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The Elderly and September 11, 2001

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Our nation's elders are undoubtedly traumatized by the terrorist attacks of September 11, but many may be suffering in silence. Here is a technique that you can use with senior patients and clients to help them articulate the painful feelings associated with these tragic events.

By Joseph A. Lieberman, III

During the mid-morning hours of September 11, 2001, the world abruptly and dramatically changed. Millions upon millions of individuals, both in this country and abroad, were literally eyewitnesses to a tragedy that not only destroyed many lives but also many ideals. Collectively, we had just witnessed death and destruction on a scale not commonly encountered in the United States. We suddenly felt very vulnerable and fearful.

While many other parts of the world have been prey to large-scale violence for decades, this is new to the United States—and the manner in which it was carried out was an assault on our way of life as well as our citizens. The unrestricted passage of individuals from one part of the country to another is one of the hallmarks of our democratic society, and it has shaken our society to its core to see that freedom turned into an instrument of mass destruction.

As a result of this action, health care professionals have observed a surge in the occurrence of a condition known as Posttraumatic Stress Disorder (PTSD). This condition is well described in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* published by the American Psychiatric Association. That publication states that PTSD can be characterized as follows:

> The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve

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intense fear, helplessness, or horror (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than one month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. The disorder may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape). The likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increase.[1]

The probability is extremely high that many of our seniors are experiencing some form of PTSD as a result of September 11th. However, it may be very difficult to recognize this condition in this population because their frame of reference is different from that of subsequent generations. Many of today's seniors were born into the Great Depression and then went on to fight in World War II and Korea. As mature wage earners, they witnessed the assault on their traditional value systems brought about by the Kennedy assassination and the tumultuous 1960s, experienced national angst over the Vietnam War and the association of U.S. presidents with the Watergate and Monica Lewinsky scandals. They have experienced privation, shortages, and yes, insecurity—as many remember Pearl Harbor! Complicating the issue is that many younger people (e.g., Baby Boomers and Generation Xers) who interact with the elderly have known only relative peace and prosperity. They are frequently characterized as the generations that know what they want and are not afraid to ask for it.

This is not necessarily the style of the elderly, as their lot in life has been more directed at giving and self-sacrifice with less attention to self-indulgence. This is not to say that seniors are in any way blasé about the events of September 11th, as they are not. Many view September 11th as the singular most traumatic event in their lifetimes. Yes, the event is emblazoned on their consciousnesses, but the way in which they express it may be much different from that of younger generations. We need to be aware that many seniors are suffering in silence at a time when the best therapy would be, in many instances, to talk about it. As devastated as many of the members of more recent generations have been by this event, it would be a mistake to assume that seniors, because of the significant life experiences that they have endured, are somehow immune to the consequences of September 11th. Although they may be somewhat better prepared to deal with it, they may not talk about it. But anyone who interacts with the elderly needs to be aware that the impact of the events of September 11, 2001 pose a real danger to many seniors' health and well-being. This reality needs to be kept in mind, and asked about, in dealing with our colleagues, friends, and relatives—and that definitely includes the elderly.

One way to do this would be to borrow some techniques that are already widely used in the medical profession for assessing a patient's overall status. Physicians and other health care providers frequently employ the Problem Oriented Medical Record as a way of developing and maintaining patient records. In the 1970s, Dr. Larry Weed developed the SOAP technique to accomplish this. SOAP stands for: Subjective data, new Objective data, Assessment of the new data, and new Plans that are determined by the new data. To this, Dr. Marian Stuart and I added the BATHE technique, which provides a psychosocial evaluation of a patient's status and gives the clinician a way to capture those data in a format consistent with the problem-oriented medical record.[2] The BATHE acronym stands for the following:

Background: A simple question will elicit the context of the patient's visit: "What is going on in your life?"

Affect: Questions such as, "How do you feel about that?" or, "What's your mood?" allow the patient to report his or her current feeling state.

Trouble: The question, "What about the situation troubles you the most?" helps both the physician and the patient focus on the situation's subjective meaning.

Handling: The answer to, "How are you handling that?" gives an assessment of functioning.

Empathy: A statement can legitimize the patient's reactions: "That must be very difficult for you."[3]

The BATHE technique enables the practitioner to get at elements critical to understanding the "whole" patient that are not readily ascertained through standard interview techniques. But its utility is not limited to medical encounters. Rather, it can be used in many settings involving patients, clients, colleagues, and friends. It is a technique that can be quickly mastered and universally applied, and it can reveal much needed information when one is assessing or attempting to assist members of all (but particularly the "greatest") generations.

I would encourage everyone who has encounters with our senior citizens to discuss issues of this ilk and apply the BATHE technique where appropriate. Seniors need not suffer in silence—but suffer they will if the silence is misinterpreted as disinterest. Remember, the first step in problem-solving is to identify that a problem exists. Using any technique that you can to elucidate the situation, up to and including BATHEing, may be one of the most important things you can do to reduce the pain and suffering associated with the September 11, 2001 world trauma.

Endnotes

1. *American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders,* at 424 (4th ed. 1994).

2. Marian R. Stuart & Joseph A. Lieberman III, The Fifteen Minute Hour: Practical Therapeutic Interventions in Primary Care, (3rd ed. forthcoming 2002).

3. Joseph A. Lieberman III, "Using the BATHE Technique with Older Patients," 1 *Geriatric Times* 28 (May-June 2000).