

THE THINGS THEY CARRY

Advancing
Trauma-
Informed
Responses
to Elder
Abuse

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Risa Breckman, LCSW

Malya Levin, Esq.

Leslie Mantrone, LMSW

Joy Solomon, Esq.

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INTRODUCTION



The young soldiers who bring the war home with them. Families starting over after the flood waters recede and the fires are extinguished. The migrant children separated from parents. Teens shot in the streets, young people wielding guns and mothers who mourn children lost to violence and incarceration. Increasingly, we understand their lives and so many others through the lens of trauma. But the face of trauma can also be deeply lined, framed by gray and thinning hair and with eyes that convey tremendous sorrow and fear if we look closely.

In the United States today, one in 10 older Americans is the victim of abuse, typically by someone they know and should be able to trust, often a member of their own family. Many elders are abused for months or years before someone intervenes to stop it, leaving scars that are mostly invisible. For an untold number of older victims, the harm they experience is layered over abusive or otherwise traumatic events they endured earlier in life. Older people are also more likely to battle potentially life-threatening diseases and lose loved ones, which can be in themselves traumatic experiences and can make dealing with other traumatic events more

difficult. Each person's story is different—both the hurt they carry inside and their strength to overcome it.

Accumulated traumas have been called the “hidden variables” in the lives of older adults.¹ Even professionals who work routinely or exclusively with older people often fail to see and

understand the manifestations of trauma in their clients' lives—or if they do spot signs are at a loss for how to respond. The lingering effects of trauma on an older person's body, mind and emotions can be easily confused with or masked by physical ailments and cognitive impairments common later in life. Even the most well-informed and diligent professionals are limited by definitions, approaches and

tools developed for other populations, notably combat veterans, and always for younger people. We can do better; the elder justice field wants to do better.

In October 2018, Weill Cornell Medicine's NYC Elder Abuse Center (NYCEAC) and The Harry and Jeanette Weinberg Center for Elder Justice at the Hebrew Home at Riverdale (Weinberg Center) convened experts from across the country with deep

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knowledge and experience in subjects spanning neuroscience and geriatrics, innovative trauma therapies and public policy to begin to answer an overarching question: What do professionals across disciplines and systems need to know about trauma and its effects on older adults to be able to identify individuals in need and help them to heal?

The daylong symposium, “Advancing Trauma-Informed Responses to Elder Abuse,” was designed to mine the collective wisdom of the group and generate concrete, actionable recommendations in four areas: education and training, especially for professionals who routinely serve elders; promising interventions and other practices to help people heal from recent and prior trauma exposures; research to deepen and expand knowledge about trauma over the lifespan and what works best in helping older people heal; and policies and funding priorities

that will allow us to build on isolated good practices to create systemic and cultural change.

This publication culls information and insights from the symposium, along with source materials provided by participants, as context for the recommendations that are presented beginning on page 12.² Readers seeking more information about the process are invited to read “Genesis of this Report and Recommendations” on page 4. Hopefully, people around the country will begin to take up these recommendations. There is a role for everyone to play in making organizations, systems and communities more attuned and responsive to the elders who are suffering in body, mind, heart and spirit as a result of abuse and other traumatic experiences. Fundamentally, providing trauma-informed care to older victims of abuse is about supporting healing and hope among people who may have years more to live and much to give.

KEY TERMS—DEFINITIONS UTILIZED AT THE SYMPOSIUM

Elder Abuse: A single or repeated act—or lack of appropriate action—that intentionally or unintentionally causes harm, risk of harm or distress to a person 60 years or older and occurs within the context of a relationship in which there is familiarity and an expectation of trust, or when a stranger targets an older person because of his or her advanced age or limited ability. Elder abuse encompasses physical, psychological, emotional and sexual abuse; neglect of a person’s needs; and financial exploitation. *Source: New York City Elder Abuse Center*

Trauma: The results of an event, series of events or set of circumstances experienced as physically or emotionally harmful—and at the extreme, life threatening—with lasting adverse effects on a person’s mental, physical, social, emotional or spiritual functioning and well-being. *Source: United States Substance Abuse and Mental Health Administration (SAMHSA)*

Trauma-Informed: A program, organization or system that: realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others; responds by fully integrating knowledge about trauma into policies, procedures and practices; and seeks to actively resist re-traumatization. *Source: SAMHSA*

GENESIS OF THIS REPORT AND RECOMMENDATIONS

This report has its roots in a daylong symposium held on October 18, 2018, and organized by NYCEAC and the Weinberg Center. Roughly 75 experts across disciplines gathered to reflect on trauma in the lives of older victims of abuse and chart a course for advancing responses to elder abuse that are informed by the manifestations and consequences of trauma and promising strategies for healing. By drawing on the fields of trauma studies, gerontology, neuroscience, mental health care, victim services and elder justice, the symposium was breaking new ground.

The symposium was also ambitious, seeking to develop specific recommendations in four overlapping domains: education and training, professional practice, research and policy. (See Appendix on page 46 for the symposium's program.) To achieve that goal, the symposium was structured as a series of expert presentations, beginning with a detailed case study of trauma across the lifespan in one older survivor of abuse, followed by panels that focused on the science of aging, the science of trauma, the connection between individuals coping with trauma and organizational stress, and life writing as one potential therapeutic technique and a lens for thinking about healing interventions in concrete and practical terms.

The afternoon was dedicated to expert panels focused on the four domains, each followed by a decentralized brainstorming session to generate potential recommendations in that domain. Those discussions occurred around tables that also mixed people from different disciplines, in effect constructing eight mini synergistic think tanks. To allot maximum time for each of the four brainstorming sessions, a facilitator at each table documented the discussion and potential recommendations in lieu of each group to reporting back to the whole.

In the wake of the symposium, leadership and staff of NYCEAC and the Weinberg Center took the more than 500 recommendations generated during the day, eliminated duplication and refined and categorized them to produce a draft slate of concrete and actionable recommendations. Following a period of online review and comment by symposium participants, with a notable one-third responding, the recommendations were then further refined to reflect the set in this report.

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RECOGNIZING AND UNDERSTANDING TRAUMA IN OLDER VICTIMS OF ABUSE

“A traumatic experience impacts the entire person—the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people, and the way we make sense of the world are all profoundly altered by traumatic experience.”³ – Sandra Bloom, MD

Research on trauma in older adults is patchy at best, limited mainly to post-traumatic stress disorder (PTSD) among elderly combat veterans and Holocaust survivors, and with no definitive conclusions. But both studies and broader clinical experience, including work with survivors of elder abuse, show that trauma manifests on a continuum of severity with real consequences for people. Elders with “full and subthreshold PTSD suffer significant impairment in daily life, are less satisfied, receive less optimum care and report older subjective age, which is in itself related to greater health problems.”⁴

People who survive traumatic experiences are often haunted by those events. Through study of neuroscience, we now understand that traumatic experiences and the emotions attached to them are stored in specific regions of the brain, often lying dormant until some related sensation or experience brings them fully back to life. While flashbacks are a cardinal feature of PTSD, not everyone living with trauma experiences classic flashbacks

or meets diagnostic criteria for PTSD. Trauma can manifest as intrusive thoughts, nightmares and general difficulty sleeping, being easily startled, and obsessively avoiding sensations or circumstances associated with frightening and deeply hurtful events. One older woman whose husband abused her in the bedroom, always with the door shut, became visibly anxious if the door to her nursing home room was closed.

In an attempt to avoid “triggering” sensations and experiences, some older people become increasingly withdrawn and isolated. Feelings of generalized anxiety, depression, helplessness and for some, anger are also common. Even hoarding can be a response to trauma. Such reactions can be both conscious and unconscious. Over time, the chronic stress that people experience as a result of trauma can cause not only passing physical symptoms, but chronic physical and mental illness, a pattern documented in the well-known longitudinal study of adverse childhood experiences (ACEs).⁵

Perhaps the most important take-away from the limited body of knowledge accumulated to date is that trauma among the elderly needs to be understood in developmental terms. Just as childhood trauma can delay or stunt early development, we need to explore elder abuse and other trauma that manifests later in life using a similar framework. There are indications that PTSD, for example, is expressed somewhat differently among elderly people and has been described as a form of “accelerated aging.”⁶ Deficits in attention, memory and other executive functions, altered stress hormone levels and changes in brain structure that happen as a normal part of aging can occur sooner and more extensively among older people coping with trauma.⁷ And these effects of trauma—disorganized or agitated behavior, faulty memory, even self-neglect—can be confused with normative cognitive declines. As a result, for many older people in need of help and healing, the root cause of their difficulties and troubling behavior is often not understood or addressed.

There is another important developmental aspect to understanding trauma among the elderly: symptoms stemming from a traumatic event experienced long ago can recur or even develop for the first time later in life. Case studies of war-related PTSD that was under control prior to the person developing Alzheimer’s disease or other forms of dementia as well as studies of holocaust survivors have documented this pattern.⁸ The precise etiology

is unclear. It could be that traumatic memories are more resistant to the eroding effects of dementia. As other memories fade, disturbing memories are released into consciousness.⁹ Complicating the picture, according to Colleen Jackson, PhD, ABPP-CN, who studies the neuroscience of aging as well as trauma, there's evidence from a number of studies that people who have experienced trauma earlier in their lives are at elevated risk of developing conditions that may lead to cognitive impairment or dementia.

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Later-life experiences such as bereavement, serious illness, increasing physical limitations and elder abuse that resemble or symbolize past traumas can also trigger a sudden onset of PTSD or similar symptoms.¹⁰ Elders who were abused as children and never received help to process those traumatic experiences may be especially vulnerable to developing or re-experiencing PTSD and related symptoms decades later.¹¹ For one 67-year-old woman, her own unresolved traumas stemming from sexual abuse as a child and later spousal abuse were evoked by the sexual assault and emotional breakdown of her adult daughter.¹²

Elder abuse, or merely an event experienced as abusive, can be the prompt. A 70-year-old terminally ill indigenous man was hospitalized for a lung infection, and his treatment required the administration of an enema. When two male hospital aids roughly grabbed and turned him, it triggered what medical staff thought was a seizure but was actually a flashback. At the age of five, the Canadian government took him from his family and placed in a settlement school where he endured physical, psychological and sexual abuse for years.

Pervasive and structurally sanctioned poverty, racism, misogyny, homophobia and other oppressions can have a cumulative effect as well, yet are rarely discussed as traumatic and potentially debilitating experiences, on their own or in combination with abuse.¹³ Moreover, a growing body of evidence suggests that a history of traumatic and stressful life experiences not only compromises well-being later in life but also places people at greater risk of abuse.¹⁴

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When asked where she grew up, one 73-year-old African American woman said she came to New York City “in my mama’s womb,” then explained her mother had been smuggled out of town and sent north “with only the clothes on her back” after the lynching of a relative. When an older gay man was seriously abused by his much younger partner, a life lived in fear of being discovered and harshly judged by his devout Baptist family and others prolonged the abuse and compounded the trauma. “We’re only now

understanding intersectionality, but when survivors present, they bring all of it,” says Cecile Noel, MSW, commissioner of the New York City Mayor’s Office to End Domestic and Gender-Based Violence.

Nancy Needell, MD, a professor of clinical psychiatry at Weill Cornell Medicine, emphasizes that it’s not uncommon to discover a history of linked traumatic experiences in working with survivors of elder abuse. But it can be challenging to discover that history. Deborah Holt-Knight, MS, built a career in adult protective services. Even after years of working in supervisory and policymaking positions she still thinks about the perplexing behavior of her most memorable client, Ms. B., and what she herself didn’t understand about trauma as an APS caseworker: “Was Ms. B’s reclusive behavior and refusal of medical care, even after slamming her finger in an incinerator, a result of trauma? Was trauma the reason she would only talk with me in the hallway, not inside her apartment?”

Colleen Jackson cautions that, in general, older adults are less likely than younger people to report or acknowledge the role and impact of trauma in their lives, even if those experiences are significant or long-lasting. Underreporting complicates efforts to measure prevalence and provide appropriate care. More nuanced research, including efforts to reach marginalized elders, as well as longitudinal studies, are needed to better understand trauma and its consequences over the lifespan, and how to identify and engage older adults experiencing trauma.

Much like younger people, an elder’s capacity to recover from inherently painful and destabilizing experiences depends in large part of the quality of care and support the person receives.¹⁵ It’s never too late to help someone heal, and that’s true at any age. The next section of this report addresses fundamental aspects of providing trauma-informed care to older survivors of abuse and highlights some promising practices in this nascent field.

THE AGING BRAIN

S. Duke Han, PhD, ABPP-CN, studies the neuroscience of aging at University of Southern California’s Keck School of Medicine. His research reveals physiological changes in the human brain that occur as people age, changes that affect how we process information, what information we retain and even how we express ourselves. Understanding normal age-related shifts in cognition as well as more extreme disease-related declines provides an important baseline of knowledge for professionals working with survivors of elder abuse.

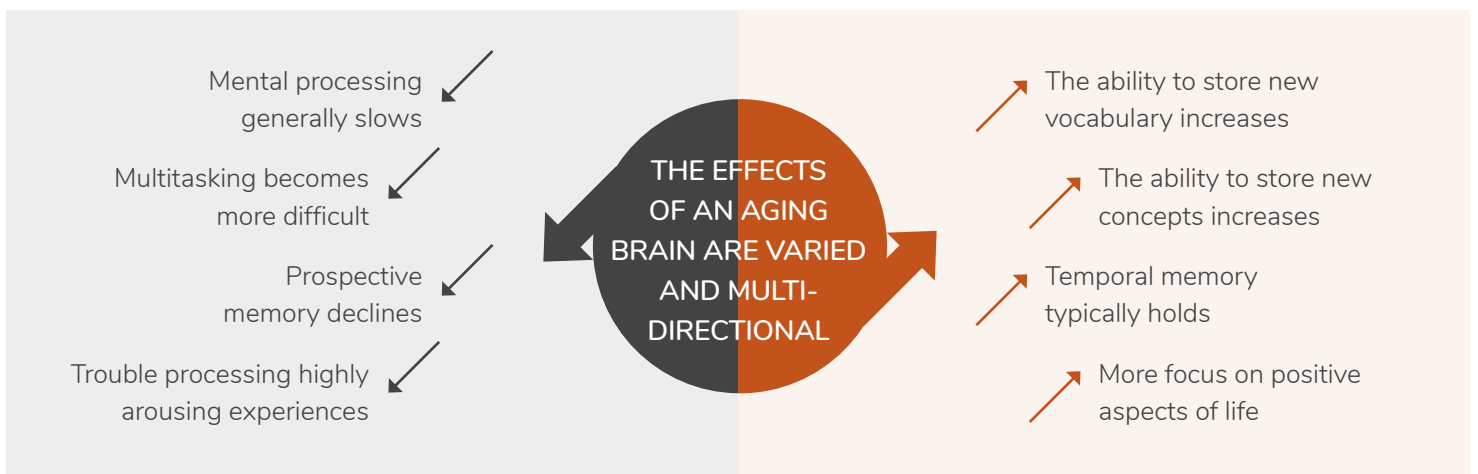
Far from a simple decline in cognition across the board, the effects of an aging brain are varied and multidirectional, according to Han. While mental processing generally slows and multitasking becomes more difficult, the ability to store new vocabulary and concepts actually increases, giving credence to the phrase, “with age comes wisdom.” Changes in memory are similarly varied: some functions decline and while others hold strong. Prospective memory (e.g., remembering to take daily medication) declines as does delayed free recall (e.g., remembering what you need when you arrive at the grocery store). On the other hand, the ability to accurately recall the timing or sequence of past events, known as temporal memory, typically holds, as does recognition.

While an older person at the grocery store is less likely to be able to recall what items are needed, a written list will spark a memory of what to replenish. If the list no longer makes sense, that could be a sign of accelerated changes in the brain that are the hallmark of dementia. To offer a starker example: forgetting where you put your car keys is normal; holding the

keys in your hand but not understanding why you have them and what they’re used for is not normal. The more stable aspects of memory have important implications for identifying and responding to elder abuse. In the absence of advanced dementia, one can and should trust the recollections of older adults, although trauma itself can make it difficult for people to recall painful events.

The brain’s processing of emotions also changes as we age. According to Han, older people tend to focus more on positive aspects of life, a dynamic coined “the positivity effect.” On the other hand, an emerging body of research suggests that elders have trouble processing highly arousing experiences, something that can be called “the intensity effect,” which coupled with slower mental processing overall can make it more difficult for older adults to make sound decisions under pressure. Han and others have pointed to these normative age-related cognitive changes as one reason older people can be more vulnerable to financial exploitation, the most common form of elder abuse nationwide. The state of hyperarousal commonly associated with trauma can further impede decision-making, although Han and others haven’t studied this dynamic specifically.

Of course, all of these age-related changes in cognition vary in degree from person to person: two 75-year-olds are unlikely to have the same mental acuity and memory. And Han admits his field has been slow to rigorously examine the interaction between trauma and the aging brain.



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A Revolution in Care for Elder Abuse Victims: Creating Organizational, Systemic and Cultural Change to Support Trauma- Responsive Practice

EDUCATION AND TRAINING
PROFESSIONAL PRACTICE
RESEARCH
POLICY STRATEGY

Introduction

The following recommendations emerged from the October 2018 symposium "Advancing Trauma-Informed Responses in Elder Abuse." Collectively, they suggest how to improve the elder justice field's work in the largely unexplored area of trauma and pose questions we should be asking ourselves along the way. The recommendations are clustered in four areas: education and training, professional practice, research and policy strategy, mirroring the structure of the symposium itself.

Far from being mutually exclusive, these four realms heavily influence one another. Research leads to improvements in practice, and when we know what works, we can train professionals more effectively and argue more persuasively

for policies and funding to support good practice. But the feedback loop also winds in the opposite direction: conscious changes in policy, and when necessary with accompanied funding, help create environments in which good practices are encouraged and supported. Even small-scale experimental shifts in practice often reveal key questions for future research, just as investments in training and education can lead to breakthrough discoveries by maverick practitioners whose first introduction to elder abuse and the concept of trauma-informed care may have occurred in a university classroom. The ultimate goal is to change older people's lives and futures, so that no one is defined and limited by the traumatic experience of abuse.

Education and Training

To universalize trauma-informed care requires training people who currently serve older adults, energizing and equipping emerging professionals and raising public awareness, because people won't support what they don't know and care about. Bonnie Brandl, MSW, founder and head of the National Clearinghouse on Abuse in Later Life, recently conducted a limited environmental scan, looking for professional education and training specifically on providing trauma-informed care to older victims of abuse. She found very little, leading her to conclude, "We have a long way to go in terms of incorporating teaching and training on trauma-informed care."

The elder justice field needs centers of training and excellence to educate and equip the current workforce. Also important, according to Brandl, is working with allied fields and centers, such

as the National Resource Center for Reaching Victims, which focuses on underserved crime victims, including older adults, and the National Center on Domestic Violence, Trauma and Mental Health. To prepare emerging professions, schools of social work, medicine, law and other relevant professions need to incorporate fundamental principles of trauma-informed care into their curricula, to be accompanied by parallel shifts in professional licensing standards. These and other priorities are reflected in the recommendations immediately below. At first glance, they may appear overly ambitious—can we really provide at least basic trauma training to everyone?—but the world is changing fast. As of November 2019, nursing homes nationally that receive Medicaid reimbursement are required to provide trauma-informed care.

1. Expand the know-how of today's professionals.

At least basic training on trauma-informed care should be provided to (and required of) any professional who routinely serves or is likely to encounter an older survivor of abuse. In other words, mandatory training must encompass elder abuse professionals *per se* and far beyond, to include, for example, all domestic violence service providers and all first responders. The following are some practical ways to deliver basic education and training:

- a. Develop a concise, easy-to-use guide that explains trauma and its manifestations among older adults and describes simple steps to support them—and conversely, what to be aware of to avoid retraumatizing people. This generic guide should be accessible and relevant across professions.
- b. Create a short video (e.g., five minutes) covering the basics of providing trauma-informed care to older adults.
- c. Develop webinars on the various dimensions of this topic and archive those.
- d. Work with relevant licensing bodies (e.g., social work, medicine, law) to integrate and require basic training on providing trauma-informed care to older adults as

part of mandatory continuing education for relevant professionals.

- e. Create and hold a national conference, perhaps annually, specifically on trauma-informed care, making sure the voices of older adults are heard. Also make use of existing professional conferences as key venues for education and training, as well as opportunities for cross-disciplinary discussion and learning, on how to take a trauma-informed approach to older victims of abuse.
- f. Develop more intensive model training programs as well as mentoring and apprenticeships in trauma-informed care for older victims with investment by government and foundations.
- g. To be most effective, training at any level should always include use of first-person narratives by older survivors of abuse, similar case studies and/or role playing.

2. Educate the next generation of professionals.

Improving practice in the long run depends on changing what and how we teach students across disciplines, e.g., medicine, nursing, physical therapy, social work, law, criminal justice and public health about elder abuse and trauma. Currently, many students emerge from professional and para-professional schools without any awareness

of or training in elder abuse and trauma-informed strategies to serving older victims.

As accrediting bodies, the American Medical Association, Council on Social Work Education, American Bar Association and Council on Education for Public Health are among the crucial intermediaries in changing the landscape of professional education. Leading experts in trauma-informed care for older adults—perhaps even a council of such experts—should partner with these accrediting bodies and perhaps also their state-based counterparts to advocate for expanded educational offerings and parallel changes in both graduation requirements and state licensing exams (see also #3 below).

To be most effective, courses or course modules should offer Continuing Education Units and include case studies and first-person narratives by older adults about their abuse, its traumatic aftereffects and how the services they received either helped or hurt, and why. Also important, clinical supervision and other on-the-job training should help students apply the trauma-informed perspectives and practices they learned in school.

A second wave of work in this regard should involve promoting and supporting the development of trauma-informed care for older adults as a sub-specialty within medicine, nursing, physical therapy, social

work, law and public health. The creation of loan-forgiveness programs would encourage students to specialize and begin their careers with a focus on providing trauma-informed care to older victims of abuse.

3. Raise professional standards.

Following recommendations #1 and #2 above, health care, social work, legal professionals and others whose work is subject to approval by public or private boards and other entities should be required to demonstrate mastery of basic perspectives and practices in regard to providing trauma-informed care to older victims of abuse in order to obtain and maintain a professional license.

4. Seek to change organizational culture and leadership, not just individual practitioners.

People reflect the culture of the organization in which they work, so supporting organizations to operate from a trauma-informed perspective is just as important as training for individual practitioners. This is a nascent area of work that requires an investment of energy, creativity, and funding. As noted in the Promising Practice described on page 33, the Sanctuary Model suggests what's possible in this regard.

5. Make the public more aware of elder abuse as a traumatic experience with lingering consequences.

While elder abuse is no longer in the shadows, most Americans still don't understand how damaging it can be. In particular, the trauma that remains even after the abuse has ended is not at all well understood. Reaching elders in need, helping them to heal, changing systems and marshalling the resources required depends on expanding and deepening public understanding of the problem itself. Concrete ways to make progress against this goal include:

- a. Mount a national public awareness campaign and/or create messaging and visual assets to support state and local campaigns. Seek to integrate information about trauma-informed care into existing large-scale public awareness efforts, such as World Elder Abuse Awareness Day.
- b. Develop highly accessible informational materials and friendly workshops specifically for family members and family caregivers held in settings ranging from yoga centers, to public libraries, to medical clinics.
- c. Develop a K-12 curriculum to introduce young people to the dynamics of abuse and trauma in later life and what to do if they know an elder who seems in need of help. First seek to understand what curricula other fields have developed for each of these educational levels and aim to build on those.

Professional Practice

Those directly responsible for helping elders heal need to take up and spread the best strategies and interventions known today while seeking to break new ground. It's time to get specific in our practice and to formalize the sharing of information through the creation of a virtual

national resource center and other mechanisms. The following recommendations, if implemented, would move us much closer to mainstreaming the practice of providing care that's trauma-informed to older victims of abuse.

1. Get specific by identifying, promoting and integrating concrete strategies and best practices known to work or that appear promising.

These range from assessment protocols and tools that should be widely used and promising team-based approaches such as HEART (Holistic Elder Abuse Response Team), to therapeutic strategies such as life-writing and simple steps that combat the tendency to dehumanize elderly people with dementia.²² Breaking new ground is equally important. There's great potential and yet still much to be learned by incorporating spiritual practices that resonate with elders, tapping the power of life writing and other

creative interventions to help older people process traumatic experiences, and using restorative justice practices as a path to healing, for example. Draw on the expertise of professionals using trauma-informed responses with specific older populations, notably Holocaust survivors and elder veterans.

2. Embed information about trauma-informed care into professional forums designed to share information and best practices.

This work would begin with a thorough survey of existing forums and opportunities therein.

3. Consider creating a virtual national resource center specifically on trauma-informed responses to older victims of abuse.

Such a center could curate listservs, host conferences, convene roundtables of experts, provide updated referrals and publish insights. Such a center could be paired with the development of a national network of professionals providing trauma-informed care to older victims of abuse.

4. Develop protocols to guide the provision of trauma-informed care in various settings.

Conferences or roundtables could be held specifically to develop these protocols.

5. Tap the potential of widely read publications to raise awareness and convey key insights and lessons.

Professionals with experience in providing trauma-informed care to older victims of abuse or conducting related research should take the lead in submitting or suggesting individual articles as well as curating special editions of professional journals (e.g., *Journal of Elder Abuse and Neglect*).

6. Go beyond elder abuse specialists to reach ancillary professionals, refining their approach to older clients, modifying the physical environment where services are provided and ultimately changing the organizational culture.

Over time, the goal is to fashion trauma-informed clinics and hospitals, law offices and court houses, social services agencies and senior centers—creating institutions that are not only more responsive to trauma experience by their older clients but also to vicarious trauma that staff experience. The Sanctuary Model offers a compelling example of what's possible. Establishing a consulting entity, or corps of approved consultants, with national reach would spur progress toward this goal.

7. Support professionals doing this work, as well as family, friends and neighbors assisting elder abuse victims.

Addressing vicarious trauma and compassion fatigue among all those on the front lines of assisting elder abuse victims is essential.

Research

There's more to learn about trauma in the lives of older adults, especially when abuse is part of the picture. Only by expanding our knowledge base can practitioners operate from an informed perspective, understanding trauma and its manifestations over the lifespan and the most effective interventions as supported by data and other evidence about what works. The field especially lacks knowledge about the interplay between the aging brain and trauma and how to work effectively with cognitively impaired adults in the wake of abuse.

According to Kathy Greenlee, JD, former assistant secretary for aging at the U.S. Department of Health and Human Services, the federal government is in a position to fund much of this research, if compelled to make it a priority. A broader and deeper body of evidence and accompanying metrics are also needed to persuasively advocate for the policies and accompanied funding required to mainstream a trauma-informed approach to elder abuse. With these goals in mind, the following recommendations outline a research agenda.

1. Begin to pinpoint which trauma-informed techniques and interventions work best with older victims.

Focused studies that demonstrate and evaluate particular interventions as well as studies that advance knowledge more broadly are needed. Key research questions:

- a. What are the most effective ways to identify older adults coping with trauma and encourage and support them to talk about their experiences as a step toward healing?
- b. How can trauma-informed practices commonly used with younger victims (i.e., in cases of child abuse and earlier-life domestic violence) be adapted to meet the needs of elderly victims? Studies

should identify current practice in this regard and its effectiveness and point to additional promising practices.

- c. What are the most effective modifications of solution-focused therapy and cognitive-behavioral therapy for older victims?
- d. What are the best ways to address depression, anxiety and PTSD among older victims of abuse?
- e. Which interventions overall lead to the best short- and long-term outcomes? Do the results differ when comparing outcomes in cases of financial exploitation as opposed to cases of violent abuse?
- f. Do older clients who are more satisfied with the trauma-informed care they receive make more use of these services and have better outcomes?
- g. Are trauma-informed techniques and interventions more or less time-intensive than traditional victim services?

2. Discover what promotes resilience and, conversely, how to avoid retraumatizing victims.

Key research questions:

- a. What practices harness an older victim's internal strengths?
- b. What community resources promote resilience among older victims of abuse?

- c. What other protective factors help older adults recover from trauma?
- d. Conversely, what common practices in hospitals, nursing homes and other environments unwittingly retraumatize older victims, and how can they be avoided?
- e. Why and how do mandatory reporting laws sometimes undermine efforts to provide care and services that promote recovery as opposed to retraumatizing older people?

3. Define success and figure out how to measure it.

What should we track and measure in terms of impact and outcomes in order to know whether trauma-informed interventions are actually helping older victims of abuse?

4. Better understand the relationship between trauma and the aging brain.

Much is known about trauma generally but much less about how it affects older adults, especially those with diminished cognition.

Key research questions:

- a. How does advanced age affect how someone processes a traumatic experience?

- b. Do people with cognitive impairments process abuse by a trusted person differently from how they make sense of being hurt by a stranger?
 - c. What types of trauma-informed interventions are most effective with older victims who are cognitively impaired? Does providing “trauma-informed care” to someone with diminished cognition require adjusting what we do and how we define “resilience” and other successful outcomes? In particular, what’s the safest way to share potentially traumatizing information about the person’s own abuse when that victim is cognitively impaired?
 - d. To what extent do symptoms of PTSD overlap with those of dementia, making accurate diagnosis of each more difficult? In particular, how does PTSD affect decision-making in an adult with impaired cognition?
 - e. There’s some indication that traumatic experience can accelerate the onset of dementia or exacerbate symptoms. Further research is needed, including study of whether trauma-informed care, including effective treatment for PTSD, might help alleviate dementia. Conversely, are there aspects PTSD—dissociative states in particular—that are protective to someone who is cognitively impaired and coping with a traumatic experience? If so, what are the implications for practice?
 - f. Does trauma have an epigenetic effect, activating genes that underlie certain types of dementia or other disorders that manifest later in life?
5. Go beyond anecdotes to map the connections between early life trauma and elder abuse.
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- Key research questions:
- a. What is the prevalence of earlier-life trauma among elder abuse victims?
 - b. Are particular types of trauma earlier in life correlated with particular types of elder abuse?
 - c. How do past traumas shape the experience of and response to abuse in later life?
 - d. What is the cumulative effect of experiencing trauma over a lifetime?
 - e. What is the connection, if any, between experiencing abuse earlier in life and perpetrating elder abuse?
6. Study differences, in particular, the role of culture and race.
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- Key research questions:
- a. How do older adults of different races and from different cultural backgrounds understand abuse and the resulting

trauma? How may trauma manifest differently in their lives?

- b. How does the experience of discrimination and oppression throughout one's life influence the experience of PTSD and other manifestations of trauma that are the result of elder abuse?
- c. With regard to particular trauma-informed interventions, do responses and outcomes differ based on the victim's race?

7. Understand and address vicarious trauma among professionals who work with older victims.

We need to better understand what triggers vicarious trauma, how it affects people's work and lives beyond the job, and what types of support are most effective in preventing and addressing vicarious trauma.

8. Make greater use of mixed-methods research studies.

In particular, use qualitative methods to identify both risk and protective factors and outcomes underexplored in the literature to date.

Policy Strategy

Moving beyond ad hoc good practice toward a widespread, systems-based revolution in how we respond to older victims of abuse won't happen in the absence of targeted efforts to change policy and funding priorities. While there are numerous specific changes in policy required—some of which are captured in previous recommendations related to education and training, practice and research—the following recommendations highlight promising strategies

for affecting policy change. They range from uniting powerful coalitions to advance a unified policy agenda to ensuring the voices and perspectives of elders themselves shape policy discussions. Money is of course a big part of the discussion. Experienced government officials emphasize the need to show that trauma-informed interventions are cost-effective, especially compared with the status quo.

1. Push for systemic change.

Changing the status quo to deliver culturally competent, client-centered and trauma-informed services to every older victim of abuse requires policy changes at all levels—from individually run nonprofit organizations and companies that serve older adults, to licensing bodies that set professional standards, up through federal government agencies. Elder justice coalitions at the local, state and national level and allied

advocates should craft targeted policy agendas and action plans that encompass recommendations in this report.

It will take a shift in policy, for example, to prioritize programs that build individual and communitywide resilience in the wake of elder abuse and that make our hospitals, nursing homes and court systems more aware of and responsive to trauma so that they evolve into more humane and effective institutions.

2. Mine the voices and perspectives of those directly affected.

Often the people with the most political influence are those who speak from firsthand experience. Older survivors of abuse and their family members have a significant role to play in both shaping and advocating for better policies.

3. Seize natural opportunities.

For example, current focus at the national level on both PTSD and, separately, Alzheimer's disease provides in-roads to advocate for trauma-informed responses to older victims of abuse.

4. Follow the money to generate persuasive arguments based on the cost of elder abuse.

Elder abuse is understood to be costly, yet the field still lacks an economic model that encompasses all of the costs over time—from repeated hospital visits and unforeseen nursing home care, to the expense of Adult Protective Services and court cases, to the drain on family bank accounts and more. While this kind of modeling is fundamentally a research challenge, the results will be

highly influential in the realm of public policy: quantifying the cost of elder abuse is part of convincing people to invest in trauma-informed care and other interventions that stem abuse, help people heal and lead to outcomes that are less expensive for everyone.

5. Marshall public and private funds.

Although change can sometimes occur in the absence of dedicated or additional funding, fully realizing the recommendations in this report in ways that improve the landscape of elder care nationally depends on marshalling or redirecting public and private dollars. As organizations adjust their policies to promote and require a trauma-informed response to older victims of abuse, parallel shifts in resource allocation are essential. Leadership by national and state entities that fund services, training and education, research and policy development is critical:

- a. To significantly deepen understanding of trauma in older adults and the healing process—and develop more effective responses—the National Institutes of Health, Centers for Disease Control, Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration should revise their research priorities

- and associated funding to support the research recommendations listed above.
- b. Supporting a trauma-informed response to elder abuse requires expanding the range of services that qualify for reimbursement under Medicare and Medicaid. The Centers for Medicare and Medicaid Services and state Medicaid agencies should revise reimbursement formulas to fully support crisis intervention; intensive mental health services; off-site and home-based services, including telemedicine and telebehavioral health, which are urgently needed in rural communities; and other features of an effective trauma-informed response to elder abuse.
 - c. Increased federal and state funding for Adult Protective Services is needed to support enhanced training for caseworkers; facilitate reductions in caseloads at or below a newly established maximum that allows for more thorough assessments and responses to trauma in older victims of abuse; and expand the availability of emergency safe housing.
 - d. States and localities should become pioneers in developing cutting-edge training and education programs for practitioners that serve older adults and in testing new service models. The federal government can support this work by opening up new funding channels.
 - e. The private sector also has a role to play in advancing both knowledge and

practice. While foundation and other funding streams are a fraction of the money government typically has at its disposal, private entities can be more nimble in carving out new funding priorities.

6. Expand the discussion to encompass people who cause harm, many of whom are in need of trauma-informed care themselves because of past abuse and/or mental illness.

Establishing a cross-disciplinary working group would be a good way to advance knowledge and practice in this area.

Involving individuals with direct experience and wisdom—perhaps as a result of having a family member who has been abusive—would provide perspectives often missing from such discussions.

7. Streamline the advocacy process.

Create a network of organizations in the elder justice field to advance a policy agenda that supports a trauma-informed response to elder abuse.

Care that's trauma-responsive recognizes the symptoms of trauma, acknowledges the role that trauma has and continues to play in someone's life and makes use of strategies known to be effective in working with traumatized people.



WORKING WITH OLDER VICTIMS IN DISTRESS

Care that's trauma-responsive recognizes the symptoms of trauma, acknowledges the role that trauma has and continues to play in someone's life and makes use of strategies known to be effective in working with traumatized people. Trauma-informed care is the backdrop, a guiding framework, for any number of specific interventions that serve the whole person and promote healing.

When Janet, a 68-year-old woman weakened by chemotherapy and reliant on an oxygen tank enters a rehabilitation facility, a social worker uses a screening tool to look for signs of abuse—and the results are concerning. Through a series of subsequent conversations, Janet discloses that her husband threatens to cut off her oxygen if she questions his spending choices. Janet also tells the social worker that 25 years ago she received a large monetary settlement when her young son was killed in a hit-and-run accident.

The abuse Janet experiences at the hands of her husband is wound up with the most traumatic event in her life. The thought of taking legal action against him and ending up in yet another courtroom is very upsetting to her initially. It takes several meetings with a skilled and patient attorney and in the company of the trusted social worker for Janet to forge a plan that feels right to her. This is what a trauma-informed approach to elder abuse looks like in one woman's life.

GETTING STARTED: TIPS FOR PRACTITIONERS NEW TO TRAUMA-INFORMED CARE

BE CLIENT-CENTERED

Value the person's voice, perspectives and wishes in every aspect of care.

COMMIT TO SAFETY

Create an environment and approach to providing care that feels safe to the individual you're serving.

DON'T PATHOLOGIZE PEOPLE

Concentrate on the three e's—events, experiences and effects—as a way to focus on what has happened to the person as opposed to what is wrong with the person.

SEEK TO DISCOVER AND UNDERSTAND THE WHOLE PERSON

Discuss traumatic events in the context of a person's entire life, with equal attention to positive experiences and personal strengths and achievements.

TALK LESS, LISTEN MORE AND DON'T RUSH

Make space for open-ended conversation and nonverbal expression (e.g., art, dance, yoga, etc.)

EMPOWER PEOPLE

Look for any opportunity to give people a sense of control and mastery over their lives while avoiding actions that reconfirm the victim's feelings of helplessness.

As a baseline, professionals need the knowledge and tools to identify signs of possible elder abuse—as the social worker in Janet's case relied on a screening tool—and they need to understand the characteristic ways that trauma is triggered and expressed in older adults, as discussed in the first section of this paper. In terms of intervening, it's important not to pathologize the person who is suffering, and in line with this approach, experts point to the three "E"s—events, experiences and effects—as a way to focus on what has happened to the person and the consequences as opposed to seeing something inherently wrong with the person.¹⁶ According to psychologist JoAnn Difede, PhD, this framework represents a real departure. "Twenty years ago, we weren't even taught to ask people about past traumas because events were not considered to be important in a psychodynamic framework."

Information should be elicited in a respectful and supportive way, always giving the client control over the process and framing painful events within the person's life more broadly, a life that almost always includes positive

experiences and personal strengths and achievements.¹⁷ In other words, trauma-informed care flows from getting to know a person and his or her history before raising pointed questions about abuse—precisely what the social worker did with Janet. Even in the hands of a caring and skilled practitioner, it's a difficult process. Once traumatic events are revealed and shared, a person may experience new or more extreme emotional, cognitive and physical symptoms. Practitioners across disciplines need a repertoire of interventions that diminish anxiety while helping people gain a sense of equilibrium.¹⁸

Trauma-informed care flows from getting to know a person and his or her history before raising pointed questions about abuse.

Although providing trauma-informed care in the context of elder abuse is a relatively new area of practice, there's a lot to learn from the field of trauma studies generally. In her seminal piece "Trauma Theory Abbreviated," Sandra Bloom, MD, offers some very practical guidance for practitioners rooted in a nuanced understanding of the physical, emotional and cognitive dynamics that underlying trauma.¹⁹ First and foremost, according to her, safety is essential—and not just objective safety. The physical environment and other conditions under which practitioners provide care and services must feel safe to the person. For some people, a room that is too quiet feels ominous, while for others, noise is terrifying, for example.

A sense of safety is required to counteract the cumulative effects of chronic stress, which is a by-product of our built-in fight, flight or freeze response to danger that when activated affects the whole body. As Bloom explains: "The change in every area of basic function is so dramatic that in many ways, we are not the same people when we are terrified as when we are calm. Each

episode of danger connects to every other episode of danger in our minds, so that the more danger we are exposed to, the more sensitive we are to danger.” People who are traumatized “tend to stay irritable, jumpy, and on-edge. Instead of being able to adjust their ‘volume control’ the person is reduced to only an ‘on or off’ switch,” Bloom writes. As a result, even a truly unthreatening stimulus—a closed door, the whirl of an air conditioner, the smell of cleaning fluid, etc.—can trigger an out-of-proportion response. This is why genuine healing can only occur in an environment that feels safe.

★ PROMISING PRACTICE ★

PROTECT: PROVIDING OPTIONS TO ELDERLY CLIENTS TOGETHER

Depression, anxiety and other mental health issues, which can be both a cause and an effect of elder abuse, make it even more difficult for people to take steps to protect themselves and begin to heal. In New York City, the Department for the Aging and the Mayor’s Office to End Domestic and Gender-Based Violence partner with the Weill Cornell Institute of Geriatric Psychiatry to identify elder abuse victims and provide trauma-informed mental health care. Through a series of typically eight sessions, therapists work collaboratively with older victims to help them understand the wide-ranging consequences of the abuse they’ve experienced, encourage and support them to make positive choices and to follow through on their plans.



According to Jo Anne Sirey, PhD, a professor of psychiatry at Weill Cornell Medicine involved in the development and initial testing of PROTECT, a third of elder abuse survivors in New York City meet clinical criteria for depression, and little more than half meet the criteria for PTSD. This relatively brief intervention is associated with reductions in depression and social isolation and increased safety. Overall, older victims helped through PROTECT felt their needs were recognized and met and that they emerged from therapy better able to cope with past traumas and confront life challenges. This evidence of success led to the citywide expansion of PROTECT in January 2019.

OF ELDER ABUSE SURVIVORS IN NEW YORK CITY

One-third meet clinical criteria for

A little more than half meet clinical criteria for



The sidekick to chronic stress is learned helplessness, because in most traumatic situations—and in nearly all cases of abuse—the victim is unable to fight and prevail or flee, and is in fact helpless. “As a species we cannot tolerate helplessness,” Bloom writes. “It goes against our instinct for survival.” In this context, healing is facilitated by conditions that give people a sense of control and mastery over their lives. Even small successes in this regard are meaningful. In this same vein, practitioners should avoid actions that might address an immediate problem but are experienced as coercive, reconfirming that feeling of helplessness.

“The change in every area of basic function is so dramatic that in many ways, we are not the same people when we are terrified as when we are calm. Each episode of danger connects to every other episode of danger in our minds, so that the more danger we are exposed to, the more sensitive we are to danger.”

Because traumatic experiences are stored in the brain as sensations and feelings, rather than as words, Bloom explains, people don’t remember them in the way they remember other events in their lives. “Without words, the traumatic past is experienced as being in the ever present ‘Now.’” A traumatized person is not remembering an awful experience; the person is reliving it. For this reason, people need abundant opportunities to talk about their lives overall and express their feelings, following their own lead, not in response to structured questions.

★ PROMISING PRACTICE ★

CREATING SANCTUARY: COMBINING CARE FOR OTHERS WITH SELF-CARE

Nearly 40 years ago, the now-well-known trauma expert and psychiatrist Sandra Bloom joined with a social worker and a nurse to create an acute care psychiatric unit in a hospital near Philadelphia. Within just a few years, they and the other treatment providers came to three realizations. First, most of the people they were treating for schizophrenia, bipolar disorder and other serious mental illness had survived overwhelmingly stressful and often traumatic experiences, usually beginning in childhood. Second, by focusing narrowly on their illness, healthcare providers were unwittingly marginalizing people who already felt cast out of society. And third, patients did better when the treatment providers were doing well themselves and working well together, which they often weren't because the work environment was stressful. These insights formed the basis of the Sanctuary Model, which links care for others with self-care. New York-based trauma expert Sarah Yanosy, LCSW, helped create the Sanctuary Institute that has seeded programs worldwide.

The Sanctuary Model has a particular perspective on trauma. Can you briefly explain it?

SY: The Sanctuary movement is designed to counter the deeply engrained notion here in the United States that people should just pull themselves up by their bootstraps, and when they can't, blaming them for their weaknesses, failures and inability to cope under adversity. In the wake of a discreet traumatic event or under chronic stress, some people are more resilient than others for reasons that are largely beyond their control. The study of adverse childhood experiences (ACEs) confirms this theory: a score of four or more makes someone much more vulnerable to subsequent trauma and less able to cope. A person's current life conditions and circumstances, including the work environment, also affects resilience.

What is life like for people who are less able to cope with adversity?

SY: Basically, they're in a state of high alert. Anxious, subject to extreme thoughts, unable to think clearly or take constructive action. They may over respond or under respond to circumstances, compared with someone who has stronger

coping skills. We call it "back braining." When you understand this, it changes how you respond to people in crisis, how you run organizations, even what it takes to create and sustain community.

What are the implications for professionals in the role of caring for people in crisis?

SY: First of all, we have to remember that trauma is pervasive in our society, and professional caregivers are not immune. Individuals and whole organizations can end up back braining. People freeze up, get angry and wait for someone else to "fix" the problem. Or they put blinkers on and focus on their own small role and work. This is what happens when our organizations and systems are trauma-reactive instead of trauma-informed: Clients feel unsafe and act aggressively. Staff feel unsafe and respond harshly. The organizational culture itself becomes unsafe, punitive and stuck. People need to understand these dynamics, and I'm talking about everyone, from the receptionist to kitchen staff. Of course, clinical staff need a much deeper understanding.

What's the pathway to creating Sanctuary?

SY: With both individuals and organizations, the goal is to help people gain perspective and connect with their values. No one wants to feel out of control, ineffective and isolated. Creating sanctuary involves committing to create and maintain a truly safe environment for everyone. It means valuing emotional intelligence, being open and honest, making space for each person's voice and perspective, believing people and organizations can change and then nurturing growth, and understanding that we're responsible to one another and will rise or fall together. We have a toolkit that explains why these and other commitments are important and how to put them into practice.

Parting thoughts?

SY: For understandable reasons, organizations and systems often replicate the very experiences that are proven to be toxic to the people they are supposed to be helping, but it doesn't have to be that way.

Open-ended, supported dialogue can also occur in small groups, such as a reminiscence circle. Whatever the format, it only works in an environment that feels safe and in the company of trusted others. “Warmth and affection are how we enter health and wellness,” notes Myra Sabir, PhD. Roughly 15 years ago, Sabir, whose areas of expertise are human development and family studies, began using a structured form of written reminiscence called “Life Writing” to promote healing. Jo Anne Sirey, PhD, a professor in the department of psychiatry at Weill Cornell Medicine, believes that writing about any personally and emotionally meaningful experience is as effective as writing about traumatic experiences. While conversation and writing can be useful therapeutic strategies, some people are more inclined to express themselves nonverbally, at least initially, making it important to incorporate creative arts therapies into trauma-informed care.

Creating the conditions for positive experience
is perhaps the most important aspect of
trauma-informed care.

“People who have been traumatized cannot heal themselves alone,” Bloom concludes. But by “creating sanctuary,” her term for a process in which people feel both safe and understood by others, they can make their way “down the long road of understanding—and changing—themselves.” Sherry Hamby, PhD, studies resilience. According to her, both trauma and resilience are more common than most people realize. Furthermore, while resilience used to be understood as a steady state, like many other individual attributes, it’s now understood as a process that involves drawing on internal assets and external resources to cope in the face of adversity.

Hamby underscores that most people want to thrive, not merely survive. Both she and Sirey say that elders are not less capable of thriving, from a

★ PROMISING PRACTICE ★

READY TO GO!

For many older victims, going to court is a necessary step on the road to safety, recovery and justice. Yet court itself can be stressful and anxiety-producing, emotions that compromise a person's ability to effectively participate in the legal process and slow healing. At the Weinberg Center for Elder Justice, clients and attorneys prepare for court together, in part by assembling a self-care kit unique to each

person. An individual's GO BAG holds items correlated with the five senses that provide an effective personal defense. An aromatic hand lotion, a silk scarf associated with a happy time in the person's life, a river stone, a stress-relief mint. Equipped with soothing things such as these, elders arrive in court more centered and optimistic, and they have more strength and resilience throughout the process.

psychological standpoint, than younger adults. They are, however, less likely to seek and receive social support, which makes reaching out to them crucial. The key take-away according to Hamby: creating the conditions for positive experience is perhaps the most important aspect of trauma-informed care. It could be gardening or volunteer work, mindfulness meditation, a walk in the woods—something the Japanese call “forest bathing”—or a workout at the gym. It could be religious or spiritual pursuits or political activism. What works best depends on the person's inclinations, interests and needs.

The notion of creating sanctuary can sound like a big lift, but practice suggests it's a series of small yet considered interventions and consolations. The right sensory object, for example, can be calming and with repeated use help someone feel more in control of their emotions and life. For one older victim of abuse, a jar of lavender lotion soothed her nervous system and sparked memories of happier times. Self-soothing techniques like the butterfly hug, also known as monkey tapping, have a similar effect and are always available to a person.

Monkey tapping is a technique associated with Eye Movement Desensitization and Reprocessing, more commonly known as EMDR. Developed more than 30 years ago specifically to alleviate distress associated with traumatic memories, EMDR-trained therapists instruct people to recall an aspect of what haunts them in brief, intense doses while also focusing on an external stimulus. The original EMDR technique involved moving one's eyes from side

to side, tracking the therapist's hand. Today, this technique and other forms of bilateral tapping are also commonly used.²⁰ Sarah Barnard, LCSW, MFS, a social worker formerly with the Holistic Elder Abuse Response Team (HEART) in Long Beach, California, reports using EMDR successfully with her clients as part of an array of linked interventions—hence use of the word holistic in HEART.

Nimali Jayasinghe, PhD, has studied falls and post-fall anxiety as a form of trauma among the elderly. In one study, 27 percent of elders who had fallen showed symptoms of PTSD when screened during their hospital stay. In another preliminary study, community-dwelling patients received either a mix of graded exposure plus other cognitive-behavioral therapy techniques, known as enhanced CBT, or relaxation training. The results suggested that relaxation may be just as effective in diminishing anxiety and related symptoms as enhanced CBT in this patient population, although larger-scale studies are needed to clarify the findings.

Providing trauma-informed care to elderly people with severely limited physical or cognitive capacity presents additional challenges.

Providing trauma-informed care to elderly people with severely limited physical or cognitive capacity presents additional challenges. Practitioners may need to speak slower or more simply, or rely more on sensory interventions.

Ann Wyatt, MSW, works to promote innovative, holistic palliative care programs for people with advanced dementia. According to her, caregivers become accustomed to elders crying out or acting oddly and attribute it to dementia. "But it's almost never the dementia," she says. "They are usually communicating something. We just don't take the time to figure it out." Wyatt described a nursing home client who didn't like to sleep in her bed and didn't

like to be touched. She'd sleep on the floor or in her wheel chair. Eventually, the staff made a bed for her in the nursing station, which is where she spent the last two weeks of her life—comfort provided far too late. The staff later learned she had suffered family-related trauma for years.

Limited verbal communication is not the only potential barrier to care. Clinical psychologist Irit Felsen, PhD, explores why all people, caregivers included, might unconsciously dehumanize and distance themselves from the very old and infirm. Our brains, Felsen explains, don't recognize all people as equally human, and so we're quick to categorize elders who are not fully cognizant and or severely infirm as less human. Disgust, an inbred emotional response that humans once relied on for survival, also plays a role. The bottom line: when care professionals see someone as less human or feel disgust in the person's presence, they literally step back and thus provide a lower quality of care.

Becoming aware of and "owning" these natural responses, instead of denying them out of shame or fear of judgment, is the first step to overcoming them, Felsen says. When caregivers recognize and are invited to talk about such feelings, they can begin to moderate how they respond. Brain studies show that people can rehumanize someone by thinking about what that person liked, what she once did, whom she loved—re-animating the person, at least in the clinician's mind. Felsen gave an example of a significantly incapacitated nursing home resident, appearing as little more than a body in a bed. Family hung a beloved photograph of her husband as a young man above the bed. The image of the handsome young man who had loved this woman made the staff view her as a full person.

It's tempting to think of trauma-informed care as highly specialized, limited to expert therapists—and the elder justice field does need many more expert clinicians. At the same time, anyone who works with older adults, especially victims of abuse, should understand the fundamentals of trauma and adapt their services accordingly. Malya Levin, Esq., an attorney at the Weinberg Center, has learned that what might otherwise be a straightforward discussion about advanced healthcare directives or a person's will, for example, can touch on painful and confusing family relationships in a way that can retraumatize

★ PROMISING PRACTICE ★

BEYOND PUNISHMENT TOWARD HEALING FOR ALL

Many perpetrators of elder abuse are survivors of abuse themselves, assuming a power someone else once held over them, often to avoid feeling helpless.²³ Many people who abuse elders, like Sheila's adult son Manny, are living with a mental illness or other condition that is itself traumatizing and shapes their emotions and behaviors for the worse.

Sheila was 51 and living alone when a stroke left her reliant on a wheelchair, with limited use of her hands and difficulty speaking, reading and writing. With nowhere else to turn for help, she moved in with her 83-year-old mother Evelyn whose own health is compromised and finances limited. But Evelyn has the advantage of secure, affordable housing in an otherwise expensive city. That apartment should be a place of respite for mother and daughter who are a comfort to one another, but instead they live in fear of Manny who shows up whenever he needs money or a place to stay. Manny's demands quickly escalate into threats—including to set the apartment on fire, knowing the women literally can't run—and sometimes culminate in physical violence.

It's easy to see only Manny's harmful behavior and not Manny himself—a dynamic that has shaped Manny's whole life. Without the resources and savvy to advocate for her son, Sheila watched helplessly as Manny failed his way through a school system that saw his symptoms—probably related to autism spectrum disorder—as bad behavior. Because socializing was difficult for him, as a teenager he started drinking to fit in and feel at ease. Now in his late 20s, he's addicted to opioids and has an extensive criminal record.

On one occasion when Sheila and Evelyn don't have money to hand over, Manny flies into a rage, frustrated by a lifetime of feeling out of step with those around him. Sheila looks at him from her wheelchair, afraid and also flooded with guilt and pain. "Family violence is terrifying and complex; the brain and

the heart struggle when the person harming you has access to your home, is part of your history and in many cases is someone you love who is clearly struggling him or herself," writes Joy Solomon, Esq., Director and Managing Attorney of the Weinberg Center for Elder Justice, by way of describing this case and so many others.²⁴

Emergency shelter is often essential to protecting victims in the short-term and serves as a gateway to lasting safety—yet is rarely available.²⁵ Sheila and Evelyn were fortunate; they found refuge at the Weinberg Center. The women, who arrived with no belongings, are greeted by members of the Weinberg team who offer handmade blankets and a warm embrace. It's the beginning of providing a full complement of trauma-informed services that includes placing the women in a room together, despite their very different health care needs, precisely to avoid traumatizing them further.

And what about Manny? The police arrested him; he pled guilty to harassment, only adding to his criminal record; and a judge issued an order of protection. But those responses don't address his underlying trauma and may not protect Sheila and Evelyn in the long term. Moreover, punishment is not primarily what they want for their son and grandson.

Cecile Noel, MSW, understands these dynamics. As commissioner of the New York City Mayor's Office to End Domestic and Gender-Based Violence, she believes in deferring to what victims need and want, in ways that address the root causes of abuse. The repertoire of interventions needs to stretch way beyond urging victims to leave and locking up abusers. Noel also recognizes that, like Manny, many perpetrators are or were victims themselves. The language in the office she runs is "people who cause harm," as opposed to "abusers"—a framework associated with restorative justice.

★ PROMISING PRACTICE (CONT'D) ★

When addressing a harm, the legal system begins by asking three questions:

- × What law was broken?
- × Who broke it?
- × What punishment is deserved?

In contrast, restorative or reparative processes seek to answer the following questions:

- Who was harmed?
- What do they need and want?
- Who's responsible for the harm, and what support does that person need to make things as right as possible?²⁶

These sets of questions center around very different goals. The legal system's goal is to uphold the law, while the goals of restorative justice are direct accountability and healing.

Nothing can ever justify elder abuse, but the dynamics of intrafamilial violence, especially when there's trauma on all sides, call for more creative and empathetic interventions than the legal system alone can provide—interventions that might actually keep elders safer while opening a door to recovery that everyone can walk through. Efforts to tailor restorative justice for use in cases of elder abuse and rigorously evaluate the outcomes should be a priority.

the client. To be helpful rather than harmful, Levin brings a social worker with her whenever she talks with a survivor of abuse and knows to be patient.

Veronica LoFaso, MS, MD, a geriatrician at Weill Cornell Medicine and medical director for NYCEAC believes physicians have an “obligation” to provide care that's trauma informed. Yet few doctors and nurses working in primary care and geriatrics are trained to recognize even common mental health symptoms among older people, much less post-traumatic symptoms and reactions.²¹ Their lack of knowledge means that PTSD in the elderly is often misdiagnosed as schizophrenia, alcoholism, antisocial personality disorder or depression. The root causes of chronic pain or sleep disturbance, for example, go unexplored. Even professionals who work specifically with survivors of elder abuse often lack training in trauma-informed care. “We need to get this message out to the national workforce,” LoFaso emphasizes.

When training does take place—and hopefully there will be much more of it in the future—Alessandra Scalmati, MD, PhD, a geriatric psychiatrist and specialist in trauma-informed care, emphasizes the need to rigorously

evaluate the results: “It’s not enough to know that the audience learned something. It’s not enough that they liked our teaching method. We need to know that we made an impact on practice and patient care.” Scalmati, who has trained physicians, uses the well-known Kirkpatrick Pyramid to illustrate this point. She also believes training itself should promote understanding and collaboration across disciplines.

The potential for mainstreaming trauma-informed care is significantly hampered by the sheer lack of therapeutic and case management services for older adults, including victims of abuse.

The potential for mainstreaming trauma-informed care is significantly hampered by the gaps in therapeutic and case management services for older adults, including victims of abuse. And that work “takes time, even when people have the training,” according to Donna Corrado, PhD, MSW, former commissioner of the New York City Department for the Aging. “We need to reduce caseloads, get more caseworkers in senior centers, and provide more and better supervision of those caseworkers.”

The “fundamental problem from the standpoint of elder abuse,” according to Michael Friedman, LMSW, who has worked in the mental health field for more than 40 years, “is the way mental health care is conceived of and delivered—by appointment in provider offices, usually one session per week and for a limited period, a mismatch with what victims need. Victims of abuse who are in crisis need an immediate response delivered wherever is safe and convenient for them. They need sympathetic interactions that promote safety.” Mental health regulations and funding mechanisms, according to Friedman, need to change to make this possible.

★ PROMISING PRACTICE ★

A TEAM APPROACH TO TRAUMA-INFORMED CARE

Integrating trauma-informed care into the world of enhanced multidisciplinary teams (E-MDTs) is virtually uncharted terrain, even among experienced organizations such as Weill Cornell Medicine's NYC Elder Abuse Center (NYCEAC) that have been facilitating teams and working on complex cases of elder abuse for years. The gap in expertise and how to fill it was a subject of discussion at the October 2018 symposium. With hiring expert staff considered to be too expensive for most organizations and sending existing staff out for training too diffuse and slow, one symposium participant recommended organizations work with trauma experts on a consulting basis. NYCEAC Executive Director Risa Breckman, LCSW, took up that suggestion, and in her view, "it has provided an immediate and affordable way forward for us to improve how the E-MDTs we run respond to the actual trauma people are experiencing."

With funding from the New York City Department for the Aging, NYCEAC contracted with the Crime Victims Treatment Center, a New York City-based nonprofit committed to helping people heal from crime, to provide technical assistance over several months. The consultant is training all NYCEAC's E-MDT staff in the fundamentals of trauma and trauma-informed care, coaching staff to better capture information about trauma at intake as the basis for providing care that's trauma-informed, and working specifically with the E-MDT coordinators to teach them how to frame case discussions and action plans through the lens of trauma. Beyond NYCEAC staff, the consultant is also providing basic training to all E-MDT representatives—a diverse array of professionals—and working in particular with geriatric psychiatrists to help them approach individual cases and team discussions from a trauma-informed perspective.

There's also a vast shortage of geriatric psychiatrists nationwide, according to Friedman. They provide an essential specialty, since older people respond differently to drugs commonly prescribed to treat depression, anxiety, sleep disorders and other mental illnesses and are often taking other types of medications that change the effects of these drugs. The shortage is partly the result of low Medicare reimbursement levels.

It's important to underscore that notwithstanding the promising practices described in the preceding pages, even experts are just beginning to understand what is most effective in reaching and helping the many traumatized elders nationally. Commitment with the resources to match is needed to test and refine promising practices in the context of multidisciplinary teams (MDTs), elder shelters and other communitywide responses to elder abuse while also pursuing new ideas and interventions.

CONCLUSION

The narrative sections of this report capture insights from a relatively new and highly interdisciplinary field of study and practice: trauma-informed care for older victims of abuse. The report draws heavily on presentations and discussions that took place during the daylong symposium in October 2018, "Advancing Trauma-Informed Responses in Elder Abuse," and articles distributed there. That gathering was designed specifically to generate recommendations for advancing the field and was not intended to be an exhaustive review of what is known about trauma in later life. The limited research findings, clinical insights and strategies, and even specific practices and programs mentioned in this document are offered primarily as background and context for the recommendations that appear on pages 12–26. It's those concrete, actionable recommendations that are the heart of this report and represent a better future for older victims of abuse.

ACKNOWLEDGEMENTS

The NYC Elder Abuse Center and The Weinberg Center for Elder Justice acknowledge the many professionals listed below who contributed to the Symposium's success and collectively developed the recommendations at the core of this report. We also thank our colleagues who gave their time and talents: Raphaëlle Chassagne, Cara Kenien, Allison Lasky, Anthony Palillo, Nathalie Perez and Maya Sebastian.

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Symposium Participants

| | | |
|---------------------|---|---|
| Robert C. Abrams | Weill Cornell Medicine/NYC Elder Abuse Center | Professor of Psychiatry |
| Sarah Barnard | WISE & Healthy Aging | Manager, Elder Abuse Prevention Program |
| Lisa Bednarz | NewYork-Presbyterian Hospital | Manager, Care Coordination & Social Work |
| Roni Berger | Adelphi University | Professor |
| Jackie Berman | NYC Department for the Aging | Deputy Assistant Commissioner, Research |
| Liciele Blunte | NYS Office of Children & Family Services | Adult Services Specialist |
| Misty Boldt | Lifespan of Greater Rochester | Social Worker |
| Bonnie Brandl | National Clearinghouse on Abuse in Later Life (NCALL) | Director |
| Risa Breckman | Weill Cornell Medicine/NYC Elder Abuse Center | Executive Director |
| Kayla Chan | Womankind | Manager, Later in Life Program |
| Raphaëlle Chassagne | Weill Cornell Medicine/NYC Elder Abuse Center | MDT Administrative Assistant |
| Andrea Cianfrani | LiveOn NY | Director of Public Policy |
| Flora Colao | Private Practice | Psychotherapist and Consultant |
| Donna Corrado | NYC Department for the Aging | Commissioner |
| Cathy Cramer | Legal Information for Families Today | CEO |
| Maureen Curtis | Safe Horizon | Vice President, Criminal Justice Programs |

| | | |
|---------------------|--|---|
| Hilary Dalin | Administration for Community Living | Director, Office of Elder Justice and Adult Protective Services |
| Kathy Davidson | NYS Office of Victim Services | Crime Victim Specialist III |
| Juanita Davis | National Clearinghouse on Abuse in Later Life (NCALL) | Program Manager |
| Patricia Dawson | NYC Human Resources Administration | Director of Supportive and Senior Housing |
| JoAnn Difede | Weill Cornell Medicine | Professor of Psychology in Psychiatry |
| Sarah Duval | Center for Elder Law and Justice | Supervising Attorney |
| Irit Felsen | Irit Felsen, LLC | Clinical Psychologist |
| Robin Fenley | NYC Department for the Aging | Assistant Commissioner |
| Michael Friedman | Columbia School of Social Work, Geriatric Mental Health Alliance | Adjunct Professor, Voluntary Chair |
| Michelle Galligan | Carter Burden Network | Program Director |
| Leigh Goulbourne | Weill Cornell Medicine/NYC Elder Abuse Center | MDT Program Specialist |
| Kathy Greenlee | Greenlee Global, LLC | Principal |
| Sherry Hamby | Life Paths Appalachian Research Center | Director, Research Professor |
| Duke Han | University of Southern California | Associate Professor of Family Medicine |
| Susan Herman | NYC Police Department | Deputy Commissioner |
| Deborah Holt-Knight | HRA NYC Adult Protective Services | Deputy Commissioner |
| Peg Horan | Weill Cornell Medicine/NYC Elder Abuse Center | Senior Program Coordinator |
| Laura Ivkovich | DOJ Office for Victims of Crime | Policy Analyst |
| Colleen Jackson | VA Boston Healthcare System | Clinical Neuropsychologist |
| Nimali Jayasinghe | Private Practice | Clinical Psychologist |
| Khi-Lynn Johnson | Weill Cornell Medicine/NYC Elder Abuse Center | E-MDT Coordinator |
| Tovah Kasdin | ElderSAFE Center | Director |
| Phillip Kim | Weill Cornell Medicine/NYC Elder Abuse Center | E-MDT Program Specialist |
| Amanda Lebron | The Weinberg Center for Elder Justice | Case Coordinator |
| Malya Levin | The Weinberg Center for Elder Justice | Senior Staff Attorney |
| Veronica LoFaso | Weill Cornell Medicine/NYC Elder Abuse Center | Associate Professor of Clinical Medicine |
| Deirdre Lok | The Weinberg Center for Elder Justice | Assistant Director and General Counsel |
| Leslie Mantrone | Weill Cornell Medicine/NYC Elder Abuse Center | Helpline Service Specialist |
| Arlene Markarian | Nassau County District Attorney's Office | Chief, Elder Abuse Unit |
| Katherine Martinez | Neighborhood SHOPP | President/CEO |
| Nancy Needell | Weill Cornell Medicine | Assistant Professor of Clinical Psychiatry |
| Cecile Noel | Mayor's Office to End Domestic and Gender-Based Violence | Commissioner |

| | | |
|---------------------|---|--|
| Nikki Odzivak | Community Agency for Senior Citizens, Inc.(CASC) | President/CEO |
| Glendalee Olivera | The Weinberg Center for Elder Justice | Senior Elder Justice Specialist |
| Nathalie Perez | Weill Cornell Medicine/NYC Elder Abuse Center | Program Assistant |
| Carla Perissinotto | University of California San Francisco | Associate Professor in the Division of Geriatrics |
| Beverly Pincus | CHE Behavioral Health Services | Psychologist |
| Martha Pollack | JASA | Manhattan District Director |
| Lisa Rachmuth | Weill Cornell Medicine/NYC Elder Abuse Center | Deputy Director |
| Valerie Radu | City of Chattanooga | Executive Director, Family Justice Center |
| Daniel Reingold | The Hebrew Home at Riverdale | President & Chief Executive Officer |
| Marlene Riquelme | The Weinberg Center for Elder Justice | Public Health Specialist |
| Myra Sabir | Binghamton University | Associate Dean/Associate Professor |
| Aurora Salamone | NYC Department for the Aging | Director, ECVRC |
| Alessandra Scalmati | Montefiore Medical Center | Associate Director, Division of Geriatric Psychiatry |
| Deena Schwartz | Weill Cornell Medicine/NYC Elder Abuse Center | E-MDT Coordinator |
| Kasey Sinha | Weill Cornell Medicine/NYC Elder Abuse Center | E-MDT Program Specialist |
| Jo Anne Sirey | Weill Cornell Medicine | Professor |
| Judith Smith | Fordham University | Associate Professor |
| Joy Solomon | The Weinberg Center for Elder Justice | Director & Managing Attorney |
| Audrey Stone | New York State Office of Court Administration | Chief Counsel, Family Violence Case |
| Teresa Theophano | SAGE | Assistant Director of Care Management Services |
| Jennifer Trone | Independent Consultant | |
| Cheryl Udell | New York State Office for the Aging | Long Term Care Systems Specialist 2 |
| Julio Urbina | The Fan Fox and Leslie R. Samuels Foundation | Vice President, Director, Healthy Aging |
| Lauren Weisenfeld | The Fan Fox and Leslie R. Samuels Foundation | Deputy Director, Healthy Aging Program |
| Bess White | Weill Cornell Medicine/NYC Elder Abuse Center | Operations Liaison |
| Ann Wyatt | CaringKind | Manager of Palliative & Residential Care |
| Jean Wynne | Weill Cornell Medicine | Counselor |
| Sarah Yanosy | Fordham University Graduate School of Social Work | Adjunct Professor |

Symposium Program p.1

Advancing Trauma-Informed Responses to Elder Abuse: PRACTICE, RESEARCH, EDUCATION AND POLICY

Thursday, October 18, 2018 • 8:00 AM - 5:00 PM

WELCOME & BREAKFAST

8:00 AM

WELCOMING REMARKS

8:30 AM

Risa Breckman, LCSW, Director, NYC Elder Abuse Center at Weill Cornell Medicine, Division of Geriatrics and Palliative Medicine, NYC.
Joy Solomon, Esq., Director and Managing Attorney, The Harry and Jeanette Weinberg Center for Elder Justice at the Hebrew Home at Riverdale, NYC.

MORNING PROGRAM

8:40 AM - 12:40 PM

A COMPLEX CASE OF ELDER ABUSE

Nancy J. Needell, MD, Assistant Professor of Clinical Psychiatry, Weill Cornell Medicine, NYC.

NEUROSCIENCE OF AGING

Duke Han, PhD, ABPP-CN, Director of Neuropsychology in Family Medicine and Associate Professor of Family Medicine, Neurology, Psychology, and Gerontology, Keck School of Medicine, University of Southern California, CA.

NEUROSCIENCE OF TRAUMA

Colleen Jackson, PhD, ABPP-CN, Clinical Neuropsychologist, VA Boston Healthcare System; Assistant Professor of Psychiatry, Boston University School of Medicine, MA.

ORGANIZATIONAL STRESS AND TRAUMA-INFORMED CARE FOR ELDERLY

Sarah Yanosy, LCSW, Trauma Specialist and Founding Director, Sanctuary Institute; Adjunct Professor, School of Social Work, Fordham University, NYC.

PRACTICE PANEL

11:20 AM - 12:00 PM

MODERATOR

Deborah Holt-Knight, MS, Deputy Commissioner, NYC Adult Protective Services, NYC.

PANELISTS

Irit Felsen, PhD, Clinical Psychologist in private practice, NJ; Adjunct Professor of Psychology, Ferkauf Graduate School of Psychology, Yeshiva University, Bronx, NY.

Presentation Title: *Less Human: Unintentional Dehumanization in the Care of Elderly Patients*

Sarah Barnard, LCSW, MFS, Manager, Elder Abuse Prevention Program, WISE & Healthy Aging, CA.

Presentation Title: *An Intervention with HEART*

Ann Wyatt, MSW, Consultant, Palliative & Residential Care, CaringKind, The Heart of Alzheimer's Caregiving, NYC.

Presentation Title: *How Trauma Can Affect the Person with Dementia*

LUNCH

12:00 - 12:40 PM

Symposium Program p.2

AFTERNOON PROGRAM**12:45 - 5:00 PM****USING LIFE-WRITING TO HEAL TRAUMA****12:45 - 1:15 PM****Myra Sabir, PhD**, Associate Dean, College of Community & Public Affairs, Binghamton University, NY.**PRACTICE RECOMMENDATIONS****1:20 - 1:40 PM****RESEARCH PANEL AND RECOMMENDATIONS****1:45 - 2:45 PM**

MODERATOR

JoAnn Difede, PhD, Professor of Psychology in Psychiatry, Department of Psychiatry Weill Cornell Medical College; Director, Program of Anxiety and Traumatic Stress Studies and Military Family Wellness Center at NY Presbyterian-Weill Cornell, NYC.

PANELISTS

Sherry Hamby, PhD, Director, Life Paths Appalachian Research Center; Research Professor, University of the South, TN.
Presentation Title: *The Importance of Strengths to the Resilience of Older Adult Victims***Nimali Jayasinghe, PhD**, Clinical Assistant Professor of Psychology in Psychiatry (Volunteer Faculty), Weill Cornell Medicine, NYC.
Presentation Title: *What Can Be Learned from a Trauma-Informed Approach to Falls Anxiety?***Jo Anne Sirey, PhD**, Professor, Department of Psychiatry, Weill Cornell Medicine, NYC.
Presentation Title: *Improving Mental Health Among Elder Abuse Victims***EDUCATION PANEL AND RECOMMENDATIONS****2:50 - 3:40 PM**

MODERATOR

Veronica LoFaso, MS, MD, Associate Professor of Clinical Medicine, Weill Cornell Medicine, NYC; Medical Director, NYC Elder Abuse Center, NYC.

PANELISTS

Bonnie Brandl, MSW, Founder and Director of the National Clearinghouse on Abuse in Later Life (NCALL), WI.
Presentation Title: *Educating Elder Abuse Professionals on Trauma-Informed Approaches: Where We Are and Possible Next Steps***Alessandra Scalmati, MD, PhD**, Associate Professor and Associate Director of the Division of Geriatric Psychiatry, Department of Psychiatry and Behavioral Sciences, Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, NY.
Presentation Title: *What's Different about Geriatric-Trauma Education?***POLICY PANEL AND RECOMMENDATIONS****3:45 - 4:45 PM**

MODERATOR

Michael B. Friedman, LMSW, Chair, Geriatric Mental Health Alliance, NY.

PANELISTS

Donna Corrado, Ph.D., MSW, Commissioner, New York City Department for the Aging, NYC.**Cecile Noel, MSW**, Commissioner, Mayor's Office to End Domestic and Gender-Based Violence, NYC.
Presentation Title: *Intimate Partner Violence and Trauma: Lessons Learned***Kathy Greenlee, JD**, CEO, Greenlee Global LLC; Adjunct Professor, University of Missouri-Kansas City School of Law, MO.**CLOSING REMARKS****4:45 - 5:00 PM**

- 1 Joan M. Cook and Casey O'Donnell, "Assessment and Psychological Treatment of Posttraumatic Stress Disorder in Older Adults," *Journal of Geriatric Psychiatry and Neurology*, 18, no. 2 (June, 2005), 61-71, <https://doi.org/10.1177/0891988705276052>.
- 2 With the exception of sources cited in endnotes and case examples provided by the authors of this report, all other information provided comes from expert presentations made during the October 18, 2019, Symposium.
- 3 "Trauma Theory Abbreviated," originally published in Pennsylvania Attorney General Mike Fisher's Family Violence Task Force, *Final Action Plan: A Coordinated Community Response to Family Violence*, ed. Sandra L. Bloom (Harrisburg, PA: Pennsylvania Office of the Attorney General, 1999), accessible at <http://sanctuaryweb.com/Portals/0/Bloom%20Pubs/1999%20Bloom%20Trauma%20Theory%20Abbreviated.pdf>. Dr. Bloom was not present at the October 18th Symposium, but her work influenced the conversations.
- 4 Leann K. Lapp, Catherine Agbokou and Florian Ferreri, "PTSD in the Elderly: The Interaction Between Trauma and Aging," *International Psychogeriatrics*, 23, no. 6 (March, 2011), 858-868, doi: 10.1017/S1041610211000366.
- 5 For information about the CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study, visit <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html>.
- 6 Lapp, Agbokou and Ferreri, "PTSD in the Elderly."
- 7 Ibid.
- 8 Ibid. See also Roberta Graziano, "Trauma and Aging," ch. 1 in *Journal of Gerontological Social Work*, 40, no. 4 (October, 2008), 3-21, http://dx.doi.org/10.1300/J083v40n04_02.
- 9 Lapp, Agbokou and Ferreri, "PTSD in the Elderly."
- 10 Graziano, "Trauma and Aging." See also Lapp, Agbokou and Ferreri, "PTSD in the Elderly."
- 11 Graziano, "Trauma and Aging."
- 12 Ibid.
- 13 Ibid.
- 14 Joy Swanson Ernst and Tina Maschi, "Trauma-informed Care and Elder Abuse: A Synergistic Alliance," *Journal of Elder Abuse and Neglect* (August, 2018), <https://doi.org/10.1080/08946566.2018.1510353>.
- 15 Graziano, "Trauma and Aging"; and Lapp, Agbokou and Ferreri, "PTSD in the Elderly."
- 16 Swanson and Maschi, "Trauma-informed Care and Elder Abuse."
- 17 Graziano, "Trauma and Aging."
- 18 Graziano, "Trauma and Aging."
- 19 "Trauma Theory Abbreviated."
- 20 See EMDR Institute at emdr.com.
- 21 Graziano, "Trauma and Aging."
- 22 The Holistic Elder Abuse Response Team is a project of WISE and Healthy Aging serving older adults in Los Angeles County, www.wiseandhealthyaging.org.
- 23 "Trauma Theory Abbreviated."
- 24 Joy Solomon, Opening Remarks, Annual Awards of Distinction Breakfast, Weinberg Center for Elder Justice (New York, NY, May 15, 2019).
- 25 Jennifer Trone, *Shelter: The Missing Link In a Coordinated Community Response to Elder Abuse* (Riverdale, NY: Weinberg Center for Elder Justice, 2019).
- 26 Howard Zehr, *The Little Book of Restorative Justice* (New York: Skyhorse Publishing, 2015).

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