Every resident as a trauma survivor. The authors were probably also not followers of the late Arthur Janov, the developer of the “primal scream” approach to psychotherapy, which attributed all mental illness to repressed emotionally traumatic episodes in childhood. Janov’s patients, who included John Lennon and Yoko Ono, were encouraged to scream, call out for their parents, and, if possible, vomit to relive and remove the memories of these painful episodes. I suspect that most surveyors would not congratulate a facility whose residents were screaming and vomiting for providing trauma-informed care in accordance with professional standards.

Unfortunately, this is no joking matter: the sequelae of past traumatic episodes are real, serious, and certainly prevalent among the patient population cared for in nursing homes. PTSD is real, sometimes hard to recognize, and frequently very emotionally painful.

**A Brief History of PTSD**

Medical descriptions of PTSD date back at least to Hippocrates, but it became a well-known, urgent problem during World War I, when it was labeled “shell-shock” and initially was attributed to the concussive effects of bombardment on the brain. Soldiers with onset during shelling were labeled as “wounded”; those whose onset of symptoms did not occur during active bombardment were considered “sick.” By 1917, the British army banned the term shell-shock and began returning the sufferers to the front after a few days’ rest for “nervous exhaustion.” Ten years after the end of the war, 65,000 veterans were still in psychiatric hospitals in Britain receiving treatment for the condition.

After World War II, Korea, and Vietnam, the familiar symptoms of anxiety with hypervigilance, emotional isolation, flashbacks, nightmares, palpitations with chest tightness, and emotional lability with episodes of rage or violence were again recognized and were given various names, including “battle fatigue” and “combat stress reaction.” The frequent association with alcohol and drug abuse, perhaps feeding each other in response to painful emotional symptoms, contributed to the confusion regarding the diagnosis. Willful societal indifference towards PTSD, based on the results of phase 2 studies.

The medical literature regarding trauma-informed care is remarkably sparse and largely addresses children. There is an extensive network of resources directed at survivors of childhood cancers and their families. The Robert Wood Johnson Foundation has funded 10 sites with model projects, none of which feature populations of seniors, much less nursing home residents. CMS explicitly recommends the principles set forth in a Substance Abuse and Mental Health Services Agency publication (No. SMA 14-4884), whose title promises “Guidance for a Trauma-Informed Approach.” Unfortunately, this publication contains virtually nothing of use to a skilled nursing facility, with recommendations like maintaining a bright, clean, quiet environment with cheerful staff. Even the major guidance to avoid physical restraints and involuntary seclusion comes 30 years after the Omnibus Budget Reconciliation Act of 1987 (OBRA 87).

**Traumatic Life Events**

Linking PTSD to battle-related trauma, even if that population now includes a number of women veterans, is consistent with our historic unwillingness to acknowledge and address the frequent painful, emotionally traumatic episodes in the lives of women. For example, medical and family history reviews for new admissions often ask about childbirth, including the number of pregnancies and living children. Yet the statistics regarding PTSD after childbirth are little known; those that are available are generally glossed over with bromides about amnesia for the pain related to “the happy event.” The prevalence of PTSD after the quintessentially emotionally stressful and physically painful experience of a vaginal delivery varies from a low of 1% in some studies to as high as 25% in others. Fortunately, the majority of these women, but by no means all, will experience substantial or complete recovery over 5 years. (This PTSD should not be confused with postpartum depression, which produces different symptoms and is not subject to later life triggers.) In my medical school obstetrics course, the professor referred to “pathological fear of childbirth” as a valid indication for an elective cesarean delivery. Women with postpartum PTSD tend to shun newborn babies and may even burst into tears when exposed to a newborn or baby pictures due to flashbacks to their trauma. The patients who state, “One was all I wanted,” may be pointing to this trauma.

More prevalent are residents who have experienced childhood or teenage physical or sexual abuse. These traumas frequently lead to distrust of those entrusted with providing for their needs and protecting them. As we know, most perpetrators of child abuse are not satanic cults or strangers with candy; typically they are parents, other close family members, teachers, clergy, or others who have unsupervised access to children. The child’s actual trauma is compounded by the perceived, and often real, betrayal by the parents of their duty to protect their child either through overt acts or by exposing the child to abusers — and then, all too often, ignoring the child’s direct or indirect complaints and signs of abuse.

Every news cycle seems to produce additional reports of sexual abuse and assault against adults, primarily women.
No specific screening tool is required. General staff training regarding the care of trauma sufferers is certainly desirable, with an emphasis on listening and believing. At a minimum, there should be evidence of training for behavioral health staff. The care planning for residents, particularly the residents with dementia, who exhibit unexplained episodes of anxiety, rage, tearfulness, or resistance to care should address the possibility that these are reactions to a prior trauma, rather than being simply unexplained, random behaviors. Because quality dementia care is person-centered, being open to these portions of a resident’s history is valuable in planning treatment and avoiding triggers.

Some experts have recommended substituting the supportive question “What did you live through that made you do that?” for the negative “What made you do that?” as a more successful approach to identifying prior trauma. Certainly, the workup for any resident receiving psychotropics without a clear diagnosis should address the possible contribution of prior trauma. If we cannot completely heal all old wounds, we must at least try not to ignore or reopen them.

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The estimates continue to rise, but current reports would suggest that more than one-third of women and one-tenth of men are survivors of such episodes, most of which are never formally reported as crimes. Although incidents involving entertainment and sports celebrities, politicians, and college campuses receive the most attention, victims are equally or more common among those with the least ability to protect themselves — the poor, the ordinary looking, LGBT populations, and especially transgender populations, where such assaults are particularly common. Although the sexual aspects are usually highlighted, these assaults are not primarily about lust: they are demonstrations of power and control. The Trump Access Hollywood tape made clear that he was bragging primarily about the ability of a “star” to grab anything he wanted, including female genitalia. Sexual abuse often overlaps with domestic violence, and often includes humiliation along with verbal, physical, and sexual assaults.

A traumatic episode that induces PTSD does not need to be directly experienced by the patient. I recently saw a patient exhibiting the classic symptoms after a home invasion; he was unharmed, but the incident triggered his teenage memories of a beloved cousin being shot in front of him. The world in which we live — which includes escalating man-made natural disasters, refugees fleeing their homes due to declared and undeclared wars, gang violence targeting civilian populations, omnipresent firearms with weekly mass shootings, widespread patterns of entitlement and abuse within our social framework, misogyny embedded in our legal and political systems, and stressful medical experiences — suggests that the population of residents potentially requiring trauma-informed care is very large indeed.

In one large survey, despite tendencies to deny or hide the incidents, two-thirds of adult respondents reported having experienced at least one significant life trauma. And the higher the score on the Adverse Childhood Events (ACE) scale, the greater the likelihood of significant lifetime illnesses such as diabetes. For nursing home residents, surviving a lifetime trauma may be the norm.

Trauma-Informed Care

Sensible plans to address the requirement for trauma-informed care can and should be initiated. Elaborate screening is not required and probably is not useful, but a single question directed to whether the resident has experienced trauma, with subsequent emotional scars, could be valuable. Knowing that a resident lost her house during a hurricane might lead to extra emotional support for the resident during a storm. Awareness of prior abuse could help with the resident’s adjustment to the facility and suggest special approaches to attempt to develop trust.