Smith ScholarWorks

Theses, Dissertations, and Projects

2010

The power of relationships : long-term outcomes for older adults with a history of interpersonal trauma : a project based upon an independent investigation

Miriam Lasden Elwell
Smith College

Follow this and additional works at: https://scholarworks.smith.edu/theses

Part of the Social and Behavioral Sciences Commons

Miriam Elwell
The Power of Relationships:
Long-term Outcomes for
Older Adults with a History
of Interpersonal Trauma

ABSTRACT

The research question of this theoretical thesis was to examine the manifestation

of prior trauma in the older adult population. Previous research focused mainly on

interpersonal trauma theory. The literature on elders who were survivors of childhood

interpersonal trauma was minimal. The experiences of older adults who have a history of

interpersonal trauma were further examined through attachment theory and Relational-

cultural theory. Attachment theory speaks to the difficultly of a child exposed to

prolonged interpersonal trauma to develop an adaptive method to regulate affect and seek

help from others when distressed. These experiences later influence the relational

capabilities of the older adult. Relational-cultural theory (RCT) speaks to the relational

isolation and shame that survivors of trauma may experience. RCT states that bringing

survivors of trauma into growth fostering connections will promote healing. Implications

for psychotherapy interventions are further discussed combining the ideas from trauma

theory, attachment theory, and Relational-cultural theory.

THE POWER OF RELATIONSHIPS:

LONG-TERM OUTCOMES FOR OLDER ADULTS WITH A HISTORY OF

INTERPERSONAL TRAUMA

A project based upon an independent investigation,
submitted in partial fulfillment of the
requirements for the degree of Master of Social Work.

Miriam Elwell
Smith College School for Social Work
Northampton, Massachusetts 01063
2010

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

Negative reactions to childhood traumas can persist throughout an individual's lifetime, but there is a lack of research about how trauma specifically manifests during the later years of life. Both relational cultural and attachment theory postulate that social support may mediate the reactions to trauma in two different ways. Social support, such as a partner, relative, or friend, can prevent some of the negative reactions to trauma experiences (Cutrona & Russell, 1990). Also, the positive effect of psychotherapy with survivors exemplifies how a strong interpersonal connection can heal the wounds left by trauma.

Attachment theory and relational cultural theory, although created during different generations of psychological thought, both suggest that social support does play a positive role in later life adjustment. Attachment theory focuses on the importance of relationships and its effect on the development of regulation from a young age. If an individual did not make secure attachments with caregivers as a child, attachments later in adulthood may be able to strengthen the person's ability to relate to the world and therefore improve their overall ability to adjust to the surrounding environment. Relational cultural theory extends this concept into a treatment method move clients out of isolation and into growth-fostering relationships in their community. Through the therapeutic relationship, traumatized clients can explore their relational patterns and strive to form healthy and mutually empathic relationships that may help heal the scars of previous trauma experiences.

This theory of the positive role of social support can be further extended to trauma survivors, where social support may aid a person positively before and after the traumatic experience. Those with secure, healthy relationships in their lives may not experience as severe of a negative trauma response compared to those who are isolated. During the later years of life, when social support may change with the death of partners, family, or friends, individuals with a history of trauma may start to see more trauma reaction symptoms. The large population of baby boomers who are becoming tomorrow's elderly community, will require additional support from clinicians to cope with their prior trauma experiences and make social connections in their community.

The research question for this paper will examine is how prior interpersonal traumatization will manifest in the elderly population. The previous literature on interpersonal trauma, attachment theory, and Relational-cultural theory will be critiqued and analyzed in the context of the research question.

CHAPTER 2

TRAUMA

Trauma vs. PTSD

When defining trauma it is important to distinguish it from the DSM-IV-TR diagnosis of

posttraumatic stress disorder (PTSD) (APA, 2000). Individuals who experience similar traumatic events

may have different responses. Trauma can be defined in many ways. The DSM defines a traumatic event

when "the person experienced, witnessed, or was confronted with an event or events that involved actual

or threatened death or serious injury, or a threat to the physical integrity of self or others" (APA, 2000).

The variety of responses to a traumatic event may depend on a number of factors, which will be

discussed later in this chapter. While some individuals will develop symptomatology that meets the

criteria for PTSD, other responses to the trauma vary but may still have significant negative effects on

the person (Breslau, 1998). After a traumatic event, most people experience some symptomatology

related to the event, such as recurrent memories, which can be an adaptive response (van der Kolk,

1996). Other people find themselves experiencing hyper arousal and avoidant behavior related to the

trauma and when they start to organize their life around the trauma is when the PTSD diagnosis starts to

manifest as a psychiatric disorder (van der Kolk, 1996).

PTSD, as a diagnosis in the DSM-IV-TR, has changed the way clinicians and researchers

understand and work with clients who have been traumatized. "The development of posttraumatic stress

disorder (PTSD) as a diagnosis has created an organized framework for understanding how people's

biology, conceptions of the world, and personalities are inextricably intertwined and shaped by

experience," (van der Kolk & McFarlane, 1996, p. 4). Before the introduction of this diagnosis, clients with exposure to trauma would carry various diagnoses (such as depression or anxiety) related to the symptoms they experienced. The study of trauma and PTSD has resulted in a better understanding of trauma symptoms and effective treatments. By targeting the trauma symptoms, clinicians are better able resolve psychiatric symptoms that were previously, before advanced knowledge of trauma, treated as independent issues. Having a better understanding of the cause of such psychiatric symptoms also has improved the treatment of trauma reactions.

The DSM-IV-TR organizes PTSD symptoms into three categories: re-experiencing, hyperarousal and avoidance and numbing. Some of the *re-experiencing* symptoms include: distressing memories, images, and dreams; acting or feeling as if the events were recurring; and intense psychological distress and physiological reactivity to internal or external cues that are reminders of the event. The intrusive re-experiencing of the trauma in memory is often referred to as flashbacks (APA, 2000). Some clients find these flashbacks disorganizing as well as emotionally intense (Allen, 2001). Traumatic memories are generally a reconstruction of a subjective process rather than an actual reproduction of the event (Brewin & Andrews, 1998). The appearance of past trauma in nightmares occurs more often in a metaphorical interpretation than a literal depiction of the trauma events (Hartmann, 1998).

Hyperarousal can be seen in PTSD as well as other anxiety disorders. Examples of *hyperarousal* include: irritability or outbursts of anger, difficulty concentrating, hypervigilance, sleep disturbance, and exaggerated startle response (APA, 2000). Grillon and Morgan (1999) found an elevated fear-startle response in individuals with PTSD. This type of symptom causes persons diagnosed with PTSD to startle strongly when are frightened. These conditioned

responses occur quickly, before the mind has a chance to prevent these reactions (Grillon & Morgan, 1999).

Avoidance and numbing are placed in the same category in the DSM-IV-TR. *Avoidance* refers to efforts to avoid thoughts, feelings, or conversations associated with the trauma, and efforts to avoid activities, places, or people that arouse recollections of the trauma (APA, 2000). *Numbing* criteria include: detachment or estrangement from others, restricted range of affect, markedly diminished interest or participation in significant activities. Both numbing and avoidance hinder the trauma resolution process (Horowitz, 1997). These symptoms can be recognized as a defense mechanism for coping with traumatic experiences.

Foa, Zinbarg, and Rothbaum (1992) found that the core elements of how clients define trauma involves the aspects of lack of control and unpredictability. These authors note that clients find that losing control is one of the most difficult parts of experiencing trauma. There are many types of traumatic events and countless types of responses to these events, some of which are adaptive and others that are maladaptive. There are fairly impersonal traumas such as natural disasters (floods, fires, hurricanes, earthquakes, volcanoes, and tornadoes). However, this paper will focus on the long-term effects of interpersonal trauma.

Interpersonal Trauma

For the purpose of this paper, interpersonal trauma will be defined as a trauma that occurs in the context of a relationship. Examples of interpersonal traumas are physical abuse, sexual abuse, psychological abuse, complex abuse, witnessing violence, and neglect. This type of trauma is best examined on a spectrum, including violations by people inside and outside close intimate relationships. The abuser may be someone the client had known for a short time period, or someone they have known their whole life (Allen, 2001).

This paper will also focus on what Adam, Sheldon, Keller, and West (1995) define as *attachment trauma*. This type of trauma occurs specifically in an attachment relationship, where the purpose is to provide a safe environment and soothing in the event of distress. Later chapters will present the organization of attachment and demonstrate how violations in these relationships can undermine the goal of attachment, which is to feel secure.

Prolonged Interpersonal Trauma

Kessler, Sonnega, Bromet, Hughes, & Nelson (1995) were some of the first researchers to find that childhood abuse is the most frequent trauma perpetrated against women. Trauma of an interpersonal nature that begins at an early age and endures for a long period of time has been shown to produce psychological symptoms that are not entirely explained by the PTSD diagnosis. Some of these negative outcomes include: characterological difficulties, somatization, dissociative states, aggression against self and others, and lack of control over affect regulation (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Judith Herman (1992) introduced the term *complex posttraumatic stress disorder* as a new way to examine 'prolonged, repeated' trauma exposure. Herman describes the need for a new concept beyond PTSD, as "an essential step toward granting those who have endured prolonged exploitation a measure of the recognition they deserve" (Herman, 1992, p.122). She breaks down the diagnostic criteria into seven sections: 1) history of subjection to totalitarian control over a prolonged period, 2) alterations to affect regulation, 3) in consciousness 4) in self-perception 5) perception of the perpetrator, 6) relations with others and 7) systems of meaning. This set of criteria emphasizes the relational changes, such as avoidance and withdrawal from social situations that were not formally discussed in the DSM-IV-TR criteria for PTSD. This change in thinking about PSTD is necessary because clients in the mental health community are

often people who have a history of abuse. Those in the community who have been victims of trauma may find it difficult to elicit help from others due to the shaming and isolating effect trauma has on individuals.

Long-term outcomes of Trauma

The long-term effects of traumatic events can vary depending on the developmental stage and environment of the person exposed, among other factors. This paper will take a biopsychosocial approach to examine how trauma affects victims biologically, psychologically, and socially. This paper will also attempt to explain how psychological trauma can affect a victim on so many levels, which later explains why treatment is such a complex process due to the biological, psychological, and social areas needing healing.

Biologically, clients may experience changes in their physical health as well as neurobiological make-up. "Early interpersonal trauma in the form of emotional and physical abuse, sexual abuse, and neglect shape the structure of the brain in ways that negatively affect all stages of social, emotional, and intellectual development," (Cozolino, 2006, pp. 230). This quote speaks to the overwhelming neurobiological effect interpersonal trauma has on a developing child. Cozolino describes that parts of the brain, such as the cerebral cortex, corpus callosum, and hippocampus develop abnormally. The cause of these abnormalities is partly due to the stress of the abuse, but also caused by the lack of stimulation and regulation by the caregiver, which is required for proper brain development. As far as physical health, a gastrointestinal practice found a high (44%) prevalence of patients with functional gastrointestinal disorder had sexual and physical abuse histories (Drossman, Leserman, Nachman, Li, Gluck, Toomey, & Mitchell, 1990).

Psychologically, clients with adverse trauma reactions may experience difficulties with affect and arousal regulation; decline in self-worth; self-destructive behaviors; and dissociation. Clinicians have found that trauma affects the perceived self-worth of individuals with trauma exposure. Allen, Coyne, & Console (2000) found that women with previous traumatization had impaired self-worth, which was expressed by feelings of inadequacy in physical attractiveness and explicit feelings of shame and guilt. Briere & Runtz (1990) found that low self worth was found in clients who were victims of psychological abuse more frequently compared to physical and sexual abuse. Janoff-Bulman (1992) introduced one explanation of the self-blame that occurs after exposure to abuse. Clients may believe that events happen for a reason and incorrectly attribute the reason for the abuse to their own "badness". This logic may be used as a method of organizing the trauma as an alternative to the randomness and helplessness that victims often feel when attempting to make sense of the traumatic experience. Even in adulthood clients may be reluctant to change their internalized sense of "badness" because it would feel like betrayal to the attachment figure.

Cole and Putnam (1992) studied abused children who were unable to develop or lost their self-regulatory processes. They found these children had difficulties in defining their sense of self (separateness, loss of autobiographical memories, and disturbances of body image); unable to regulate affect and control impulse (aggression against self and others); insecurity in relationships (distrust, suspiciousness, lack of intimacy, and isolation) leaving these individuals with social difficulties. All of the above developmental problems were caused by the destructive nature of the abusive relationship and the lack of other attachment figures in the child's life to help overcome the negative effects of the abuse.

Children who had unresponsive or abusive caregivers often experience chronic hyperarousal due to the caregiver's inability to sustain optimal levels of physiological arousal. This hyperarousal can endure throughout the child's life, making it more difficult for the person to modulate strong emotional states. This unhealthy environment combined with the child's inborn temperament can create situations where the individual is unable to regulate affect and can have long-term affects on future vulnerabilities throughout their lifetime. As the child ages he/she makes gains in his/her ability to regulate emotional states and learn to tolerate higher levels of stimulation (van de Kolk, 1996).

Traumatized individuals will attempt to regain control over affect regulation. Some of these methods to regain control over affect regulation are maladaptive, such as self-mutilation, bingeing and purging, and drug and alcohol abuse. These self-destructive behaviors can be seen as a way of attempting to self-regulate. Self-mutilation has been linked to those who have been traumatized (Bowlby, 1984). Substance abuse has been prevalent in individuals with a history of abuse in childhood (Lisak, 1993). Keane and Wolfe (1990) found that adults abuse alcohol and drugs after being traumatized in adulthood. A self-medication theory (Khantzian, 1985) proposes that substance abuse is common in the population of persons diagnosed with PTSD as a maladaptive method of regulating affect and arousal.

Research on dissociation has found strong ties to the traumatized individuals. The DSM-IV-TR defines dissociation as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" (APA, 2000, p. 822). This somewhat vague description reflects a large amount of research about how this mechanism can be used by victims to leave their bodies and observe what is happening to them from outside themselves (van der Hart, Steele, Boon, & Brown, 1993). Van der Kolk, Hart, and Marmar (1996) describes to

9

dissociation as "a compartmentalization of experience: elements of a trauma are not integrated into a unitary whole or an integrated sense of self" (pp.306). Dissociation can be an adaptive method of coping with overwhelming states elicited during the trauma, but after the acute trauma it can hamper daily living (van der Kolk, 1996). Zlotnick et al. (1996) found dissociation most frequent in victims of childhood sexual abuse compared to victims of sexual and physical abuse in adulthood.

Trauma can also affect relational dynamics in one's life. "Trauma impels people both to withdraw from close relationships and to seek them desperately" (Herman, 1992, p.56). Judith Herman (1992) speaks to the heart of the relational conflict that occurs in traumatized individuals. A part of the person wants to isolate and the other part of them wants to anxiously cling to others It can be difficult for those who have been abused to have a basic sense of trust in others, as past abusive relationships may cloud new experiences (Herman, 1992). Also, the survivors' hyperawareness to the needs and feelings of those around them may be an outcome of having a parent be an unpredictable abuser (van der Kolk, 1996) and may leave the survivor unable to maintain an intimate, trusting relationship where they may derive some satisfaction.

Trauma Focused Psychotherapy

Herman (1992) lays out three different stages of recovery that trauma survivors may experience. The goals of recovery are feeling empowered and fostering new connections and relieving symptoms that negatively impact daily life. It is through relational connections with others that this recovery process can be undertaken. The therapeutic relationship between client and clinician is one example of a space where the model can be applied. Herman (1992) stated that the power dynamics within this relationship should be given attention as to avoid abusing power. The client enters into the dyad somewhat unequally as the clinician guides the treatment.

Clients who have been victims in the past may find this power imbalance triggering or this dynamic may place the client in a vulnerable place for further exploitation. Clinicians should take responsibility to not abuse this power.

The first stage of recovery involves *restoring safety* in a client's life. The first step for the clinician is to properly diagnose the trauma syndrome in order to work through the symptoms that had a negative impact on functioning. Due to the many symptoms of trauma that overlap with other psychiatric problems, it is sometimes difficult to uncover the trauma as the root of the client's difficulty. It is important for the clinician to share his/her thoughts regarding a possible trauma diagnosis because some relief may be felt by the client when his/her symptoms can be explained. Also during the first stage of recovery it is important for the client to regain control over his or her life. Clients left feeling powerless after the trauma will benefit from taking back control of their lives. The model suggests attempting to begin to have control over the body and then work outward into the environment. Crisis intervention may be needed to ensure that victims of violence are not currently in danger of continued abuse. Once the immediate safety of the client is established, the clinician can work with the client on establishing other safe relationships. Further trauma work cannot be explored until safety has been achieved. If the necessary safety groundwork is not laid down, the client may not be able tolerate the next stages of recovery.

The second stage of recovery, *remembrance and mourning* is when the survivor hopes to integrate her trauma memories into her life. Clients are asked, when they feel more comfortable, to share their story. Since traumatic memories tend to be non-verbal and they may lack narrative when the client attempts to convey the story. Together, client and clinician try to reconstruct the

trauma memory. During this stage some therapists use techniques to "transform" the traumatic memory with the use of "flooding" or "testimony".

   Reconnection is the third stage of trauma recovery. As expected, the trauma survivor is encouraged to think about the future. During the third stage of recovery, the client starts to better understand his/her victimized state and how that has affected his/her life. Being aware of how their traumatized past may be influencing their current behavior, survivors may start to take back control of their lives. Hopefully clients will also be able to gain back some of their trust in others and be able to reconnect socially. This connection can also be deepened through the therapeutic relationship. Some clients will find a survivor mission, or public social action, as one way to resolve the trauma, while most clients find that resolving the trauma in their personal lives more helpful. Since there is not a way to finalize the resolution of trauma, clients may be triggered by major events in the future that will bring up some of the past trauma symptoms. With time clients will be able to focus more on their lives not have the trauma recovery be a major focus of their lives. "The best indices of resolution are the survivor's restored capacity to take pleasure in her life and to engage fully in relationships with others" (Herman, 1992, p. 212).

   Group psychotherapy is another applied method of using the stage model to treat PTSD and other disorders caused by trauma. Mendelson, Zachary, and Harney (2007) speak to the benefit of this modality, noting that "Group therapy counteracts the isolating effects of interpersonal trauma and enables survivors to connect with sources of resilience within themselves and others" (p.227). Sitting in a group with other trauma survivors, members can lessen feelings of isolation, shame, stigma, and perhaps become empowered by sharing ways of coping with other members of the group. Foy et al. (2000) found that psychotherapy groups for trauma survivors had positive outcomes, independent of the approach used. A manual for the

remembrance and mourning groups is currently in the process of being written and published so other agencies can implement these groups (Herman, personal communication, February 12, 2010).

There are other modalities of trauma treatment that can be used in conjunction with the stage model (Herman, 1992) or independently, depending on the severity of the trauma response. Psychopharmacology can be indicated to treat some of the PTSD symptoms, but is usually recommended for use in concert with psychotherapy (Opler, Grennan, & Ford, 2009). EMDR (eye movement desensitization and reprocessing) uses bilateral eye movements that change emotional-cognitive processing in hopes of resolving traumatic experiences (Shapiro, 2001). Another method, internal family systems, applies family systems theories to intrapsychic conflict and hopes to resolve fragmented parts of victims of trauma (Schwartz, 1995).

The various treatment strategies for trauma survivors target trauma symptoms and also address the relational difficulties that survivors of interpersonal trauma often experience. Next I will examine literature that focuses on older adults and what has been studied in regard to this populations experience with prior childhood trauma and how that manifests in the later years of life.

CHAPTER 3

TRAUMA AND AGING

Later life presents numerous challenges such as loss of a partner, retirement, changes in

living arrangements, and financial and physical decline (Federal Interagency Forum on Aging-

Related Statistics, 2008). The negotiation of these tasks in the older population (65+) poses a

challenge to this growing cohort. Older adults coping with the additional aftermath of

psychological trauma that occurred earlier in life may complicate the diagnostic picture when

seniors present with psychiatric symptoms.

Who are the elderly?

There were 37 million people age 65 and over living in the United States in 2006, which

was 12% of the population. The oldest-old (age 85 and over) population grew considerably in the

last century. In 2011, the baby boomers (people born between 1946 and 1964) will start to enter

the older population, causing the rate of the elderly population to increase dramatically. In 2030

there are estimates that the older population will be twice as large as it was in 2000 and represent

20% of the population (Federal Interagency Forum on Aging-Related Statistics, 2008).

Aging and Physical Health

Chronic illness seems to differentiate the younger adults from older adults. Older adults

have a higher prevalence of chronic illness. It has been found that 80% of older adults have a

least one chronic illness (Federal Interagency Forum on Aging-Related Statistics, 2004).

Scharlach, Damron-Rodriguez, Robinson, & Feldman, (2000) demonstrate another perspective.

They propose that the aging process does seem to weaken the body's threshold to cope with stress related to common chronic conditions, such as arthritis, hypertension, hearing loss, and heart disease. However, there also seems to be a connection between an older person's ability to manage such illness and elders' experience with self-care, social support, community resources, and mental health interventions Perhaps if more of those resources were accessible to older adults than there would be a decrease in the prevalence of chronic illness and increased ability to care for one's chronic conditions.

Another outcome of physical health changes is that older adults show a decrease in their ability to perform daily activities. These are often referred to as ADL's (activities of daily living) that have to do with an elder's ability to perform basic tasks such as eating, toileting, and bathing. Another level of daily activities are instrumental activities of daily living (IADLs), which refer to activities that require a basic level of cognitive ability such as paying bills, taking medications properly, and shopping (Moody, 1998). A surprisingly small number (21%) of seniors (aged 65+) reported having any impairment to ADLs or IADLs (Federal Interagency Forum on Aging-Related Statistics, 2000). Perhaps this high level of functioning is due to the ability of older adults to adapt to the physical changes by changing the way they perform these daily tasks or changing their environment (housing) to better accommodate them.

Cognitive Changes in the Later Years of Life

Misconceptions exist in terms of normal aging processes and the prevalence of depression and memory loss. It is often not emphasized that there are some positive effects of aging, including crystallized intelligence and increased creativity and wisdom that accompany the later years of life (Hinrichsen, 2006). There are two types of intellectual functioning: fluid and crystallized intelligence. *Fluid intelligence,* the ability to draw from inferences, abstract

ideas, and relate concepts, does decrease in the later years of life (Hinrichsen, 2006). On the other hand, *crystallized intelligence*, knowledge acquired through learning and life experience, increases in the elderly population. Memory deficits are not a normal process of aging, but dementia, commonly seen in Alzheimer's disease, does occur more readily during that later years of life and does negatively impact memory. Only 5% of the senior community (aged 65+) reported dementia (Raskind, Bonner, & Peskind, 2004), but adults aged 85 or over had a 32% rate of moderate to severe memory loss (Federal Interagency Forum on Aging-Related Statistics, 2004). In general the loss of memory does seems to be a prevalent problem among the elderly, which may cause frustration for this community as they lose some of their cognitive abilities.

Mental Health of the Aging Community

Depression is no more prevalent in the older population than general population, but is common among persons in old age who have chronic medical conditions. Depression in the elderly population may also be related to an inability to resolve losses related to functioning, significant others, careers, and homes (Scharlach et al., 2000).

Trauma in the Elderly

Few studies have examined the effects of elders with a history of interpersonal trauma. Higgins and Follette (2002) found that 72% of women 60 years and older experienced some type of interpersonal trauma in their lifetime. The researchers screened for childhood physical and sexual abuse, adolescent sexual abuse, adult rape, and domestic violence. Although there were a high number of participants who experienced interpersonal trauma, only a small number of participants developed significant trauma responses, consistent with PTSD research in younger populations (Polusny & Follette, 1995). Those individuals who did experience more than one interpersonal trauma were more likely to experience symptoms such as avoidance behaviors,

16

difficulty sleeping, hypervigilance, and comorbid anxiety or depression. Some older women with exposure to interpersonal trauma earlier in their lives mention that they experience lifelong impairment due to these earlier experiences (Bright & Bowland, 2008). Higgins and Follete (2002) highlighted that revicitimization, declining health, loss of family/friends, and other psychosocial stressors may place older women at a higher risk for developing trauma symptoms.

The PTSD symptoms that are prevalent in the elderly population seem to vary. Yehuda, Kahana, Schmeidler, Southwick, Wilson, & Giller (1995) found that intrusive thoughts, avoidance, hyperarousal, and dissociation were the most common symptoms reported by Holocaust survivors with a PTSD diagnosis compared to survivors who were not diagnosed with PTSD and a control group. World War II veterans reported that intrusive PTSD symptoms decreased over time, but avoidance symptoms and social isolation increased with age (McFarlane, 1990). Unfortunately veterans and Holocaust survivors are the only two groups that have been studied to assess the long-term evolution of reactions to trauma. There is a lack of research examining long-term effects of childhood abuse and other forms of interpersonal trauma, such as physical, emotional, and sexual abuse.

Delayed Onset vs. Lifelong Experience of Trauma Symptoms

There are two different ways prior trauma reactions can manifest in the elderly population: on-going experience of PTSD-related symptoms throughout the developmental stages of life and the delayed onset of PTSD-related symptoms that occur in late life. Many individuals fall into the first category and may experience exacerbations and/or remissions of their symptoms over their lifetime (Aarts & Op den Velde, 1996). World War II veterans who were diagnosed with PTSD were found to initially cope well with the trauma of war, but in their older years experienced an exacerbation of symptoms for about 5 years (McLeod, 1994). Some

men found that during the middle adulthood when they were busy with their careers, their PTSD symptoms went into remission, but as they aged PTSD symptoms returned (McLeod, 1994).

Delayed-onset reactions to trauma are less common, but can be found in the elderly population. Case studies have demonstrated that some WWII survivors who did not experience any PTSD symptoms most of their lives unexpectedly experienced PTSD symptoms in their later stages of life (Aarts & Op den Velde, 1996). A theory to explain late onset PTSD or trauma symptoms among the elderly relates the physical and mental decline in the later years to the onset of trauma symptoms (Aarts and Op den Velde (1996)). Therefore, older adults are less able to "ward off or master repressed trauma-related memories and associated affects" (Aarts & Op den Velde, 1996, p. 364) due to their inability to utilize coping mechanisms. Combining that with stressful life events such as retirement or bereavement that often occur during this stage may be enough to precipitate delayed onset PTSD symptoms. Another theory proposes that the increased time available for reflecting upon life due to entering retirement creates a space for elders to also reflect on past traumas (Hertz, 1990). A study shows that retirement seems to be a common time for late onset PTSD to occur (Kahana, 1981). So in conclusion, the combination of stressful life events and age-related mental and physical decline hinders the ability to cope with prior trauma-related memories.

Theories of Aging and Trauma

Aarts and Op den Velde (1996) combined the ideas of Coleman (1986), Schmid (1991), and Erickson (1965) to create a list of tasks that need to be completed for successful aging, which can help explain the range of trauma reactions that are experience in the later years of life. These tasks include: "mourning for losses, giving meaning to past and present experiences, accepting one's past and present states, (re)establishing self-coherence and self continuity, and

achieving ego integration" (Aarts and Op den Velde,1996, pp. 368). The authors compared these

tasks to the trauma recovery process and found some similarities. The tasks they referenced for

the trauma recovery process include: "mourning for losses, giving meaning (congruity) to

trauma, accepting trauma, (re)establishing self-coherence and self-continuity, and ego

integration" (Aarts and Op den Velde, 1996, p.368). The authors hypothesize that "posttraumatic

states and the specific developmental problems belonging to old age interfere with each other"

(Aarts and Op den Velde, 1996, p.373). Traumatized older adults have to mourn both trauma

related memories that have not been resolved as well as the losses that accompany old age.

Having a trauma history may also inhibit traumatized elders ability to mourn, which can

complicate the aging process. The ability to maintain a sense of self-coherence is another task

shared by both the aging individual and the trauma survivor, but the trauma survivor will be

additionally challenged by this task due to possible dysregulation. Therefore, during the process

of aging, unresolved trauma may surface, creating the presence of PTSD related symptoms

(Aarts & Op den Velde, 1996).

Social support has been found to be a protective factor in preventing the development of

PTSD. Veterans who had friends while at war and reported strong social support from friends

and family developed fewer and less severe PTSD symptoms upon return from war as compared

to veterans with less social support (Elder & Clipp, 1988). The positive effects of social support

can be seen throughout the aging process as protective factors against the development of

negative reactions to trauma. It is important to assess elders for their current social supports

because, as mentioned earlier, this can often change during the later years of life when partners,

family, and friends may pass away. Therefore, changes in an elder's social support system is a

critical time for a clinical intervention to help the elder adapt and find other ways to stay

connected to others. Ongoing isolation could trigger previous trauma symptoms that were well managed until this point.

This paper hopes to explore the resiliency that is noted in elderly individuals who were exposed to interpersonal trauma earlier in life and later do not suffer from a lifetime of psychological distress. Viewed through the lens of attachment theory and relational cultural theory, relationships with others seem to be a way that earlier trauma is resolved and therefore may not have a negative long-term impact on individuals in their later years.

CHAPTER 4

ATTACHMENT THEORY

History of Attachment Theory

Bowlby (1969/1982) introduced attachment theory to explain the dynamic that occurs between an infant and her caregiver, which has a biological function to ensure the survival of the infant. In the attachment system, the goal of the infant is to maintain close enough proximity to caregiver in order to protect the infant against danger. Bowlby (1973) found that attachment behaviors are activated when the infant becomes fearful about their security. The threshold for the activation of the attachment system improves with age, as coping strategies and problem solving abilities improve.

Bowlby (1982) observed four attachment behaviors in one-year-old infants in relation to their primary caregivers. They include: proximity maintenance, safe haven, separation distress, and secure base. Infants are constantly observing their caregivers in order to maintain a comfortable distance in case they need the security of that attachment. The behavior of maintaining a comfortable distance between infant and their caregiver is referred to as proximity maintenance. A safe haven refers to the protection the caregiver provides in case the infant perceives a threat. Therefore, the infant becomes distressed when the caregiver is separated from the caregiver (separation distress). In the presence of the caregiver (secure base) the infant feels safe enough to explore the surrounding environment.

Bowlby (1982) outlines four phases infants experience to develop attachments to caregivers. The first, pre-attachment phrase (approx 0-2 months), occurs when the infant begins having interest and becomes responsive to eliciting social contact. The infant is still relatively open to social interactions with a variety of individuals, not only the primary caregiver. The second phrase, attachment in making (approx 2-6 months), is when the infant begins to discriminate among caregivers. The infant will direct social signals (smiles) and respond preferentially (greeting more enthusiastically) towards different caregivers. Clear-cut attachment occurs during the third stage of attachment development (approx 6-7 months). The four attachment behaviors (proximity maintenance, safe haven, separation distress, and secure base) are found during this stage and these behaviors are directed around one caregiver in particular. The final stage, goal-corrected partnership (approx 36 months), is when the child needs less physical proximity with the caregiver and the infant is able to negotiate with the caregiver about his/her availability.

The attachment figure serves three distinct functions in order to protect and support the infant (Mikulincer & Shaver, 2007). These functions follow with the attachment behaviors discussed above. The attachment figure must serve as the secure base, the target for proximity seeking, and a safe haven. The absence or disappearance of this attachment figure will induce separation distress (Bowlby, 1969/1982). Infants will initially protest the separation with crying or clinging, but than later the infant will present with symptoms of despair such as depressed mood.

Long-term romantic relationships in adulthood can be compared to attachment bonds for infants (Mikulincer & Shaver, 2007). Ainsworth (1989) also suggested that attachment relationships are formed throughout life. She described these relationships as unique with a

desire to maintain closeness as to feel secure and comforted. These concepts of adult attachment are similar to Bowlby's (1979) attachment behaviors (as discussed above) of proximity maintenance and felt security as seen in infants. Ainsworth suggests that sexual adult relationships seem to be the most similar to mother-infant attachment.

Individual Differences:

According to Bowlby (1969), all infants are born with an attachment system that activates behaviors that attempt to maintain proximity and security to the attachment figure/caregiver, but not all infants develop a secure attachment to their caregiver. Throughout the child's lifetime these behaviors can be observed with partners and other close relationships. The differences that arise out of each attachment pair are due to the interactions that ensue between an individual and attachment figure. A secure attachment is formed when the partner is perceived to be available, sensitive, and responsive to an individual's needs (Mikulincer & Shaver, 2007). When the system is functioning properly, the individual will perceive the world as a safe place and a partner available for aid and support when needed. Problems in the attachment system arise when the attachment figure is perceived as unavailable or unable to sooth the individual in times of distress and/or is unresponsive to proximity seeking behavior.

When individuals cannot rely upon their attachment system to feel safe and secure, they can adapt the system in an attempt to meet their attachment needs. Hyperactivation and deactivation are two alternative methods that have been referred to as secondary attachment strategies by Main (1990). *Hyperactivation* is an attempt to "fight" (referring to fight or flight) to regain a functional attachment system. These behaviors involve an attempt to elicit the attention of the attachment figure. On the other hand, *deactivation* strategies are oriented around "flight"

from the attachment system, which may be causing distress due to the attachment figure's unavailability.

Adult Attachment Styles

The concept of adult attachment styles has been taken from Ainsworth's (1967) early work with infants. Through her development of the Strange Situation, infants were classified into three attachment styles: secure, avoidant, and anxious. A forth style was later added from the work of Main and Solomon (1990) who discovered "Disorganized/disoriented" infants whose behavior was a disorganized combination of anxious and avoidant tendencies.

Influenced by the ideas of Bowlby and Ainsworth on childhood attachment styles, Hazan and Shaver (1987) examined romantic attachment styles in adulthood to examine how these concepts of attachment play out in adulthood. Hazan and Shaver (1987) created a self-report measure of attachment in which they asked participants about their feelings and behavioral tendencies in romantic relationships.

Hazan and Shaver (1987) discovered that two dimensions of insecurity appeared within the measures: avoidance and anxiety. *Avoidance* refers to the preference for emotional distance and self-reliance and the use of deactivating strategies to cope with distress; and *anxiety* relates to the desire for closeness and protection, worries about partner availability and one's own value in the relationship, and the use of hyperactivating strategies to cope with distress. If a person is low in both anxious and avoidant categories than they are considered to have a secure attachment style.

Three types of attachment categories were created. A secure attachment describes a person who is comfortable becoming close to others and having healthy dependency as an aspect of the relationship. Avoidant attachment refers to a person who is somewhat uncomfortable

being close to others and finds it difficult to trust them completely. This individual may find it difficult to allow herself/himself to depend on others and are nervous when anyone gets too close emotionally. This individual may feel that want to be more intimate than she/he is comfortable being. An anxious attachment describes a person that feels that others are reluctant to get as close as she/he would like. This person often worries that her/his partner doesn't really love her/him or won't want to stay with her/him They want to get very close to a partner and this sometimes scares people away.

Bartholomew and Horowitz (1991) added to the measure created by Hazan and Shaver. They created four similar attachment style categories. The insecure attachment styles differ from the previous ones created by Hazan and Shaver (1987) by splitting them into the following categories: secure, dismissing, preoccupied, and fearful. Securely attached adults feel that it is relatively easy to become emotionally close to others. They feel comfortable depending on others and having others depend on them. They don't worry about being alone or having others not accept them. Dismissing individuals feel uncomfortable with close emotional relationships and find it very important for to feel independent and self-sufficient. Preoccupied adults want to be completely emotionally intimate with others, but often find that others are reluctant to get as close as they would like. They are uncomfortable being without close relationships and sometimes worry that others don't value them as much as they value others. Fearfully attached individuals are somewhat uncomfortable getting close to others. They want to be emotionally close to others, but find it difficult to trust others completely or to depend on them. They sometimes worry that they will be hurt if they allow themselves to become too close to others.

These categories in Bartholomew and Horowitz's (1991) model are similar to Hazan and Shaver's (1987) three categories. Bartholomew suggested that attachment styles could be

organized whether the self is perceived as positive or negative. Ideas about how people perceive others can also be categorized as either positive or negative, which is related to Bowlby's (1969) concept of internal working models. These two concepts comprise the four attachment strategies as presented by Bartholomew (1990).

Mikulincer & Shaver's (2007) Model of Attachment

Mikulincer & Shaver (2007) proposed a model of behavior to help explain adult attachment theory, based on the ideas of Bowlby (1969/1982, 1973, 1980), Ainsworth (1991), Cassidy and Kobak (1988), and Main (1995). The model aims to describe attachment system activation and functioning in adulthood. Three modules represent "if-then propositions" in regard to attachment behaviors. The first proposition states that if an individual is threatened then he/she will seek proximity and protection from an attachment figure. Depending on the perception of the availability of the attachment figure, the individual will choose proposition two or three. The second module assumes that the attachment figure is perceived as available and supportive. In this case, the individual can relax and feel secure with the support and protection provided by the attachment figure. If the individual perceives the attachment figure as unavailable or unresponsive than the individual can either increase efforts to get the attention of the attachment figure or can decide to rely on oneself for comfort and decide to stop attempting to activate support from the attachment system.

Overall Adjustment and Wellbeing

The assessment of attachment and its influence on the overall wellbeing of adults is still a new topic. Most of the research has involved adolescents, using parental attachment as a mediating factor in their overall wellbeing. Greenberg and colleagues (Armsden & Greenberg, 1987; Greenberg, Siegel, & Leitch, 1983) used the Inventory of Parent and Peer Attachment, a

self-report measure, to determine the quality of the adolescents' attachment to their parents. The researchers found that quality of attachment with parents has a positive correlation to self-esteem and life satisfaction. They also found that emotional functioning was also linked to attachment. Lower levels of anxiety, anger, depression, resentment, and guilt were associated with higher quality of attachment to parents. Further research is needed to assess the well-being of adults older than adolescence.

Another study by Rice (1990) also looked into adolescent attachment and interactions with academic, social, and emotional adjustment. The researcher performed a meta-analysis of 30 studies published between 1975 and 1990. The findings did show a positive association between attachment quality and measures of social and emotional adjustment, but not enough evidence to find an association with academic adjustment. The study is a bit dated and did not including any studies after 1990. Further investigation on the relationship between adult adjustment and attachment using modern attachment measurements would be an important contribution to the literature.

Internal Working Models

Bowlby's (1969) concept of "internal working models" is central to the attachment system as the mental representations that are formed in childhood influence the way we think about ourselves and others throughout our lives. According to Bowlby, the child forms expectations regarding the accessibility and responsiveness of her/his attachment figure. These expectations inform the development of their representation of self, their caregivers, and the relational world around them. Later these working models serve to aid in the understanding of new relationships and experiences. A child or adult will behave in such a way that is consistent with past experiences, at times confirming that these mental representations of relationships are

accurate. Thus, internal working models influence an individual's ability to form close, satisfying relationships and foster a positive self- concept and a more insightful, understanding of others.

Because inner working models are outside of conscious awareness (Collins & Read, 1994), they are activated automatically when an individual is experiencing distress, which also makes these mental representations somewhat resistant to change. For example, they are often self-fulfilling (Collins & Read, 1994). Behaviors that are preformed based on models can often produce results that reinforce them. Individuals who believe that others are judgmental may approach situations defensively and therefore more apt to have others have a negative response to them, which reinforces this negative model of others.

Collins and Read (1994) suggest that internal working models have four interrelated components: memories of attachment-related experiences; attachment-related beliefs and attitudes; attachment-related goals and needs; and plans and strategies. Each attachment style has different perceptions of these four categories, due to the differences in internal working models for each attachment style. Securely attached individuals have positive memories of early attachment, which is consistent with their view of others and their positive view of their close relationships. This also coincides with their high levels of trust and self-esteem, which makes it easier for them to express emotions in a way that elicits support from others when necessary. On the other hand, avoidant individuals' memories, beliefs, goals, and strategies are consistent with their fear of forming close attachments. Avoidant individuals view close relationships as a negative and feel particularly uncomfortable about disclosing too much. Due to their suspiciousness towards others they tend to keep personal reactions to themselves. Anxious-ambivalent individuals tend to have the four components of their internal working models

28

consistent with their low self-esteem and their concern with relationships. Their inability to sooth themselves perhaps makes them more prone to be emotionally dependent on others. Unfortunately, their behaviors demanding attention and emotional displays may make others all the more distant (Feeney & Noller, 1996).

Personality

Attachment security can influence the growth and design of personality processes in infancy and later personality development, due to the child's attachment security being related to the way in which the child copes with challenges, attachment security. Sroufe (2005) discusses the relationship between attachment security, seeing personality growth as a succession of developmental challenges throughout the person's life.

Feeney, Noller, and Hanrahan (1994) examined personality attachment styles in high school students and found that neuroticism was highly associated with adolescents who were highly preoccupied with relationships and wanted approval within those relationships. The personality aspect of extraversion also was found to have a positive relationship to adolescents who reported more confidence.

Shaver and Brennan (1992) compared dimensions of personality (neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness) to attachment styles in adolescents. They found that attachment styles varied significantly by their scores of neuroticism, extraversion, and agreeableness. Not surprisingly, securely attached adolescents scored low for neuroticism, high for extraversion, and high on agreeableness, compared to their more insecurely attached adolescents. These findings perhaps explain why securely attached adults have healthier relationships. Others may find these personality traits attractive when forming relationships.

Emotional Regulation

Shaver, Schwartz, Kirson, and O'Connor's (1987) model of the emotional process hypothesizes that emotional regulation is fostered by positive interactions with partners or caregivers in childhood who attend to the individual's emotional states. In other words, when a securely attached individual experiences negative affect, the secure individual is able to use problem solving, planning, and cognitive reappraisal to put the event into a manageable perspective, so the individual minimizes any overwhelmed feelings. This same securely attached individual will also be more able to illicit support from others in order to defuse these overwhelming feelings.

The ability for securely attached individuals to regulate emotions stems from reoccurring sensitive and responsive interactions with attachment figures. If the attachment figure is able to provide security and comfort during distressful situations, the individual will learn that turning to the attachment figure is an effective coping method. Additional results of these positive interactions with attachment figures lie in the positive expectations that are formed regarding the availability of social support; the increased probability to ask for help from others in the future; and increased ability to problem-solve and appraise situations. Due to the acquisition of these skills, securely attached individuals do not need to rely on defenses such as avoidance, suppression, or denial to regulate emotions (Mikulincer & Shaver, 2007).

Insecurely attached individuals, on the other hand, rely on defensive methods of regulating emotions since they did not have the same positive interactions with attachment figures. Avoidantly attached individuals suppress their uncomfortable emotional states as a method of coping. This defensive strategy is consistent with individuals with avoidant

attachment who aim to keep the attachment system deactivated (Main & Weston, 1982). Emotions such as fear, anxiety, anger, sadness, shame, guilt, or distress, can be viewed as vulnerable states because avoidant individuals prefer to be self-reliant. This defensive mechanism stems from the individual's relationship with an attachment figure who is perceived as unavailable or unresponsive. Therefore these individuals are less likely to seek support, or use problem solving and reappraisal methods of coping with overwhelming or distressing emotions (Mikulincer & Shaver, 2007).

Those individuals with anxious attachment find themselves coping with overwhelming emotions differently than securely and avoidantly attached individuals. Individuals who fall into the category of anxious attachment desire more attention from their attachment figures. Therefore, they use emotions that "call for attention and care" (jealously, anger) or "emotions that implicitly emphasize vulnerability and neediness" (sadness, anxiety, fear, and shame) (Mikulincer & Shaver, 2007, p. 193). Sometimes anxiously attached individuals can intensify affective states (hyperactivation), in comparison to avoidant persons who attempt to minimize overwhelming feelings. Problem solving does not become a method of coping for these individuals because it compromises the individuals' desire to be seen by others as helpless and incompetent, in pursuit of getting the attention of the attachment figure. Although anxiously attached individuals want to get the attention of the attachment figure, they are not likely to not ask for aid directly due to fear of rejection (Mikulincer & Shaver, 2007).

Self-Concept

Mikulincer and Shaver (2004) theorize that one's self-concept is comprised of representations of the support, or lack of support, they received from attachment figures. Individuals tend to treat themselves in a similar way to the treatment they received from

attachment figures in the past. This internalization of the attachment figure with secure attachment makes them less prone to self-criticism and more able to maintain self-worth, leading the way to the development of a cohesive self, which is defined as "the feeling that one's many qualities and experiences reside within a single, well-integrated self-structure" (Mikulincer & Shaver, 2004, p. 153). Being able to maintain a sense of self-cohesion can give a secure individual the ability to approach stressful situations in a more calm and resilient way. Insecure individuals, who may lack this self-cohesion, internalize the negative interactions with attachment figures and are left with overactive self-criticism, self-doubting, and use of defenses to cope with feelings of worthlessness and hopelessness.

View of Others

The ways in which adults formulate opinions and expectations in regard to others is related to previous social interactions. Bowlby's concept of internal working models hypothesizes that this process begins in infancy. These thoughts about other people start to generalize to future relationships (Anderson & Glassman, 1996) and adolescents and adults will approach new relationships based on experiences from former attachment figures (Brumbaugh & Fraley, 2006).

Depending on the individual's attachment style, others may be viewed differently (Mikulincer & Shaver, 2007). Securely attached individuals may view others more positively, stemming from their repeated interactions with attachment figures who treated the individual with sensitivity and responsiveness. Due to their view that others are mostly 'well-intentioned', secure adults feel more confident in relationships and expect their partners to be dependable and generous. Insecurely attached individuals hold less positive views of others, which differ depending on whether they are avoidantly or anxiously attached (Mikulincer & Shaver, 2007).

Avoidantly attached individual's use of deactiviating strategies makes it more likely for avoidant persons to miss positive signals from others due to their attempt to avoid attachment related material. Also the use of deactivating strategies by avoidant individuals creates 'defensive projection', where the individual projects suppressed relationship material onto the relationship partner. Avoidant individuals' need for emotional distance from relationship partners reinforces their negative view of others in order to preserve their own feeling of uniqueness compared to others, who they consider commonplace (Mikulincer & Shaver, 2007).

On the other hand, anxiously attached individuals who use hyperactivating strategies with attachment figures, will also hold negative views of others, but for different reasons than the avoidantly attached individuals. Hyperactivating strategies tend to make people more hypervigilant and sensitive in response to signals of unavailability, disinterest, or criticism from relationship partners due to fears of abandonment and rejection. Anxious individuals will often ruminate about what they perceive as unresponsiveness, even if the relationship partner's signals are imaginary. This process in turn makes the cognitive availability of views of partners more negative. The use of hyperactivating strategies also increases the anxious individual's need for close proximity with relationship partners, but this can create situations where anxious individuals project her/his negative views of self onto partners in order to feel more similarity with partners (Mikulincer & Shaver, 2007).

Relational affect of unresolved trauma

Researchers have found that children and adults who do not resolve prior relational trauma may suffer interpersonal consequences. These survivors may have a more difficult time organizing their behavior in order to form healthy relationships with attachment figures (Cassidy & Mohr, 2001). These individuals tend to have a history with a caregiver in childhood who is

unpredictable, which leaves these individuals fearful of unpredictable behavior in future relationships (Main & Hesse, 1990). These caregivers may have unresolved trauma themselves, furthering the cycle of disorganized attachment behavior within a family (Lyons-Ruth, Bronfman, & Atwood, 1999). These early negative interactions with unpredictable caregivers explains why individuals with unresolved trauma will be more at risk for developing relational difficulties. It is clear from reviewing the literature about adult attachment that those individuals will attachment difficulties usually struggle with social relationships because they have not developed the skills needed to access help from friends or family.

Attachment in Older Adults

Few studies have applied attachment theory to the relational experiences of older adults (Magai, 2008). Longitudinal studies are needed to assess how attachment styles progress from middle adulthood to late adulthood. However, there do seem to be three areas of research where Bowlby's original theory (1969) has been examined with regards to the distribution of attachment styles with older adults, the general well-being of the aging population, as well as their ability to cope with aged-related issues, such as bereavement and loss.

Researchers have found that avoidant or dismissing attachment appears to be more prevalent in the elderly population, but ambivalent and/or preoccupied attachment styles are sparse compared to the distribution of young adult attachment styles. This trend may be explained by the number of losses that in an elder's life. Perhaps these losses have made older adults approach relationships differently than they had in previous stages of life when loss was not as much a prominent theme (Magai, 2008).

For those seniors who are securely attached, they seem to follow a similar trend in regard to their overall wellbeing. Securely attached elders, compared to avoidantly attached elders, have

been found to have larger networks of friends, received and gave more support from their families, and reported more family members who they would describe as supportive. Avoidantly attached seniors, on the other hand, were more self-reliant, which is consistent how avoidantly attached younger adults operate (Wensauser & Grossman, 1995).

Another study by Webster (1997) compared elders identified as secure and dismissive based on their classification on the Relationship Questionnaire (Bartholomew and Horowitz, 1991). Greater subjective wellbeing was found in securely and dismissively attached older adults compared to the fearful-avoidant attached elders, which coincides with attachment theory. The majority of participants (52%) were dismissive in their attachment style, which differs from what is usually seen in the general population. Only 33% of participants in Webster's study were identified as securely attached. Webster offers the explanation that the high levels of dismissively attached elders in this particular study may be the result of participants knowing of the possible loss of their partner in the near future, and the elder now minimizing feelings of connection they once had for that attachment figure. This concept is consistent with the study presented above.

Another explanation of the greater number of avoidantly attached adults in later life related to a cohort effect (Magai, 2001; Magai et al., 2001). These researchers compared two cohorts of elders and found that there were differences in attachment styles respective of each cohort. They propose that the reason for the larger number of avoidantly attached elders is due to Watsonian behaviorism, which was popular in the 1920's and 1930's and therefore influences the younger cohort born between 1922 and 1932. Watsonian behaviorism encouraged parents to withhold affection from their children, which may have influenced their attachment style with

their children. The older cohort born between 1911 and 1921 was not influenced by this phenomenon, which could explain why that cohort had more securely attached seniors.

Andersson and Stevens (1993) approached attachment retrospectively. They found that elders who remembered their parents/caretakers negatively reported lower current life satisfaction as compared with those who looked back on more positive caregiving experiences. Relating the late negative parenting experiences to insecure attachment, this study supports the idea that adult secure attachment relates to positive outcomes such as overall psychological well-being. This study also found a mediating relationship with elders who currently reported close relationships. Those elders who reported a close relationship with a partner or friend reported more life satisfaction, regardless of childhood experiences of caregiving. The difficulty in applying these studies to attachment theory is due to the loose connection that the measures had to attachment measures. Although the measures used in these studies aimed to inquire about the elder's attachment style, the researchers strayed from the attachment concept, so only a loose association could be made from the studies in regard to attachment phenomenon.

Another area of research related to applied attachment theory examines the losses and grief. Bradley and Cafferty (2001) stated that studying reactions to the death of an attachment figure has been a focal point of interest, even before the mention of attachment theory. Ambivalent relationships with the deceased lead to a difficult mourning period characterized by shame and guilt (Freud, 1917/1957). Bowlby found similar responses with martial couples who reported engaging in frequent fighting and overall marital distress. Individuals in these couples would react to the death of a spouse with depression, physical symptoms, guilt and self-reproach.

Bowlby went on to clarify that reorganizing internal working models was key to experiencing adaptive mourning of an attachment figure. This process is more problematic in the

insecurely attached elders due to their rigid or defensive approach to attachment, which can make incorporating change difficult (Bowlby, 1980). Other factors that may influence reactions to loss of an attachment figure later in life include social isolation and degree of expectation of loss. An increase in isolation can negatively influence an individual's reaction to a partner's loss (Parkes, 1991). Also, the more unexpected the loss of an attachment figure, the more severe the grief reaction may become (Scharlach, 1991). This factor may work in favor of an elder's experience with loss because death in old age is more expected, especially if medical issues are present. Perhaps an elder's earlier experiences with loss and grief will influence her/his ability to tolerate or adaptively cope with the loss during the later years of life.

Only a limited amount of research has been completed to examine the bereavement reactions in the elderly. Sable (1989) worked with a group of older adult widows and found that those who reported a secure attachment in childhood also reported a more adaptive mourning reaction to the death of their partners. The researchers also screened for dependency towards their husband using a structured interview and noted that those who reported dependency also reported more distress surrounding the death of their partner. Perhaps this furthers the notion that elders, who report a secure attachment, are better able to adapt to challenges later in life, including the loss of a partner. As mentioned before with securely attached younger adults, securely attached individuals are more able to meet their needs due to their ability to seek help from supportive friends or family and also emotionally more prepared to cope with the negative affect that usually accompanies grieving the loss of a loved one.

Another area of research in regard to challenges faced in the later years of life involves changes in roles, specifically movement into more of a dependent role. As discussed in previous chapters, elders may experience a number of physical and cognitive declines that make it more

difficult to remain as independent as they did once before. This slow change into a more dependent role may be more difficult for insecurely attached elders. Anxiously attached older adults may act needy and seek attention from caregivers in a way that may appear intense and persistent. Caregivers may react to this behavior by distancing themselves, which in turn perpetuates more insecurity by the elderly adult. Conversely, avoidantly attached seniors tend to minimize the help they need and not seek help when needed. In both cases of insecure attachment the elder may perceive that she/he has a limited support system (Magai, 2008).

Applying Attachment Theory to Elders with a History of Interpersonal Trauma

These areas of research in regard to the elderly population apply attachment theory to psychological changes that often occur during this stage in life. Further research is indicated to explore how attachment relates to elders with a history of interpersonal trauma due to the lack of literature that addresses this issue. Based on the above reviewed research about attachment and the elderly population in general, it appears that securely attached elders tend be able to adapt to later life changes compared to insecurely attached adults. It also seems that the relational difficulties of insecurely attached adults continues into the later years and perhaps some of those who previously reported a secure attachment develop a more insecure attachment style during the later years of life, due to higher number of insecure attachment styles found in the later years of life.

Assuming that elders with a history of interpersonal trauma are more likely to have an insecure attachment style, trauma and attachment theory both agree that this will effect how these individuals relate to the world throughout life following the trauma. Attachment theory would propose that the negative relational experiences from childhood will create negative internal working models, which in turn will negatively influence they way insecurely attached

38

individuals will approach relationships. Also, not being able to seek support to regulate negative affect throughout life seems like a difficult way to negotiate life, so further research is needed to assess how that effects the emotional development into old age.

CHAPTER 5

RELATIONAL-CULTURAL THEORY

Many psychodynamic therapies focus on helping individuals strive for independence, autonomy, agency, but Relational-Cultural Theory (RCT) focuses on human growth through connections with others (Miller & Stiver, 1997). RCT critiques the Western/US psychological ideas that focus on individuation and separation as goals of development (Jordon, 2001). This western way of thinking can pathologize minority groups, such as women and persons of color, who perhaps place more important on growth that occurs in the context of community (Jordon, 2000). Jordon (2000) argues that women can be portrayed as needy, dependent, or emotional by the traditional psychological models. Likewise, people of color can be seen by traditional psychological models as deviant or deficient due to their collectivist cultures (Jordan, 2000). RCT focuses on the dynamics between individuals and on strengthening connections so they have promote emotional growth and wellness.

Concepts of RCT

The basic premise of RCT is that growth occurs through connections to others. Humans are relationship-seeking and these relationships are created through mutual empathy and mutual empowerment. There are *five good things* that Miller (1986) outlines that characterize a growth-fostering relationship: 1) vitality, 2) empowerment, 3) increased clarity, 4) increased sense of worth, 5) desire for relationships (other than that particular one).

Clinicians working at The Stone Center at Wellesley College developed RCT into the following core ideas about relating to the world (Jordan, 2000). The first principle, which was also stated above, is that individuals grow in the context of relationships throughout their lives. The second principle states that mature functioning is characterized by movement towards mutuality rather than separation. RCT also emphasizes that relational differentiation (differentiation within a relationship) and elaboration of connection characterize growth and mutual empathy and that mutual empowerment are at the core of growth fostering relationships. In growth fostering relationships, all people contribute and grow or benefit from the relationship. When clients are involved in psychotherapy, those relationships are characterized by a special kind of mutuality, mutual empathy, which according to RCT, is where the person is able to grow and strengthen. Real engagement and therapeutic authenticity are necessary for the development of mutual empathy.

Relational/cultural theory examines patterns of connection and disconnection. RCT views disconnection as an inevitable part of relationships that can be caused by empathic failures, relational violations, and injuries, among other things. Disconnection may result in a strengthened relationship and increased sense of relational competence (Jordan, 2000)) if the person who holds less power in the relationship is able to communicate her feelings and the other person is able to engage empathically. If the less powerful person is unable to have this empathic response to her feelings and thoughts than she may choose to keep certain aspects of herself out of the relationship in an attempt to maintain the relationship (Carol Gilligan, 1982). Miller and Striver (1997) refer to this phenomenon as "the central relational paradox". These strategies that individuals use to maintain relationships by changing the self slightly are known as "strategies of disconnection".

Strategies of disconnection are a protective mechanism in hopes of preventing the hurt that often accompanies disconnection. Isolation stems from chronic disconnection, and RCT considers isolation to be a major source of emotional pain. RCT refers to isolation as the state of being out of connection, not necessarily being physically isolated. Isolation provokes feelings of immoblization, self-blame, and shame. People can often feel unworthy of connection when they are in the state of isolation. The way to resolve the painful feelings associated with isolation is to move back into connection with an empathic community. Empathy is used as a tool for connecting in relationships and in the therapeutic alliance (Jordan, 2000).

Mutual empathy, therefore, is an important aspect of the therapeutic relationship, as it works to heal disconnections. Mutual empathy refers to the acknowledgement by both parties that they affect each other and that this is a valuable to both of them. RCT emphasizes the importance of the client being able to feel the therapist's empathic response. This notion goes against traditional neutral stances adopted by analytic therapists, where the therapist takes on more of a neutral role in the psychotherapy. RCT takes a much more interactive approach to therapy, as RCT clinicians believe that an overly neutral therapeutic stance may interfere with the therapeutic healing with someone who has been exposed to chronic disconnection, as it may invoke feelings of shame and unworthiness, such feelings they have felt in previous disconnections (Jordan, 2000).

These chronic disconnections can occur in the context of non-responsive or aggressive responses from people who possess more power in the relationship. For example a disconnection could occur if a child who was not comforted when she was sad or was told that those feelings were not valid or made to feel bad about those feelings. Therefore, in therapy, it is important to acknowledge a client's feelings and have an emotional response to them. Growth will occur in

this type of therapeutic alliance when the client feels that what she/he does in therapy has an effect on the therapist. This will increase the client's feeling of worthiness in a relationship. This dynamic is particularly sensitive with trauma survivors, as a non-responsive therapist may remind them of the power dynamic with their abusers (Jordan, 2000).

Applying Relational Therapy to Traumatized Clients

The benefit of relational therapy for the trauma survivors is twofold: it provides both a healing experience as well as psychoeducation about the trauma reaction (Banks, 2006). Relational-cultural theorists understand therapy as a healing relationship in which clients are exposed to a non-violating interaction with clearly defined boundaries that is based on mutual respect, honesty, vulnerability, and empathy. It is within the context of this relationship that patterns of disconnection and connection can be explored and the client will hopefully be able to establish awareness about these dynamics that play out in the therapeutic relationship and likely also occur in relationships outside of therapy.

The psychoeducational piece of the psychotherapy with trauma survivors is also vital to helping the client feeling more comfortable in the therapeutic relationship. Clinicians work to provide a deeper understanding of how relational violations earlier in life have affected clients relationally by creating shame and chronic disconnections in future relationships. The therapist also helps the client identify negative relational images that are being projected onto current relationship and may cause some of the disconnection they are experiencing (Banks, 2006).

Relational therapy with trauma survivors uses Herman's (1992) three stages of trauma therapy (safety, recovery and mourning, and reconnection) to guide the general recovery process. Stage one of trauma therapy helps survivors become more connected with their experiences. As the survivor becomes more present with her experiences, she will be better equipped to move

43

into healthy, growth fostering relationships. Dissociation is a common way that victims of trauma can disconnect from their present experiences. Working on ways methods of staying present may deepen an understanding of how the client used dissociation to cope with intense affect in the past and this may help to find more adaptive coping mechanisms. Another way that clients may stay disconnected is through self destructive behaviors that may reinforce the shame trauma victims are already experiencing. Being able to tolerate intense affects of shame, terror, rage, and grief may be a goal of stage one relational therapy (Banks, 2006). Clients with a history of abuse may also need to build basic relational skills that they were deprived of earlier in their lives. The therapist may be able to aid the clients in identifying and understand the role that emotions play in relationships.

Three relational cultural theory concepts (self-empathy, the central relational paradox, and mutual empathy) are vital to the safety and stabilizing stage of trauma treatment (Banks, 2006). Self-empathy (Jordon et al., 1991) refers to empathy towards oneself and relational clinicians will promote this with clients. Traumatized clients will benefit from being more compassionate about their struggles related to the traumatic experiences. A cognitive understanding of self-empathy will precede changes in attitude towards oneself. Banks (2006) recommends trauma groups to help promote this more compassionate change in attitude. By experiencing the empathic responses of others, clients may be able to internalize the group experience and increase their self-empathy.

Miller and Stiver (1997) believed that clients with a history of abuse or trauma might have some fears about entering into a therapeutic relationship alongside a deep longing to receive help from therapy. This dynamic illustrates "the relational paradox" (Miller & Stiver, 1997) that may play out in therapy. Therapists should be mindful of this phenomenon and attempt to make

the therapy as safe and comfortable for the client as possible. Jordan et al. (1991) suggest that relational therapy diverge slightly from other, traditional models of therapies where the therapist acts responds as a blank slate. Relational therapy supports therapists being more responsive and authentic in their work with clients with a history of trauma. This does not mean that the therapist responds with complete honesty or spontaneous action but rather the therapist carefully considers the impact that such responses have on the client (Jordan, 2001).

Mutual empathy, as felt through the therapist's response during psychotherapy, aids the healing of the traumatized client. Mutual empathy is the dynamic in therapy where the client is able to see the impact she has on the therapist (Jordan, 2001). This gives the client a place to discuss responses of the therapist and therefore strengthen that relationship. If clients are deprived of seeing the empathic response from the therapist it can remind them of past abusive relationships. Another way of making the therapy more comfortable and safe for the client is to demystify the therapist's role and further discuss the process of therapy. This will hopefully leave the client feeling more empowered in the therapy relationship. This more interactive approach to therapy contrasts the more traditional models where the therapist listens for unconscious conflict and attempts to interpret for the client. Relational cultural theory assumes that this model is less effective with trauma victims as it creates more of a power differential between therapist and client (Banks, 2006).

Although therapists attempt to make the therapeutic relationship as safe as possible, disconnections are always a possibility. In these situations, Miller and Striver (1997) suggest to "honor the strategies of disconnection," (p. 149) meaning honoring the strategies that clients have developed to cope with their external world. By doing so clients and therapists can gain a deeper understanding of the how the disconnection plays a role in keeping the client in a

perceived safe state. If the therapist pushes against the strategy, as is done in more traditional therapies, it may trigger trauma memories. The honoring of the strategies of disconnection helps clients move back into connection.

Another hope of the first stage of relational therapy with trauma survivors is that clients will gain a basic understanding of what a "growth fostering relationship" looks like through their relationship with their therapist. In time, clients will be able to identify safe and supportive outside of the therapy. Observing healthy relational patterns will also be important part of helping the client move into connection (Banks, 2006).

The second trauma recovery stage, remembrance and mourning, involves having the client developing a narrative about the trauma when she feels safe enough. Herman (1992) points out that this is not a cathartic retelling of the trauma but rather a way to reintegrate the story into the client's newly developed authentic self. This process prevents the survivor from leaving out those parts of her-self in relational connections. The therapist aims to connect the trauma story with affective experience in hope of helping the client understand how past abuse may play into present relational patterns (Banks, 2006).

Reconnection is the third stage of trauma recovery (Herman, 1992), which is marked by the client developing positive connections with others. The therapy will focus less on the trauma memories and when memories are triggered the trauma victim is better able to adjust to the situation and appropriately seek help from healthy relationships. At this stage of recovery the client has come out of isolation and formed the growth fostering relationships that were the original goal of the trauma treatment, according to Relational-cultural theory (Miller & Stiver, 1987).

Relational therapy, as used through the lens of Relational-cultural theory, can be an effective treatment for those victims of trauma. RCT addresses the disconnection that often affects victims of abuse or trauma. The loss of control in the relationship between an abuser and victim can negatively influence future relational behavior, but RCT attempt to restore relational connection and empowers clients through the use of an interactive, authentic therapeutic experience.

Relational-cultural therapy with older adults with a history of interpersonal trauma

Applying RCT to the population of elders who present with unresolved trauma from their childhood would look similar to RCT trauma focused psychotherapy, which was outlined above. It will be important to keep in mind the extra disconnections that seniors experience during this time in their life that could be exasperating the effects from the unresolved trauma. Some of these disconnections could be in the form of how the community treats the elder, the physical and cognitive changes that are occurring, or perhaps the losses of friends, family, and partners that often accompany this period of development.

One of the strengths of RCT is that it is so versatile to many disadvantaged populations, and for the reason, seems that it would be easily applied to treating traumatized seniors, even though there is a lack of literature directly applying the RCT concepts to elders in general. Elders with a history of trauma are certainly a disadvantaged population and the relational therapy would remind clinicians of the power dynamic in the therapy room and attempt to make it as mutual as possible.

CHAPTER 6

DISCUSSION

This concluding chapter will review trauma theory and examine older adults with a history of interpersonal trauma through the lens of attachment and relational-cultural theories. Attachment theory sheds light onto the relational difficulties that may be present in an elderly survivor of interpersonal trauma. Relational-cultural theory examines why persons following a trauma will be disconnected from the others and also informs the psychotherapy treatment for older adults suffering from the long-term effects of interpersonal trauma experienced earlier in life.

Just as a review, survivors of interpersonal trauma may have difficulties with affect regulation, negative perception of themselves, feelings of shame and humiliation. These difficulties may cause them to dissociate, use self-destructive behaviors, or isolate from relationships in an attempt to help them cope with these symptoms in the aftermath of interpersonal trauma. Depending on the severity or length of the traumatic experiences, these symptoms may vary.

There are three ways that older adults can present following a history of interpersonal trauma: lifelong trauma symptoms and other reactions to the trauma; delayed onset of trauma symptoms late in life; or never developing a negative trauma reaction to their experience of interpersonal trauma. It is the assumption of this researcher that the those elders who do not experience ongoing trauma symptoms throughout their lives perhaps were able to have a healthy

support system in place to help them cope with the trauma. Those elders who suffered their entire lives from the aftermath of their earlier trauma may not have been able to seek or receive help from friends or family, which may be due to the isolating effect trauma can have on survivors. The third group, those elders who experienced late onset trauma symptoms may have had changes during the later years of life placing them more at risk for developing these symptoms.

Trauma theory proposes that healing from trauma is best addressed in stages (Herman, 1992). The first stage is stabilizing the client. Once the client has worked through some of the presenting symptoms and has learned some adaptive behaviors to help cope with the dysregulation in the aftermath of interpersonal trauma. The second stage aims to reflect on the trauma narrative, in hopes that the past trauma can be integrated in the larger narrative of an individual's life.

Next, attachment theory creates a context in which to examine the relational effects in survivors of interpersonal trauma. According to attachment theory (Bowlby, 1969) caregivers act as a secure base to help sooth infants when they become distressed by the external world. Having this ability to access help when needed, infants who develop secure attachments to their caregivers feel more comfortable exploring their environment more freely than do insecurely attached infants. Insecurely attached infants do not feel that their caregiver would be available if they need soothing during a distressful situation. Depending on the interactions between infant and caregiver, the infant may develop one of three insecure attachment styles: avoidant, ambivalent, or disorganized/disoriented.

Parallel attachment categories have been created to explain adult attachment behavior (Hazan & Shaver, 1987). Secure attachment refers to someone who has the capacity for

satisfying personal relationships. Avoidantly attached adults tend to have a dismissing stance on relationships. They tend to minimize the importance of relationships, remain emotionally distant, and relay on themselves for most of their needs. Ambivalent adults present as preoccupied in regard to relationships in their life but are conflicted about becoming close emotionally to others. The disorganized/disoriented adult may appear chaotic with regard to relationships, which may be due to unresolved grief or loss issues or a history of childhood abuse or neglect (Main, Kaplan, and Cassidy, 1985).

Research in the area of older adult attachment is limited. Therefore, it is unclear whether one's attachment style remains stable throughout adulthood or if there are changes that occur due to the challenges that accompany the later years of life. A few studies have given some insight into elders' attachment styles (Zhang & Labouvie-Vief, 2004; Consedine & Magai, 2006). The literature also found a larger percentage of insecurely attached individuals than securely attached individuals in the general population of older adults. There are two hypotheses about why there is a higher rate of insecurely attached older adults. The first way relates to the many losses elders experience during this period of their life. The change in attachment style to a more insecure one may be due to the attempt to cope with these losses. The second hypothesis relates to cohorts. Magai (2001), a researcher in the field of older adult attachment, believes that elders today are more insecurely attached compared to other cohorts due to the influence of behaviorism. Overall, consistent with adult attachment research (Bartholomew & Horowitz, 1991), securely attached elders tend to better adapt to the changes that occur during this period of life and also report more supportive relationship in their life (Wensauer & Grossman, 1995).

Applying attachment theory to the population of elders with a history of interpersonal trauma may create a better understanding of why trauma creates relational difficulties throughout

50

an adults' lifetime. If the trauma occurs during childhood there could be difficulties of affect

regulation, since the child was not properly attended to during times of negative affect. Therefore

the child grows up to be unable to manage negative affects independently (Feeney, 1998). These

difficulties in affect regulation are also related to the person's ability to seek support. Therefore,

insecurely attached elders with a history of trauma will have a particularly difficult time making

and maintaining relationships according to both attachment and trauma theories.

Review of RCT

RCT, like attachment theory, emphasizes the importance of healthy relationships to

adaptive development. Similarly, RCT states that everyone desires connections and all growth

occurs in the context of those relationships (Miller & Stiver, 1997). But RCT deviates from

attachment theory by placing the emphasis on empathy and empowerment. These growth-

fostering relationships emerge through from empathy and empowerment.

RCT theories go into depth about what characterizes these growth-fostering relationships

and their outcomes. Miller (1986) refers to "five good things" that should be present in these

growth-fostering relationships. These include: increased feelings of connection ("zest") within

the relationship; increased ability to feel that one is empowered; increased ability to reflect upon

one's self, the other, and the relationship; increased feelings of self-worth; and a desire to form

more growth-fostering relationships. In contrast to more traditional western psychological theory

that promotes growth towards individuation, RCT emphasizes the importance of growth within

connections.

But what if there is a disconnection in the relationship? These disconnections can take the

form of an empathic failure, relational violations and even abuse. Of course, RCT points out that

these disruptions in connection are inevitable, but the ways in which these disconnections are

handled afterwards is where the potential for isolation or growth occurs. If the person who was injured in the disconnection is able to represent her feelings and the other person is able to respond empathically to those feelings, than the person is able to increase her sense of relational competence, thus enhancing the ability to change and feel more effective within relationships (Jordan, 1999). In the event that the injured person is unable to express her feelings to the other person in the relationship or, if she is able to express her feelings and is met with a response that lacks empathy, she will adjust the way she represents herself in the relationship. Consequently, she will keep parts of herself out of the relationships in hopes of maintaining the connection. This phenomenon is known as *strategies of disconnection* (Miller, 1988). This process is referred to as the "central relational paradox" in the RCT literature (Miller & Stiver, 1997). Strategies of disconnection have been observed in adolescent girls who are less authentic in their relationships in an attempt to maintain the relationship (Gilligan, Lyons, & Hanmer, 1990). The consequences of being less authentic in a relationship are the opposite of the *five good things* and include: decreased feelings of connection, empowerment, clarity, self-worth, and yearn for more relationships. When a client feels those reactions to relationships, she may start to isolate, which according to RCT, is the heart of most of the suffering (Jordon, 2000).

Relational Psychotherapy with Elders with Prior Interpersonal Traumatization: applying RCT

A major premise of RCT believes is that the development of mutual empathy and mutual empowerment in the context of relationships is how growth and relief from the suffering occur (Miller & Stiver, 1997). When this construct is applied in treatment, mutual empathy and mutual empowerment are fostered by the client seeing and understanding the effect she/he has on the therapist. In relational therapy, the clinician takes on a more interactive role in the therapy relationship which is a step away from the neutral therapist role of more traditional

psychoanalytic therapies. RCT promotes this change in the therapist's stance due to the notion that isolation and strategies of disconnection arise when relationships are disempowering, not responsive, or lack mutual empathy.

When traumatized people of any age enter into a therapeutic relationship, RCT emphasizes relational practices that promote a safe environment where clients will feel comfortable to share all of themselves with the therapist (Hartling et al, 2004). The first strategy for therapists is to listen and respond, promoting an interactive environment. This is particularly important for those clients who have been living in isolation as a response to previous trauma. The second suggestion for working with clients with a history of trauma is to promote mutual empathy, which is done by empathizing with the client's experience and their strategies of disconnection, as these have kept the client functioning in some capacity. The third way to promote a safe and comfortable therapeutic environment for a traumatized client involves being authentic when interacting with clients. This does not mean that therapists should disclose information to their clients, but should respond authentically when engaging in therapy. The movement toward mutuality speaks to the fourth way to create the optimal space in the therapeutic relationship. Mutuality in the therapy can be maintained by being cognizant of the power dynamics in the room. For a client with a history of interpersonal trauma, it can be particularly important to not recreate the abusive dynamics that the client was exposed to earlier in their life. The last relational practice recommended to clinicians with clients with a trauma history is the use of humor. Hartling et al. (2004, pp. 104) believes that humor is an "effective method of disarming or neutralizing feelings of shame or humiliation".

Hypothetical Clinical Case

Miriam is a 75-year-old single Caucasian woman who presented with complaints of life-long depression and difficulties in relationships. After completing a comprehensive biopsychosocial assessment, the clinician wondered if the client was a victim of trauma in her childhood based on her complaints of difficulty relating to others, which may have began in her childhood with a difficult relationship to her caregivers. Miriam confirmed that her mother was cold, distant, and verbally and physically abusive when they did engage. Miriam described several incidents where her mother would not sooth her when she was emotionally upset and would seemingly randomly yell and hit her. Miriam remembers not understanding what lead to these abusive moments. The unpredictability of her mother's actions would likely have made the abuse more severe, as Miriam was unable to form strategies to avoid the abuse. The abuse also may have led her to become hyperaware of her mother's actions in an attempt to predict her behavior. Miriam likely has difficulty finding satisfaction with relationships due to her inability to trust others after the unpredictable and interpersonal nature of her childhood abuse.

Trauma theory would explain how Miriam's symptoms of depression and relational difficulties might be attributed to her abusive and neglectful experience with her mother. From a neurobiological perspective, a clinician might wonder if this early abuse has an effect on her brain development, which might have implications on her ability to regulate affect and socially relate to others. Not having a mother who contained, mirrored, and processed her internal affective states perhaps left her feeling unable to understand and regulate her affect. Also, the abuse she experienced growing up may have been internalized and the negative reactions she was used to receiving from her abusive mother may have caused her to not fully develop social parts of her brain that are helpful in reading social cues and faces, and which may be connected to her lifelong difficulty with relationships.

Applying attachment theory to this case would imply that perhaps Miriam internalized the negative responses she received from her mother. Since her mother was both the cause for her fears and also was her only source for support while she was younger, she likely was conflicted about engaging with her. Miriam may have been disorganized in her attachment style to her mother due to the frightening behaviors she observed. Throughout her life she likely had a negative image of herself and viewed others as distrustful, similar to her experience with her mother. Bowlby (1969) would assume this was due to the client's internal working model, which was based on these early abusive and neglectful experiences. Miriam then perceived all future relationships through that lens and perhaps found herself in situations that were also abusive throughout her life.

Relational-cultural theory would inform the treatment of this client. RCT would view Miriam's many disconnections from the very start of her life as what caused her to isolate from others. This isolation, in turn, prevented Miriam from forming growth-fostering relationships that would help heal her suffering. By creating a safe and comfortable environment, psychotherapy could be a place where this client is able to form a relationship based on mutual empathy in order to feel more empowered to seek out growth-fostering relationships outside of the therapy. This movement out of isolation and into connection will be a way she can resolve her difficulty relating to others and perhaps alleviate the depression.

Summary

The research on the long-term consequences of trauma in the elderly population is scarce to date. Thus, more research is needed to better understand the detrimental effects that childhood traumatization can have on an older adult's life. The power of relationships on positive psychological and physical health has been well documented (Atkins, Kaplan, & Toshima, 1991;

Ganellen & Blaney, 1984; Ornish, 1997). Theories on interpersonal trauma recovery (Herman, 1992) point to the importance of the relational component in the healing process; but this process has not been specifically examined in relation to elders who are survivors of childhood trauma and who present to psychotherapy during the later years of life.

Attachment theory and relational-cultural theory attest to the resilience of those who were either relationally connected and either did not develop or were able to overcome their negative trauma reaction earlier in life. Attachment theory (Bowlby, 1969) explains the positive impact that relationships can have on a person's overall wellbeing, which can also explain a securely attached elderly adult's ability to cope with negative life events. Attachment theory also explains why social support is a protective factor for trauma survivors. Those who are securely attached will be able to use their relational resources to cope with their experiences more easily than those who are insecurely attached, and have more difficulty accessing relational support.

Relational-cultural theory extends our knowledge of the helpfulness of relationships and uses it to direct the psychotherapy with trauma survivors. Relational-cultural therapy targets the social difficulties that often follow trauma as the therapist helps the client reengage, or engage for the first time, in growth fostering relationships. These growth-fostering relationships help the client learn about herself/himself and grow emotionally through mutual empathy. Compared to social support as defined in other research (Jordan & Hartling, 2002), RCT also emphasizes that connections should be to two-way, mutually empowering, growth-fostering relationship.

In conclusion, although relationships can hurt, as seen through interpersonal trauma, relationships also seem to be a strong healing force, according to attachment theory and RCT.

References

Aarts, P., & Op den Velde, W. (1996). Prior traumatization and the process of aging. In B. Van der Kolk, A. McFarlane, & L. Weisaeth (Eds), *Traumatic Stress: The effects of overwhelming experience on mind, body, and society* (pp. 359-377). New York: Guilford Press.

Adam, K., Sheldon Keller, A., & West, M. (1995). Attachment organization and vulnerability to loss, separation, and abuse in disturbed adolescents. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives* (pp.309-341). Hillsdale, NJ: Analytic Press.

Ainsworth, M. D. S. (1967). *Infancy in Uganda: Infant care and the growth of love.* Baltimore: Johns Hopkins University Press.

Ainsworth, M. D. S. (1989). Attachments beyond infancy. *American Psychologist, 44,* 709-716.

Ainsworth, M. D. S. (1991). Attachment and other affectional bonds across the life cycle. In C. M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds), *Attachment across the life cycle* (pp. 33-51). New York: Routledge.

Allen, J. G. (2001). *Traumatic Relationships and Serious Mental Disorders*. Chichester: Wiley.

Allen, J. G., Coyne, L., & Console, D. A. (2000). Course of illness following specialized inpatient treatment for women with trauma-related psychpathology. *Bulletin of the Menninger Clinic, 64,* 235-256.

American Psychological Association (2000). *Diagnostic and statistical manual of mental disorders, 4th edition.* Washington, D.C.: American Psychiatric Press.

Andersen, S. M., & Glassman, N. S. (1996). Responding to significant others when they are not there: Effects on interpersonal inference, motivation, and affect. In R. M. Sorrentino & E. T. Higgins (Eds.), *Handbook of motivation and cognition: Vol. 3. The interpersonal context* (pp. 262-321).

Andersson, L., & Stevens, N. (1993). Associations between early experiences with parents and well-being in old age. *Journals of Gerontology, 48,* 109-116.

Armsden, G. C., & Greenberg, M. T. (1987). The inventory of parent and peer attachment: Relationships to well-being in adolescence. *Journal of Youth and Adolescence, 16,* 427-454.

Banks, A. (2006). Relational therapy for trauma. *Journal of Trauma Practice, 5,* 25-47.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*, 226-244.

Bowlby, J. (1969). *Attachment and loss, Volume 1. Attachment.* New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss, Volume 2: Separation.* New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss, Volume 3: Loss: Sadness and depression.* New York: Basic Books.

Bowlby, J. (1982). *Attachment and loss, 2nd Edition, Vol. 1: Attachment* (2nd edn.). New York: Basic Books.

Bowlby, J. (1984). Violence in the family as a disorder of the attachment and caregiving systems. *American Journal of Psychoanalysis, 44,* 9-27.

Bradley, J. M. & Cafferty, T. P. (2001). Attachment among older adults: Current issues and directions for future research. *Attachment and Human Development, 3,* 200-221.

Breslau, N. (1998). Epidemiology of trauma and posttraumatic stress disorder. In R. Yehuda (Ed.), *Psychological trauma* (pp. 1-29). Washington, DC: American Psychiatric Press.

Brewin, C. R., & Andrews, B. (1998). Recovered memories of trauma: Phenomenology and cognitive mechanisms. *Clinical Psychology Review, 18,* 949-970.

Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse and Neglect, 14,* 357-364.

Bright, C.L., & Bowland, S. E. (2008). Assessing interpersonal trauma in older adult women. *Journal of Loss and Trauma*, *13*, 373-393.

Brumbaugh, C. C., Fraley, R. C. (2006). Transference and attachment: How do attachment patterns get carried forward from one relationship to the next? *Personality and Social Psychology Bulletin, 32,* 552-560.

Cassidy, J., & Kobak, R. R. (1988). Avoidance and its relationship with other defensive processes. In J. Belsky & T. Nezworski (Eds), *Clinical implications of attachment* (pp. 300-323).

Cassidy, J., & Mohr, J. J. (2001). Unsolvable fear, trauma, and psychopathology: Theory, research and clinical considerations related to disorganized attachment across the lifespan. *Clinical Psychology, 8,* 275-307.

Cole, P. & Putnam, F.W. (1992). Effect on incest on self and social functioning: a developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology, 60,* 174-184.

Coleman, P.G. (1986). *Aging and reminiscence process: Social and clinical implications.* New York: Wiley.

Collins, N. L., & Read, S. J. (1994). Cognitive representations of attachment: The structure and function of working models. In K. Bartholomew & D. Perlman (Eds.), *Advances in personal relationships: Vol. 5. Attachment processes in adulthood* (pp. 53-90). London: Kingsley.

Consedine, N. S., Magai, C., & Gillespie, M. (2006, July). *Patterns of relating in young, middle-aged, and older urban-dwelling adults: The metaphysics of attachment revisited.* Poster presented at the Third Biennial Conference of the International Association for Relationship Research, Rethymnon, Crete, Greece.

Cozolino, L. J. (2006). *The neuroscience of relationships: Attachment and the developing social brain.* New York: Norton.

Cutrona, C. E., & Russell, D. W. (1990). Type of social support and specific stress: Toward a theory of optimal matching. In B. R. Sarason, I. G. Sarason, & G R. Pierce (Eds), *Social Support: An interactional view* (pp. 319-366). New York: Wiley.

Drossman, D. A., Leserman, J., Nachman, G., Li, Z., Gluck, H., Toomey, T. C., Mitchell, C. M. (1990). Sexual and physical abuse in women with functional or organic gastrointestinal disorders. *Annals of Internal Medicine, 113,* 828-833.

Elder, G.H. Jr. and Clipp, E.C. (1988). Combat experience, comradeship, and psychological health. In Wilson JP, Harel, Z., Kahana, B., eds *Human adaptation to extreme stress: from the Holocaust to Vietnam*. New York: Plenum, pp. 131-56.

Erikson, E. (1965). *Childhood and society (2nd ed.).* Harmondsworth, England: Penguin Books.

Federal Interagency Forum on Aging Related Statistics: Older Americans 2004: Key Indicators of Well-Being. http://www.agingstats.gov/chartbook2004/population.htm

Feeney, J. (1998). Adult attachment and relationship-centered anxiety: Responses to physical and emotional distancing. In J. Simpson & W. Rholes (Eds.), *Attachment theory and close relationships* (pp. 189-217). New York: Guilford Press.

Feeney, J. A. & Noller, P. (1996). *Adult Attachment.* Beverly Hills, CA: Sage.

Feeney, J. A., Noller, P., & Hanrahan, M. (1994). Assessing adult attachment. In M. B. Sperling & W. H. Berman (Eds), *Attachment in adults: Clinical and developmental perspectives* (pp. 128-152). New York: Guilford Press.

Freud, S. (1957). Mourning and Melancholia. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 243-258). London: Hogarth Press. (Original work published 1917.)

Figley, C. (1988). A five-phrase treatment of PTSD in families. *Journal of Traumatic Stress, 1*(1): 127-41.

Foa, E., Zinbarg, R., & Rothbaum, B. (1992) Uncontrollability and unpredictability in post-traumatic stress disorder: An animal model. *Psychological Bulletin, 112,* 218-238.

Foy, D., Glynn, S., Schnurr, P., Jankowski, M., Wattenberg, M., Weiss, D., Marmar, C., & Gusman, F. (2000). Group therapy. In E. Foa, T. Keane, & M. Friedman (Eds.), *Effective treatments for PTSD* (pp. 155-175). New York, NY: The Guilford Press.

Greenberg, M. T., Siegel, J. M., & Leitch, C. J. (1983). The nature and importance of attachment relations to parents and peers during adolescence. *Journal of Youth and Adolescence, 12,* 373- 386.

Gilligan, C. (1982). *In a Different Voice.* Cambridge, MA: Harvard University Press.

Gilligan, C., Lyons, N. P. & Hammer, T. J. (Eds.). (1990). *Making connections: The relational worlds of adolescent girls at Emma Willard School.* Cambridge, MA: Harvard Univeristy Press.

Graziano, R. (2003). Trauma and aging. *Journal of Gerontological Social Work, 40*(4), 3-21.

Grillon, C., & Morgan, C. (1999). Fear potentiated startle conditioning to explicit and contextual cues in Gulf War veterans with posttraumatic stress disorder. *Journal of Abnormal Psychology, 108,* 134-142.

Hartmann, E. (1998). Nightmare after trauma as a paradigm for all dreams: A new approach to the nature and functions of dreaming. *Psychiatry, 61,* 223-238.

Hartling, L. M., Rosen, W. B., Walker, M., Jordan, J. (2004). Shame and humiliation: From isolation to relational transformation. In J. Jordon, M. Walker, & L. Hartling (Eds), *The Complexity of Connection.* (pp. 103-128). New York: Guilford Press.

Hazan, C., & Shaver, P. R. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52,* 511-524.

Herman, J. (1992). *Trauma and recovery.* New York: Basic Books.

Hertz, D. (1990). Trauma and nostalgia. *International Journal of Psychiatry and Related Sciences, 27,* 189-198.

Higgins, A., & Follette, V. (2002). Frequency and impact of interpersonal trauma in older women. *Journal of Clinical Geropsychology, 83,* 215-226.

Horowitz, M. J. (1997). *Stress response syndromes: PTSD, grief, and adjustment disorders* (3rd Ed.). Northvale, NJ: Aronson.

Janoff-Bulmam, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* New York: Free Press.

Jordan, J. (2000). The role of mutual empathy in relational/cultural therapy. *Psychotherapy in Practice, 56*, 1005-1016.

Jordan, J. (2001). A relational-cultural model: Healing through mutual empathy. *Bulletin of the Menninger Clinic, 65,* 92-103.

Jordan, J., Kaplan, A., Miller,J., Stiver, I., & Surrey, J. (1991). *Women's growth in connection.* New York: Guilford Press.

Kahana, B. (1981). Discussion: Reconciliation between the generations. *Journal of Geriatric Psychiatry*, *14*, 225-289.

Keane, T., & Wolfe, J. (1990). Comorbidity in post-traumatic stress disorder: An analysis of community and clinical studies. *Journal of Applied Social Psychology, 50,* 138-140.

Kessler, R., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, *52*, 1048-1060.

Khantzian, E. J. (1985). The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. *American Journal of Psychiatry, 142,* 1259-1264.

Lisak, D. (1993). Men as victims: Challenging cultural myths. *Journal of Traumatic Stress, 6,* 577-580.

Lysons-Ruth, K., Bronfman, E., & Atwood, G. (1999). A Relational diathesis model of hostile-helpless states of mind: Expressions in mother-infant interactions. In J. Solomon & C. C. George (Eds.), *Attachment disorganization.* New York: Guilford Press.

Magai, C. (2001). Emotions over the lifespan. In J. E. Birren & K. W. Schaie (Eds), *Handbook of the psychology of aging* (5th ed., pp. 310-344). San Diego, CA: Academic Press.

Magai, C. (2008). Attachment in middle and later life. In J. Cassidy & P. R. Shaver (Eds), *Handbook of Attachment: Theory, research, and clinical applications.* (pp. 532-551). New York: Guilford Press.

Magai, C., Cohen, C., Milburn, N., Thorpe, B., McPherson, R., & Peralta, D. (2001). Attachment styles in older European American and African American adults. *Journals of Gerontology: Series B. Psychological Sciences and Social Sciences, 56B,* 28-35.

Main, M. (1990). Cross-cultural studies of attachment organization: Recent studies, changing methodologies, and the concept of conditional strategies. *Human Development, 33*, 48-61.

Main, M. Attachment: Overview with implications for clinical work. In S. Goldberg, R. Muir, & J. Kerr (Eds), *Attachment theory: Social, developmental, and clinical perspectives* (pp. 407-474). Hillsdale, NJ: Erlbaum.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 161-182). Chicago: University of Chicago Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.), *Growing points of attachment theory and research* (Monographs of the Society for Research in Child Development, Serial 209, Vol. 50, No. 1-2, pp. 66-104). Ann Arbor, MI: University of Michigan.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during Ainsworth strange situation. In M. Greenberg, D. Cicchetti, & E.M. Cummings (Eds.), *Attachment during the preschool years: Theory, research and intervention* (pp. 121-160). Chicago: University of Chicago Press.

McFarlane, A. (1990). Posttraumatic stress disorder. *International Review of Psychiatry*, *3*, 203-213.

McFarlane, A. C., & Rachel Yehuda. (1996). Resilience, vulnerability, and the course of posttraumatic reactions. In B.A. van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.), Traumatic stress: the effects of overwhelming experience on mind, body, and society (pp. 155-181). New York: Guilford Press.

McLeod, A. (1994). The reactivation of posttraumatic stress disorder in later life. *Australian and New Zealand Journal of Psychiatry, 28*, 625-634.

McLeod, A. (1994). The reactivation of posttraumatic stress disorder in later life. *Australian and New Zealand Journal of Psychiatry*, 28, 625-634.

Mendelson, M., Zachary, R., & Harney, P. (2007). Group therapy as an ecological bridge to new community for trauma survivors. *Journal of Aggression, Maltreatment, and Trauma, 14* (1/2), 227-243.

Mikulincer, M., & Shaver, P. R. (2004). Security-based self-presentations in adulthood: Contents and processes. In W.S. Rholes & J.A. Simpson (Eds.), *Adult attachment: Theory, research, and clinical implications*. (pp. 159-195). New York: Guilford Press.

Mikulincer, M., & Shaver, P. R. (2007). Attachment in adulthood: Structure, dynamics, and change. New York: Guilford Press.

Miller, J. B. (1986). *What do we mean by relationship?* (Work in Progress, No. 70). Wellesley, MA: Stone Center Working Paper Series.

Miller, J. & Striver, I. (1997). *The healing connection*. Boston, MA: Beacon Press.

Moody, H. R. (1998). Why dignity in old age matters. *Journal of Gerontological Social Work, 29,* 13-38.

Opler, L., Grennan, M., & Ford, J.. (2009). Pharmacotherapy. In Courtois, C. & Ford, J. (Eds.), *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide,* (pp. 329-350) New York: Guilford Press.

Parkes, C. M. (1991). Attachment, bonding, and psychiatric problems after bereavement in adult life. In C. M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds), *Attachment across the life cycle* (pp. 268-292). New York/London: Tavistock/Routledge.

Polusny, M., and Follette, V. (1995). Long term correlates of child sexual abuse: Theory and review of the empirical literature. *Appl. Prev. Psychol. 4*: 143–166.

Rice, K. G. (1990). Attachment in adolescence: A narrative and meta-analytic review. *Journal of Youth and Adolescence, 19,* 511-538.

Sable, P. (1989). Attachment, anxiety, and loss of a husband. *American Journal of Orthopsychiatry, 59,* 550-556.

Scharlach, A. E. (1991). Factors associated with filial grief following the death of an elderly parent. *American Journal of Orthopsychiatry, 61,* 307-313.

Scharlach, A., Damron-Rodriguez, J., Robinson, B., & Feldman, R. (2000). Educating social workers for an aging society: A vision for the 21st century. *Journal of Social Work Education, 36,* 521–538.

Schmid, A. H. (1991). The deficiency model: An exploration of current approaches to late-life disorders. *Psychiatry, 54*, 358-367.

Schwartz, R.C. (1995). *Internal Family Systems Therapy*. New York: Guilford Press.

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*. New York: Guilford Press.

Shaver, P. R. & Brennan, K. A. (1992). Attachment styles and the "Big Five" personality traits: Their connections with each other and with romantic relationship outcomes. *Personality and Social Psychology Bulletin, 18,* 536-545.

Shaver, P. R., Schwartz, J., Kirson, D., & O'Connor, C. (1987). Emotion knowledge: Further exploration of a prototype approach. *Journal of Personality and Social Psychology, 52,* 1061-1086.

Sroufe, L.A., Egeland, B., Carlson, E. & Collins, W. (2005). *The development of the person: The Minnesota study of risk and adaption from birth to adulthood*. New York: Guilford Press.

van der Hart, O., Steele, K., Boon, S., & Brown, P. (1993). The treatment of traumatic memories: Synthesis, realization, and integration. *Dissociation, 6,* 162-180.

van der Kolk, B. A. (1996). *The body keeps score: approaches to psychobiology of posttraumatic stress disorder.* In B.A. van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: the effects of overwhelming experience on mind, body and society* (pp. 214-241). New York: Guilford Press.

van der Kolk, B. A. (1996). *The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development.* In B.A. van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.), Traumatic stress: the effects of overwhelming experience on mind, body, and society (pp. 182-213). New York: Guilford Press.

van der Kolk, B. A., McFarlane, A. C. (1996) *The black hole of trauma, in Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society.* In B. A. van der Kolk, A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society*, (pp 3-23). New York: Guilford Press.

van der Kolk, B., A., van der Hart, O., & Marmar, C.R. (1996). Dissociation and information processing in posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 303-327). New York: Guilford Press.

van der Kolk, B., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of Extreme Stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*, 389-399.

Webster, J. D. (1997). Attachment style and well-being in elderly adults: A preliminary investigation. *Canadian Journal on Aging, 61,* 101-111.

Wensauser, M., & Grossmann, K.E. (1995). Quality of attachment representations, social interaction, and use of network resources in old age. *Zeitschrift fuer Gerontologie und Geriatrie, 28,* 444-456.

Yehuda, R., Kahana, B., Schmeidler, J., Southwick, S., Wilson, S., & Giller, E. (1995). Impact of cumulative lifetime trauma and recent stress on current posttraumatic stress disorder symptoms in Holocaust survivors. *American Journal of Psychiatry, 152*, 1815-1818.

Zhang & Labouvie-Vief, G. (2004). Stability and fluctuation in adult attachment style over 6-year period. *Attachment and Human Development, 6,* 419-437.

Zlotnick, C., Shea, M., Pearlstein, T., Begin, A., Simpson, E., & Costello, E. (1996). Differences in dissociative experiences between survivors of childhood incest and survivors of assault in adulthood. *Journal of Nervous and Mental Disease, 184,* 52-54.