



PTSD 101 Course

Transcript for: Aging and PTSD

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Today we are going to talk about a topic that is near and dear to my heart, Aging and PTSD.

Hello and welcome. My name is Dr. Joan Cook and I am a psychologist on faculty in the Yale School of Medicine, Department of Psychiatry and am a researcher at the National Center for PTSD.

Veteran 1: Our company went in with 220 men and by nightfall only 23 of us were still able to fight. We lost almost 90% that day. I got captured in September 30th of 1944, and I was a POW from the 30th of September until April the 15th of '45. And I never told anybody about my experiences, because I didn't want to remember exactly what I'd seen. What I've seen, you cannot describe! It's too horrible.

Why is the topic of aging and PTSD so important? The answer is for numerous reasons.

The number, proportion and diversity of older adults in the general population are steadily increasing, particularly in industrialized countries, where older adults are expected to constitute 33% of the population by 2050.

Compared to the scientific investigation of exposure to potentially traumatic events and potential mental health effects in other age groups, much less is known about those aged 65 and over.

The graying of the population can particularly be seen in Veterans served in the U.S. Department of Veterans Affairs (VA). In Fiscal Year 2009, almost 100,000 Veterans received services in the VA Specialized Outpatient PTSD Programs. Of these, 41% served during the Vietnam War era, 1% during the Korean War era, and 1% during the World War II era. The remainder served during other eras. So although we are losing our World War II and Korean Conflict Veterans to death, our Vietnam Veterans, which comprise a large part of our patient care in VA, are on average 59 years old and aging.

A number of my colleagues and I suspect that trauma and PTSD in older adults is under-recognized and thus under-treated. Lack of recognition of the effects of trauma including PTSD or misattribution of symptoms to other psychiatric or medical problems can have serious consequences for older adults. Indeed it may have negative implications for older adults' treatment and recovery, including the design of inadequate treatment plans, administration of poorly focused or inappropriate psychotherapy, medication or other medical intervention.

There are three main learning objectives for this course. They are: To review the prevalence and longitudinal course of PTSD in older adults; to describe the potential impact of aging on PTSD; and to provide information on the assessment and treatment of PTSD in older adults.

The purpose of this next section is to review the prevalence and longitudinal course of PTSD in older adults.

The majority of the empirical literature on PTSD in older adults comes primarily from one of three groups: Those who experienced trauma earlier in life during military combat or captivity, namely, World War II and the Korean Conflict, or the Holocaust, and those who experienced trauma later in life namely, in natural and man-made disaster.

There is relatively less investigation on exposure to particular types of trauma in older adults, such as sexual or physical assault, and particular subgroups, such as ethnic and racial minorities.

In addition, the current literature on older adult trauma survivors reviewed here is likely influenced by cohort variables, specific to certain birth-year-defined groupings, as well as maturational effects attributable to aging.

Until recently, most epidemiological investigations did not include any older adults or sufficient numbers of older adults on whom estimates could be established. Additionally, studies on prevalence rates in older adults typically focused on one particular event, relied on non-random or convenience samples, and grouped all older adults into one age category.

Over the past decade, several large epidemiological studies utilizing representative samples have examined the prevalence of trauma and rates of PTSD in older adults. In one of the largest epidemiological investigations of psychiatric disorders in the United States, the National Comorbidity Survey-Replication, lifetime prevalence of PTSD in adults aged 60 or older was 2.5%, significantly lower than in other age groups. Similarly, in a nationally representative sample of adults residing in the Netherlands, there was a steady decrease in lifetime prevalence of PTSD with age, with a rate of 2.7% in those aged over 65. Only one large population-based survey of individuals, residing in Germany, indicated that lifetime and current PTSD prevalence rates did not differ among young, middle-aged and older adults, with lifetime and current PTSD rates in older adults at 3.1% and 1.5%, respectively.

In a large national survey of Australian community-residing adults, 12-month prevalence rates generally decreased across age cohorts, with a rate of 0.2% among those aged 65 or older.

Although these investigations represent significant advancement in the field, it is important to note that there are still limitations with these investigations, particularly the exclusion of the least healthy and perhaps most vulnerable older adults, those who are physically or emotionally impaired, homebound, or long-term care residents.

There is little investigation on partial or subsyndromal PTSD in older adults. One population-based epidemiological study of PTSD in older adults, conducted in the Netherlands, found that while the prevalence rates for full syndromal PTSD was less than one percent, 13.1% met criteria for subsyndromal or partial PTSD. This suggests that older adults may experience significant posttraumatic stress symptoms, and attending only to full syndromal PTSD may neglect important problems in this population.

Data from the Normative Aging Study, a large longitudinal cohort study of community-residing male U.S. Veterans, many of whom were highly educated and had relatively high socioeconomic levels, suggest

that, while many older Veterans have been exposed to traumatic events, less than 1% met criteria for PTSD and nearly 10% met criteria for partial PTSD.

Of course, estimates derived from clinical samples, such as patients in psychiatric or medical settings, are much higher. For example, in those hospitalized for medical illness, the prevalence of current PTSD in WWII and Korean Conflict Veterans who never sought psychiatric treatment was 8% and 7%, respectively. Among those who had previously sought psychiatric treatment, 37% of the WWII and 80% of the Korean Conflict Veterans had current PTSD.

Traumatic exposure and PTSD have been described as “hidden variables” and “silent problems” in older adults because they are often neglected by clinicians, researchers, and older adults themselves. This may arise because PTSD is a relatively new and evolving psychiatric disorder. Since PTSD did not enter the official psychiatric diagnostic nomenclature until 1980, individuals who met criteria for PTSD in prior years, such as Veterans of World War II and Korea, were not diagnosed during or soon after their traumatic event.

In addition, retrospective estimates of PTSD are likely biased by deficits in recall and by avoidance of thinking about or talking about the trauma. There is also increased mortality among individuals with PTSD relative to those who do not meet diagnostic criteria, so those who may have died as a direct result of traumatic events or subsequent complications are not counted in prevalence estimates.

Apart from a few exceptions, most studies do not follow trauma survivors longitudinally in old age or for an extended period of time. The limited information on the course of PTSD symptoms primarily comes from former prisoners of war. For these survivors of prolonged and extreme stress, retrospective recall of PTSD symptoms indicates that the course is variable, with some survivors being continuously troubled, others having waxing and waning of symptoms across the lifespan, and some remaining symptom-free.

Only one investigation thus far obtained retrospective and longitudinal data indicating that older former prisoners of war showed an immediate onset and then a gradual decline of PTSD symptoms after the war, followed by a return of higher PTSD symptoms later in life.

Veteran 2: My PTSD has changed as I've gotten older, like in my 50's, in that things have gotten more intense: my feelings, sounds, startle response. It seems like my health problems, I'm finding out now, are more related to Vietnam and the side effects of the herbicides.

And the stress, heart condition, diabetes, it just seems to pile on year after year. I find I'm getting more and more illnesses associated with my tour in Vietnam. As I've gotten older, I'm getting the nightmares more intense; waking up with the heart palpitations the sweating, you know, shortness of breath.

The National Vietnam Veterans' Readjustment Study was the largest epidemiological investigation of PTSD and other postwar psychological problems among Vietnam Veterans. One of the major findings was that the majority of Vietnam Veterans appeared to have successfully readjusted and had few symptoms of psychological disorders. Another key finding was that 15.2% of male and 8.5% of female Vietnam theater Veterans met criteria for current PTSD.

The National Vietnam Veterans Longitudinal Study is currently underway. This is a follow up to the National Vietnam Veterans Readjustment Study conducted almost 20 years ago. This kind of longitudinal investigation is crucial in elucidating the course of PTSD over the lifespan. This study will help to illuminate the heterogeneity of mental health trajectories following exposure to war-zone trauma in a comprehensive and systematic manner. Data collection is scheduled to begin in 2011. Analysis of data, and preparation and submission of the report to Congress, is planned for 2013.

What factors mediate the relationship between trauma and PTSD in late life or influence the ebb and flow of symptoms across the life course are not yet known. Clinical lore suggests that occurrence or reactivation of traumatic stress symptoms may be due in part to aging-related life events such as illness, decrements in functional status, bereavement, and changes in occupational, social and familial roles. Additionally, aging can be tied to loss of control or increased vulnerability. These changes and losses can elicit traumatic memories of death, physical injury and lack of control.

Veteran 3: Well for me, when I retired, I struggled with--I had more time to think with my PTSD so, even though I was getting the treatment, I felt like I was doing well, there were episodes where, because I was getting older, I didn't feel as strong as I used to. I felt more vulnerable.

Although there have been many clinical reports of late-onset PTSD, primarily in male combat Veterans, this phenomena has rarely been empirically examined. In a systematic review of delayed-onset PTSD in heterogeneous samples including older adults, Andrews, Brewin and colleagues found that although delayed-onset is empirically verified, it is rare in the absence of any prior symptoms. Thus, delayed-onset is more likely sub-threshold PTSD that worsens over time and may be more accurately conceptualized as delayed recognition.

A recently reported phenomena termed late-onset stress symptomatology or LOSS may be similar to late-onset PTSD. In LOSS, older Veterans who were exposed to combat in early adulthood and who have had no difficulties in trauma-related functioning throughout most of their lives, experience trauma-related symptoms for the first time in old age. Although qualitative data from a focus group of WWII, Korean Conflict and Vietnam combat Veterans indicated preliminary evidence for LOSS, empirical investigation is required to verify this construct, differentiate it from late onset-PTSD and test its applicability to other older adult trauma populations.

PTSD symptoms in older adults are associated with greater depressive symptomatology and higher likelihood of suicidal ideation. PTSD in older adults is also associated with poorer interpersonal functioning, namely poorer marital adjustment and more difficulties with intimacy.

The relationships among trauma, PTSD and physical health has also been examined in older adults, primarily in samples of military Veterans. Both combat exposure and PTSD were related to poorer self-reported physical health. These relationships are not mediated by smoking or alcohol use. The association between physician-diagnosed medical disorders and combat-related PTSD symptoms confirms this link. PTSD symptoms were associated with increased onset of arterial, lower gastrointestinal, dermatologic, and musculoskeletal disorders.

Relatively little is known in regards to potential mediators between traumatic exposure and subsequent mental health functioning in older adults. In one investigation, older Veterans' perceptions of the effects of their military experience mediated the effect of combat on PTSD symptoms in later life. That is, older male Veterans reporting predominately desirable effects of military service, such as increased mastery and self-esteem, as opposed to undesirable effects, reported fewer PTSD symptoms.

Another research study found that higher instrumental coping and lower emotional coping were found to be significant predictors of psychological well-being in Holocaust survivors. In addition, a lower sense of mastery, negative perception of self-efficacy, and passive response style were associated with higher psychological distress in elder abuse victims.

These studies have potential clinical implications in that strategies designed to increase locus of control, perceived self-efficacy, and positive reappraisal may alleviate distress and increase coping ability in older trauma survivors.

The purpose of this next section, Objective 2, is to describe the potential impact of aging on PTSD

There is some evidence to suggest that PTSD may be experienced or expressed differently in older as opposed to younger adults. The majority of this work has been done in Veterans but there are a handful of studies on this topic in the disaster and the interpersonal violence areas as well.

Vietnam Veterans reported several more emotional difficulties than older Veterans, including greater PTSD, depression, hostility, guilt, impairment at work, derealization and suicidal tendencies. WWII Veterans only reported greater somatic complaints.

One investigation compared Veterans of WWII, Korea, and Vietnam on PTSD, general psychiatric symptoms, guilt and suicidality. There were no significant differences between the groups on PTSD. Korean Veterans had more general psychiatric distress compared to the other two cohorts. Vietnam Veterans reported more guilt compared to the other two cohorts. And lastly, both Korean and Vietnam Veterans reported more suicidal ideations than WWII Veterans.

Another study reported that older Veterans had lower overall PTSD, particularly on arousal and avoidance and numbing symptom clusters, than younger Veterans. However, there were no significant differences between age groups on re-experiencing symptoms or on depressive or dissociative symptoms.

There are several hypotheses as to why there are generally higher rates of psychiatric distress in younger as opposed to older trauma survivors. These hypotheses include: younger individuals may admit to more psychiatric symptoms because there are relatively fewer stigmas for that age group; younger Veterans may be better able to identify psychological problems and thus be treated for such; older Veterans may be more likely to label their mental health problems as somatic complaints; and older adults may have a lack of familiarity with psychotherapy.

The social context in which most of the current cohort of older adults grew up did not encourage open discussions of personal issues. At that time, traditional gender roles discouraged men from emotional expression and women from speaking out against violence. In addition, negative disclosure experiences earlier in life might have prohibited current acknowledgement of trauma. For example, several of my WWII Veterans that I have had the pleasure of working with over the years have told me that, when they initially returned home from war and tried to share their experiences with health care professionals, friends or family members, they felt rejected, shamed or misunderstood and thus decided never to tell anyone about their war experiences again.

Cohort differences can also significantly influence understanding of language, in this case language used to define trauma. For example, specific terminology about traumatic events was often not available to earlier cohorts, such as the term rape. Behaviorally specific terms thus should be used to clarify any language discrepancies.

In regards to differences between Veterans, there are a couple of additional hypotheses. Vietnam Veterans were typically younger in age at the time of service in the war-zone than the Korean Conflict or WWII Veterans, making them potentially more vulnerable to experience symptoms.

Additionally, there were differences between the wars. For example, many WWII Veterans returned home to parades and were shown appreciation, whereas Vietnam Veterans reportedly did not typically receive such a warm reception upon homecoming and thus perhaps did not receive the social support important to heal from trauma.

Veteran 4: I served in Vietnam in 1970 with a light infantry unit. We would be choppered out and come back a few weeks later. We'd either hump back, or we'd get picked up, and in my 11th month I was jumping out of a chopper, and I tore up my knee. So they medi-vacced me to Japan and then to Ft. Dix.

Well I was basically kicked to the curb. I went back to my job and they told me they were moving down south. So I went down to the VA, downtown, and they said, "We can get your job back, but it's not going to happen. They're going to get rid of you." So I just went back and hung out on the corner, looking for work.

So, that's what happened when I came back. There was no work, no job, no support. The VA just said, "That's it." I was angry, didn't trust the government, didn't trust people. So that stayed with me for a long time.

In addition, differences in rates of PTSD between younger and older trauma survivors may be due to the normal aging process. For example, older adults typically experience some hearing loss, which may cut down on the noises they hear and thus possibly reduce their startle response.

Lower rates may also be due to the "wisdom" of aging. For example, older adults with PTSD may have less expressions of anger, because they recognize that they "aren't as young as they used to be" and could get physically hurt.

Additionally, maybe the passage of time may heal some of emotional wounds of trauma.

I am briefly going to note some important findings on PTSD and cognitive impairment in older adults.

There are a few case studies indicating that dementia may exacerbate existing PTSD symptoms. These include reports of combat Veterans, a Holocaust survivor and an individual who survived the sinking of the Titanic, that were asymptomatic or with symptoms under control until the onset of cognitive impairment. There are a number of plausible explanations for the association besides the obvious one of trauma causing both PTSD and vulnerability to subsequent cognitive impairment. PTSD may mediate the effects of earlier trauma on cognitive impairment and cognitive impairment may disinhibit symptoms of PTSD that may have been less apparent or more controlled for years.

Two empirical studies present the strongest evidence to date of a link between PTSD and dementia. In one investigation, researchers followed over 181,000 Veterans over six years, including more than 53,000 with PTSD. Those with PTSD were more than twice as likely to develop dementia.

In another investigation, older Veterans with a diagnosis of PTSD, or who were Purple Heart recipients, were compared to age and gender matched Veterans with no PTSD or Purple Heart. There was a greater prevalence and incidence of dementia in older Veterans with PTSD. Those who had PTSD, but whom were not Purple Heart recipients, had almost twice the odds of developing dementia as those who did not have PTSD but were Purple Heart recipients or the comparison groups. The authors concluded that PTSD may be a greater risk factor for dementia than combat-related trauma alone.

The purpose of this next section, Objective 3, is to provide some basic but important information on the assessment and treatment of PTSD in older adults.

Most research on the psychometric properties of PTSD assessments in older adults has been conducted with older combat Veterans or former Prisoners of War (POW). For review and details on suggested cut-points, see Cook and O'Donnell (2005).

Clinician administered and patient self-report measures that have demonstrated good reliability and discriminative validity with older combat Veterans or former prisoners of war include: the Clinician Administered PTSD Scale; the Mississippi Scale for Combat Related PTSD; the Minnesota Multiphasic Personality Inventory PTSD Scale; the Impact of Events Scale; the PTSD subscale of the Symptom Check List 90-Revised; and the PTSD Checklist.

Unfortunately to date there are no randomized controlled trials currently published examining the efficacy of psychotherapy for PTSD in older adults. The literature, to date, contains primarily descriptions of treatment in the resolve of distal traumas, in particular Holocaust survivors and combat Veterans.

Of the few case reports of therapy for PTSD in older adult Veterans, most are largely descriptive. These small investigations indicate that supportive and cognitive-behavioral type therapies have been successfully applied to older combat Veterans.

There is one manualized group treatment program for older combat Veterans, which was developed at the Cleveland VA Medical Center. This group program included therapy education, education about trauma and its effects, and cognitive-behavioral therapy skills training, such as anxiety, stress, and anger managements. Additionally, elements of life-review, grief and loss work as well as forgiveness were incorporated.

Veteran 4: I finally went to a group and realized everybody in the group had the same problems as me with anger and isolation and things triggering us, you know. And, I liked it. I didn't like it at first, but then I realized that all these guys have the same exact problems as me, and I wasn't alone anymore.

Although older adults are not typically included in PTSD interventions studies, this does not imply that the recommended empirically-based PTSD treatments should not be used with these individuals. In the absence of empirical evidence, practitioners should be aware of the PTSD treatment literature, the uniqueness of working with older adults and proceed with sound clinical judgment and practicality.

For the general population, PTSD treatments with the most empirical support are Prolonged Exposure and Cognitive Processing Therapy. These treatments are being disseminated nationally throughout the VA Health Care System.

There are a few special considerations when conducting PTSD treatments with older adults. The first is a preparatory or introduction to treatment that involves dispelling some commonly-held myths. The second is whether to do trauma processing therapies. The third is the potential effects of cognitive impairment.

Importantly, when working with older trauma survivors, mental health providers are advised to engage in an introductory preparation for therapy. The aim is to dispel stereotypes about mental health and psychotherapy, provide preliminary education about the nature of traumatic exposure and PTSD, and explain the goals of treatment. It is especially important since many older adults do not have a contemporary psychological lexicon for accurately describing their trauma symptoms and may misunderstand the process of psychological treatment. For example, older adult trauma survivors may initially describe themselves as “crazy” or request “truth serum” to rid themselves of trauma-related distress.

There are several trauma processing type therapies including Prolonged Exposure, Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing, Life Review and Narrative Story Telling. Some mental health providers may be reluctant to directly work with the traumatic memory in older individuals. Some of this reluctance may reinforce patient's pathological avoidance but some concern may be warranted.

It has been suggested that intense trauma processing therapies are undesirable and counterproductive for older trauma survivors because they lead to increased autonomic arousal and decreased cognitive performance.

Others suggest that increased physiological arousal is expected in trauma processing therapies and can be tolerated by older adults. It is advisable to closely monitor older adults who are at risk from high arousal, such as patients with serious cardiac or respiratory problems. A mental health provider can certainly seek consultation from an older adults' primary care physician and also ask the patient to alert them if the experience is physically uncomfortable.

There is some evidence that exposure treatments are successful and well-tolerated for older adults with non-PTSD anxiety disorders, namely panic disorder, phobias, and obsessive-compulsive disorder.

There is one pilot study of exposure therapy for older Veterans with PTSD conducted by Dr. Steven Thorp and his colleagues at the University of California, San Diego and the San Diego VA. Eleven older male Veterans with PTSD from military (mostly combat) traumas completed 12 sessions of Prolonged Exposure. The main objectives of the investigation were to determine feasibility of recruitment, assessment, and treatment protocol and to provide an initial indication of efficacy.

The results from Dr. Thorp's pilot investigation are promising. In particular, there were significant differences pre-post on overall PTSD scores as well as on all three of the PTSD symptom clusters.

The first randomized clinical trial of psychotherapy for older adults with PTSD is currently underway by Dr. Thorp and his colleagues in California. They are comparing 12 sessions of relaxation training to Prolonged Exposure for older male Veterans. The trial also includes extensive neuropsychological testing to examine performance on executive functioning tasks as a potential predictor of treatment outcome.

There is some indication of how "older" female trauma survivors may fare in trauma processing therapies. In a randomized controlled trial of sexual assault survivors with PTSD, older women in Prolonged Exposure and younger women in Cognitive Processing Therapy had the best outcomes. The authors posit this may be due to "long standing cognitions" in the older adults, but perhaps older adults' abstraction abilities and the need to complete numerous written assignments in Cognitive Processing Therapy may also contribute to these findings. It is important to note that the age range for this trial was 18 through 70, with the average age of 32. Thus, more research with larger numbers of those over age 65 are needed to definitively indicate the efficacy of Prolonged Exposure and Cognitive Processing Therapy in older adults.

Older adults' cognitive abilities must be considered before determining an intervention. In cognitively intact older adults, interventions can be similar to those used with younger adults, including psychoeducation, relaxation training, and development of coping skills. However, psychotherapies are learning-based interventions, and individuals with moderate to severe cognitive impairment may not be appropriate for traditional psychotherapy. More specifically, older adults with declining cognitive abilities may not support the use of self-management strategies that require retention of new information about PTSD and implementation of recommendations for effective coping.

Additionally, older trauma survivors with cognitive impairment may have lower thresholds for emotional response to cues or "triggers" for PTSD symptoms and other problem behaviors. This may be particularly pertinent for older adults with both PTSD and cognitive impairment residing in long-term care settings.

Depending on the traumatic experience, these triggers may include television news coverage of past or current traumatic events, the sounds of other people in distress or loud noises. Vulnerable individuals may misinterpret neutral sensory stimuli as trauma-related and they may be less capable of using avoidance strategies and thus more susceptible to trauma reminders.

For example, waking older trauma survivors with co-morbid PTSD and cognitive impairment at night for mandatory routine checks or to administer medication may startle them and result in reactions of striking out. Trauma survivors may also be triggered by a range of interpersonal behaviors, for example care providers' use of authority or control. For women who have experienced captivity or violent assault, the presence of unrecognized males or physical contact by male health professionals may bring up unresolved interpersonal violence-related distress. Examples of other possible triggers of negative reactions and clinical interventions have been reported in Cook and colleagues (2001).

In these next few slides, I briefly provide some information on pharmacotherapy for PTSD in older adults.

The recommended first-line pharmaceutical treatments for PTSD for the general adult population are selective serotonin reuptake inhibitors or SSRIs. In particular, Sertraline and Paroxetine are the only pharmaceutical agents that are FDA approved for the treatment of PTSD.

The majority of pharmacotherapy studies for PTSD have not included older adults, and if they have, those results have not been analyzed separately.

Only two pharmacotherapy studies have been conducted specifically with older adults, one with Prazosin and the other with the atypical antipsychotic Quetiapine. Both medications were found to reduce PTSD symptoms.

There are several general issues to consider that may inform the psychiatric care of older adults with PTSD. Pharmacotherapy can be complicated by age-related changes and issues. For example, older adults are often more sensitive to side effects, and the probability of side effects may be increased because medications remain in the body for longer periods of time due to changes in physiology associated with aging. Medical comorbidity, especially diseases that affect the heart, liver, or kidneys, may exacerbate the diminished metabolic efficiency and slower drug clearance demonstrated by many older adults.

In addition, polypharmacy is common among older adults. This may compound the risk of drug interactions and make it difficult to determine the cause(s) of subsequent side effects.

Given these considerations, best practices in older trauma survivors suggest that it is advisable to consider the side effect profiles of psychotropic medications, start with low dosages and increase levels slowly, and make single medication adjustments if possible so that responses can be interpreted more readily.

Although the combination of pharmacotherapy and psychotherapy are often promoted, there is little evidence to guide clinical decisions about when and how to make such combinations. Until more data are available, patient and provider preference for medications and psychotherapy should be considered.

In general, rates of PTSD are lower in older adults compared to other age groups. However PTSD can persist for some older adults for decades. Additionally, PTSD in older adults has been linked to increased interpersonal problems, suicidal ideation, functional impairment, and physical health.

There are some differences between younger and older trauma survivors.

Although delayed-onset of PTSD has been empirically verified in some military samples, it is rare in the absence of any prior symptoms and might more accurately be labeled delayed recognition.

Dementia may exacerbate PTSD symptoms, and cognitive problems may limit response to psychotherapy.

Both pharmacotherapy and psychotherapy have shown promise for ameliorating PTSD in older adults.

Veteran 5: I didn't know what was wrong with me. I knew something was wrong with me, so I just kept coming back to the VA. Surely they'd know something to do. And then Vietnam ended, and I found a new life. I'm living now! I'm living great! I have a wonderful life now.

In conclusion, I would like to say that helping our aging Veterans with PTSD has been one of the most gratifying clinical experiences in my life. I urge you to join me in these efforts to recognize and address trauma-related issues in the lives of older adults. Thank you.