Perspective

Soma Crisis

Nora Johnson

Clinical Practices of the University of Pennsylvania, United States

A R T I C L E   I N F O

Article history:
Received 21 April 2015
Received in revised form
23 April 2015
Accepted 24 April 2015
Available online 3 June 2015

Keywords:
Soma crisis
Life crisis
Aging
Health crisis
Sexagenarian
PM&R

I used to think that growing older would bring more control to my life, that decisions would be easier and dilemmas fewer with the benefit of acquired experience and wisdom. After all, isn’t that the trade-off for our loss of collagen and flexibility? Our culture reinforces this assumption. So dominant is this thinking that adages abound coupling the aging process with the growth of wisdom. In fact, experience usually does comb our paths through life. And in most instances, our ability to adapt, predict, and adjust do increase as we age.

Yet for one out of every three adults over sixty, crisis strikes that no amount of experience can ameliorate. The aptly named “later life crisis” affects one-third of all sexagenarians. This type of crisis is the result of the confluence of several concurrent dilemmas that overwhelm the unwitting individual. For example, consider a 64-year-old lan who is faced with a divorce while planning for retirement and taking in a troubled adult daughter. If he becomes emotionally overwhelmed, his triune of dilemmas constitutes a later life crisis that signals a special set of responses in the sexagenarian. Any of these changes taken individually would likely have been manageable, but together they become unbearable, bringing lan’s self-image and life roles into question.

Being in crisis is not a new concept. In fact, if you’ve made it to mid-life, chances are 96% that you have dealt with at least one crisis in your life. And most of us have grappled with more than one. Research, observation, and interpersonal experience may substantiate the idea that crises are more common and perhaps longer lasting than originally postulated. In reality, so pervasive are individual crises that we identify them by life stage. The “identity crisis” presents itself in our teen years as we grapple with our imminent adult roles and how we will master them. As the first life crisis identified—and for years the only one identified—the phrase and concept “identity crisis” entered common parlance and became a fixture of pop and academic psychology. Identified in the 90’s, the “quarterlife crisis” appears in our twenties when young professionals struggle to distinguish themselves career-wise and by selecting a mate. Identified in 1965, the “midlife crisis” arrives in the fourth and fifth decades of life and results from the emotional adjustment to career, family, and the physical changes confronting a person during these years (e.g., menopause or andropause, decline in athleticism or career, and empty-nest syndrome). Next in the sequence is the “later life crisis” experienced by persons in their sixties. As mentioned before, this phenomenon is common amongst sexagenarians though newly identified and not yet well understood.

Oliver Robinson’s research (2012) in Harrogate, England points to 32% of those in their sixth decade who face a coalescence of crises that is often triggered by a physical health crisis. Robinson’s research takes a step further down the road to correlate ability to cope and life experience. For example, he states that a negative response after crisis, like withdrawal, leads to increased deterioration in mental and physical health; whereas, a positive response to physical crisis, like confronting one’s feelings and actively coping and life experience. For example, he states that a negative response after crisis, like withdrawal, leads to increased deterioration in mental and physical health; whereas, a positive response to physical crisis, like confronting one’s feelings and actively improving one’s situation, leads to improved health. Responses expressed by many patients support Robinson’s research.

What is often encountered in the acute physical rehabilitation setting is a subset of the later life crisis that surfaces after a physical health catastrophe, such as a stroke or a spinal cord injury. I call this subset the “Soma Crisis” because it strikes people in their sixties as they encounter a health or bodily crisis while dealing with extraordinary family, work, and personal stressors. The health complications that lead to Soma Crises arise abruptly and without much warning. Consider a neurological condition that decimates gait (e.g., Guillain-Barre Syndrome, multiple sclerosis) or a motor vehicular accident that paralyzes an individual. It is precisely the acute onset of the health predicament and its timing that
precipitate a crisis because individuals are unable to prepare for or adjust to the physical changes accompanying their dire straits.

Despite its frequent occurrence, Soma Crisis is rarely recognized by either patient or healthcare staff because even in the rehabilitation phase focus must necessarily be on the patient’s medical needs. Additionally, because the dynamic of this crisis is unacknowledged, it is not seen as distinct from other rehab recovery processes.

1. The progression

As a clinical neuropsychologist, I meet this niche of patients in my physical medicine and rehabilitation unit. Soma Crisis patients show a more traumatized and paradoxically less adaptive approach in their coping mechanisms than do the 20- or 30-something patients in similar situations. This may seem counter-intuitive. If experience teaches us to deal with life punches in smarter ways, why is a crisis at this point in life more difficult?

It is for three reasons. First, the number of calamities coalescing at one time can readily overwhelm a person. Second, the responsibilities this age group juggles often present themselves on three fronts: aging parents, adult children problems, and career transitions. Third, the sexagenarians’ expectations have led them astray thinking life would be easier as it progresses. The first reason is self-explanatory, so let’s concentrate on the latter two. Responsibilities generally accumulate with age. By the time they reach their sixties, most adults have accumulated responsibilities, established careers, and built roles that are far more complicated than those of a 30-year old. To boot, the sexagenarian is, more often than not, part of the sandwich generation navigating or responsible for the changes in children’s and parents’ lives. Frequently, the 60-something patient is trying to balance care for both. Because of their accumulated roles and responsibilities, it follows that people in this age bracket have more to lose from their caches of familial, financial, career, and social involvement. Some may be transitioning to retirement or reevaluating careers, changing life activities as they find new interests or retire old ones. Others may want to spend more time with grandchildren. Most are redefining their roles with friends and family.

When these plans and expectations are suddenly altered by grave physical changes, sexagenarians often respond to their new dilemmas by looking inward, questioning their ability to fulfill or resume roles as providers, problem-solvers, and contributors to the workplace. They question their futures and wonder whether a recently anticipated retirement will morph into a form of bodily imprisonment and the reality of astronomical health costs.

The scale of disaster of a health crisis at any age is all-changing. However, younger patients in their 20s and 30s show a different type, duration, and strength of response. They are generally more concerned about repositioning themselves within their social groups, returning to work, making a living, or resuming support of a young family. The younger in crisis often adapt more quickly because their life roles are fewer in number and less well formed. In addition, they typically don’t question their self-worth for as long because they have fewer people relying upon them.

Expressions of grief and wonder about why they were victims of such grave mishap swirls in the air unresolved for days, sometimes weeks. This phase is the initial and core component common to any type of crisis, and individuals show varying degrees of denial at this time.

Gradually, the shock wears off and yields to a second stage of grief and questioning.

The patients grieve what is lost of their functioning, their life roles. In this stage individuals question their self-esteem and identity in ways similar to the adolescent identity crisis. At this point in the process, working with a mental health professional to redefine life roles and directions is paramount to successfully navigating this maze of emotional and physical turbulence. Many individuals do not pass through the second stage. Those who do not, show little progress, usually decline in physical health, withdraw emotionally and socially, and live in ever-shrinking worlds. They gradually redefine their worlds by their conditions.

If one is determined to move ahead, the third phase is about marshaling resources, garnering motivation, and redirecting one’s focus away from the why’s and why-me and toward enjoining help from hospital staff, family, friends, work resources. This stage demands tremendous focus and energy, but its dividends are significant.

Finally, the fourth stage routinizes life again and rebuilds infrastructures. While patients are in rehabilitation, Healthcare providers are generally privy to only the first two or three stages. The third and fourth more often happen when the patient returns home; however, patients have returned to demonstrate their adjustments. The entire 4-stage process is long, taking at least a year to manifest itself.

3. Patients

Following are two amalgams of patient identities. These patients entered Soma Crises during their stays on my rehabilitation unit.

Consider a 63 year-old woman of Spanish birth (we’ll call her Annalin) who was in and out of hospitals and specialists’ offices for two prior years only to succumb to back surgery for a spinal fusion. Initially, when transferred to the rehab unit from the acute hospital, Annalin showed a mixture of responses: sociability, loquaciousness, joking, crying, anxiety, and depression (Stage 1). While some symptoms improved during her physical rehabilitation, others symptoms re-appeared or worsened, aggravating her chronic depression and anxiety. Eventually, Annalin continued to make mobility gains, so her discharge to home was imminent, but her mood plummeted. She sank into negative and cyclical thinking and thought about suicide (Stage 2). Annalin reasoned that her husband and grown children might be better off without the responsibility of caring for her. In our daily sessions, the patient focused on the negative, resisted logic and measures of her physical improvement, and wallowed in her loss. She voiced confusion about who she was and how disconnected she felt from her former self. Even her body felt alien to her as she perceived less control over it. Annalin’s suicidal ideation demanded action on my part. Because prior verbal agreements had not held her, I wrote a safety agreement that invoked her written promise to not attempt suicide while in the rehab unit. The agreement helps the patient conceptualize the ramifications of his/her ideation and actions on themselves and others. Like the snap of a band against the wrist, it confronts the depressed person with reality. According to our contract, if she did attempt suicide, she could expect the consequence of being sent to a psychiatric unit for evaluation. This agreement spurred serious consideration on her part to think about the consequences of threatening self-harm. In fact, her binding agreement with me was the basis for her rethinking how she was acting. Because she signed
the agreement, Annalin had to think twice about her threats and her willingness to stay emotionally stuck.

Within a few weeks, Annalin developed renewed purpose and decided to reconnect with her family and to persist in redefining herself (Stage 3). However, change is not easy. This patient continued to struggle with mood fluctuation and spent a great deal more time, post-rehab, sorting through her doubts.

Such doubts are at the crux of any crisis. A sudden shattering of self-images that we've built over years (as a parent, athlete, artist, construction worker, or business owner) can throw us into a state of doubt or fear about future functioning. Annalin strongly identified herself as a woman in charge, the owner of a successful business, a wife and mother, and more recently as a woman planning her retirement. But why at this juncture of her life would Annalin's physical disabilities affect her self-image? For one, she had recently retired though had neither planned for nor considered the enormous change invoked by this life transition. A transitional phase, such as working part-time or investigating her new paths, would have helped prepare her. This formerly high-powered entrepreneur continued to see herself as an active business woman, told anyone who would listen her entrepreneurial war stories and continued to socialize with professionals still in the workplace, signaling that she had not mentally released herself from past roles.

For another, a similar dynamic held true for her family role as the one who solved other people's problems. She tried to maintain this role from her hospital bedside. Although Annalin's husband and adult children fully supported her current role as recovering patient, she was confused and searching. The patient exerted her need to remain in control and was alternately needy, which resulted in her family feeling like ping-pong balls. Anne focused on her losses and became attached to the idea that everything else in her life would follow suit. Her suicidal ideation was an attempt to return to visit us on the year anniversary of when GBS changed his life. He was excited to share his progress, which he readily performed a magic that individual psychotherapy cannot. In it, you guides his functioning within the rehab unit.

In time, Mark's limbs began to respond. He recovered. Nonetheless, he showed enthusiasm at having made it to this stage of recovery, where staff was working intensely with him to regain functioning.

Conflicts of interest

The author has none to declare.

References

1. Erikson H. Childhood and Society. New York: Norton; 1950.
2. Erikson EH. "Identity crisis" in perspective. In: Erikson EH, ed. Life History and the Historical Moment. New York: Norton; 1970, 1975.
3. Jacques Elliott. Death and the midlife crisis. Int J Psychoanal. 1965;46:502–514.
4. Robbins Alexandra, Wilner Abby. Quarterlife Crisis: The Unique Challenges of Life in Your Twenties. New York: J.P. Tarcher; 2001.
5. Robinson O. Later Life Crisis. 2012. www2.gre.ac.uk/about/news/articles/2012/a2599-later-life-crisis-dr-oliver-robinson.
6. Whittbourne SK. Are You Having an Identity Crisis? The Search for Fulfillment. New York: Ballantine Books; 2010.