not going to say this again.
10. I’m doing this for your own good.
11. Why don’t you be reasonable?

STATEMENTS: REFLECTION, EMPATHY, VALIDATION

Verbally **reflect** another's emotional state:

- "It sounds like you feel very angry about this."

Offer the ultimate **empathic** statement:

- "Let me be sure what I heard is what you just said."

Validate the person's emotions:

- "You had to wait three days for me to return your call, and your question was really important to you. I understand why you're mad about this."

BE CONCISE

When persons are agitated, their ability to process verbal information may be compromised; thus, use short sentences and simple vocabulary.

Give the individual time to process what has been been said to him/her and to respond before providing additional information.

REPETITION IS ESSENTIAL

Persistently repeat your message until it is heard.

Repetition is essential whenever making requests, setting limits, offering choices, or proposing alternatives.

Combine this skill with assertiveness skills such as active listening and agreeing with the individual's position whenever possible.

IDENTIFY WANTS AND FEELINGS

Whether or not a request by the individual can be fulfilled or granted, all persons need to be asked what their request is:

- "I really need to know what you expected when you came here" and,
- "Even if I cannot provide it, I would like to know so we can work on it."

USE ACTIVE LISTENING

Convey through verbal acknowledgement, conversation, and body language that you are really paying attention to the individual, and what they are saying and feeling.

Use clarifying statements such as, “Tell me if I have this right…”

This does not mean you agree with the individual, but that you understanding what he/she is saying.

A WORD ON ETHICS

Autonomy

Protection

Beneficence

Dignity of Risk

REVISITING MRS. MARTINEZ

APS visits Mrs. Martinez at her home and discovers there is only spoiled food in the refrigerator. The client states that she hasn't seen her son in 5 days and thus, has no way of getting to the grocery store or the pharmacy. When asked about her relationship with her son, Mrs. Martinez states,

"Cisco has always had trouble, since he was a young boy. I feel guilty because I had to work while he was young and his older brothers were already out of the house. I know I neglected him, so I try to help him as much as possible. I haven't slept or eaten since I last saw him. I worry that something bad has happened, but he usually comes back when he's out of money or food."

MULTIPLE QUESTIONS FOR CONSIDERATION

What is the least restrictive intervention for Mrs. Martinez?

What are her vulnerabilities that put her at risk for declining physical and mental wellness?

What are her inherent strengths?

What agencies or professionals could assist to keep Mrs. Martinez independent and thriving in her current situation?

Hint: Think BIOPSYCHSOCIAL model as a framework!

Q&A

TRAUMA INFORMED CARE: FURTHER READING

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Linda Sanford (1991) Strong at the Broken Places

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Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

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Wisconsin Department of Health Services. Trauma Informed Care Skill Development. Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services. https://www.dhs.wisconsin.gov/tic/skilldev.pdf

QUESTIONS?

If we cannot get to your question today,
please e-mail us at elder.justice@usdoj.gov