Trauma and PTSD in Older Adults

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Purpose of the Presentation

- Review the prevalence of trauma and PTSD and longitudinal course of PTSD in older adults
- Describe the potential impact of aging on PTSD
- Provide information on the assessment and treatment of PTSD in older adults
Why is this Important?

- “Graying” of America and other industrialized countries
- Relatively less is known
- Under-recognized and under-treated
- Lack of recognition or misattribution of symptoms can have serious effects
Review the Prevalence and Longitudinal Course of PTSD in Older Adults
Epidemiological Literature on Trauma and PTSD in Older Adults

• Prior to the past decade,
  – Most epidemiological studies either excluded older adults or did not include sufficient numbers of them
  – Most studies examining prevalence rates typically focused on a particular event type (i.e., combat, Holocaust, natural disaster) and relied on non-random or convenience samples
Trauma Exposure

• Creamer and Parslow (2008) found that 52.5% of adults aged 65 and older in Australia had experienced a traumatic event during their lifetime.

• Spitzer et al. (2008) found that 77% of German older adults had experienced a trauma, with older men at higher risk for exposure compared to older women.
Epidemiological Studies: Rates of PTSD in Older Adults

• **Lifetime PTSD prevalence**
  - 2.5% (Kessler et al., 2005)
  - 2.6% (Reynolds et al., 2016)
  - 2.7% (De Vries & Olff, 2009)
  - 3.1% (Spitzer et al., 2008)

• **12-month PTSD prevalence**
  - 0.2% (Creamer & Parslow, 2008)
  - 1.5% (Spitzer et al., 2008)
Epidemiological Study: Partial PTSD in Older Adults

• 6-month prevalence rate of PTSD
  – 0.9% for full criteria PTSD
  – 13.1% met criteria for subsyndromal PTSD
    (Van Zelst, de Beurs, Beekman, Deeg, & van Dyck, 2003)

• Lifetime prevalence estimate –
  – 4.5% for full criteria PTSD
  – 5.5% met criteria for subsyndromal PTSD
    (Pietrzak et al., 2012).

• In clinical or treatment seeking samples, 11% (Durai et al., 2011) to 18%
  (Bramsen & van der Ploeg, 1999) of older veterans had partial PTSD.
Rates of PTSD in Older Veterans

- National Health and Resilience in Veterans Study
- 2,025 U.S. veterans aged 60 and older reported experiencing an average of 3.1 (SD = 2.5; range = 0–14) traumatic events in their lifetimes.
- 4.2%, 4.1%, and 3.5% met screening criteria for current major depression, generalized anxiety, and PTSD, respectively

(Pietrzak & Cook, 2013)
Cluster Analysis of Trauma and Functioning

- Cluster analysis of measures of lifetime trauma, and current PTSD, depression, and anxiety symptoms:
  - Control (low number of traumas, low distress; 60.4%)
  - Resilient (high number of traumas, low distress; 27.5%);
  - Distressed (high number of traumas, high distress; 12.1%).

(Pietrzak & Cook, 2013)
Older Women Veterans

- Long-term effects of wartime exposures in women, including verbal or physical sexual harassment, unwanted sexual experiences that involved use of threat or force, and compulsory pressure to perform their jobs under enemy fire (Magruder et al., 2015)
- Women who served in country in Vietnam meet current and lifetime criteria for PTSD at higher rates than previously documented, 13.5% and 16.9% respectively.
Older Civilian Women

• Almost 14% of women 65+ reported a history of physical or sexual assault (or both) during their lifetimes, and those who had experienced interpersonal violence were generally more likely to meet criteria for past-year and lifetime PTSD, depression, and anxiety (Cook, Pilver, Dinnen, Schnurr, & Hoff, 2013).

• 7% of older women reported adult rape, with an average of 36 years since the rape had occurred (Sachs-Ericsson et al., 2014). Older women who had been raped had lower self-esteem, psychological, and physical health functioning.
A Hidden Variable

• Trauma and PTSD may be “hidden variables” in the lives of older adults:
  – PTSD was not an official diagnosis until 1980
  – Retrospective accounts may be biased by deficits in recall and avoidance
  – Selective bias: Increased mortality in those with PTSD
Why Higher Distress in Younger versus Older?

- Younger individuals may admit to more symptoms because there are fewer stigmas.
- Younger individuals may be better able to identify psychological problems.
- Older adults are more likely to label their problems as somatic complaints.
- Older adults may have a lack of familiarity with therapy.
Disclosure

• The social context did not encourage open discussions of personal issues.
• Societal endorsement of more traditional gender roles discouraged men from emotional expression and women from speaking out against violence.
• Negative disclosure experiences
Language

• Cohort differences can significantly influence understanding and use of language.
• Specific terminology about traumatic experiences was often not available to earlier cohorts (e.g., rape).
• It is recommended that behaviorally specific terms be used to clarify any language discrepancies.
Other Reasons for Differences between Older and Younger Veterans

- Younger age at the time of services may be a factor on reporting or experiencing symptoms
- Differences between wars
Other Reasons for Differences

• Could be due to normal aging process
• Could be due to wisdom of aging
• If early trauma, passage of time may have healed some wounds
Course of PTSD and Other Negative Consequences
Course of PTSD

One retrospective report of the course of PTSD from a sample of former prisoners of war (POWs):

- Symptoms wax and wane across the lifespan:
  - 20% continuously troubled
  - 20% are symptom free
  - 60% experience intermittent symptoms

(Zeiss & Dickman, 1989)
Course of PTSD

• One investigation obtained retrospective and longitudinal data.

• Older former POWs showed:
  – an immediate onset and gradual decline of PTSD symptoms after the war,
  – followed by a return of higher PTSD symptom levels in later life

(Port, Engdahl, & Frazier, 2001)
National Vietnam Veterans’ Readjustment Study

• Largest epidemiological investigation of PTSD in Vietnam veterans:
  – 15.2% of male and 8.5% of female Vietnam theater veterans had current PTSD

(Schlenger et al., 1992)
National Vietnam Veterans’ Longitudinal Study

• Determine the prevalence, course and comorbidities of war-zone PTSD (according to DSM-5)* across a 25-year interval

• Among male theater veterans:
  – 4.5% - current PTSD (based on CAPS)
  – 10.8% - current and partial PTSD (based on CAPS)
  – 11.2% - current PTSD (based on PCL)

• Course:
  – 16% reported an increase
  – 7.6% reported decrease (of greater than 20 points)

* diagnostic bar has been raised   Marmar et al., 2015
What Predicts Ebb and Flow of PTSD Symptoms?

• This may be due in part to life changes and losses.

• With advancing age, there can be:
  • Increased risk for medical illness
  • Decrements in functional status
  • Bereavement
  • Retirement
  • Changes in social and familial roles
  • Loss of control
  • More time for reflection
Interesting Questions:

• Is it delayed onset or delayed recognition?
• Or partial PTSD that worsens over time?
• Better conceptualized as a re-emergence, intensification or delayed recognition of symptoms rather than delayed onset

(Thorp et al., 2011a).
Late-Onset Stress Symptomatology (LOSS) to Later-Adulthood Trauma Reengagement (LATR)

• In later life many combat Veterans confront and rework their wartime memories in an effort to find meaning and build coherence.

(Davison et al., 2006; Davison et al., 2016; King, King, Vickers, Davison & Spiro, 2007)
PTSD and Other Mental Health or Social Problems

• PTSD symptoms associated with greater depressive symptomatology and higher likelihood of suicidal ideation
  (Rauch et al., 2006)

• PTSD associated with poorer marital adjustment and communication with spouses and more difficulties with intimacy
  (Cook et al., 2004)
PTSD and Physical Health

• Strong association between PTSD symptoms and self-reported health
  • Not mediated by smoking or alcohol use

• Strong association between PTSD and physician-diagnosed disorders

• PTSD associated with:
  • Arterial
  • Lower gastrointestinal
  • Dermatological, and
  • Musculoskeletal disorders

(Schnurr & Spiro, 1999; Schnurr & Spiro, 2000)
PTSD and Cognitive Impairment in Older Adults
Risk of Dementia among Veterans

• Two studies present the strongest evidence to date of a link between PTSD and dementia.

• Researchers followed 181,000 Veterans over 6 years, including more than 53,000 with PTSD.
  – Those with PTSD were more than twice as likely to develop dementia.

Yaffe et al., 2010
Risk of Dementia among Veterans

- 10,481 older Veterans with diagnosis of PTSD or Purple Heart recipient were compared to age and gender match with no PTSD/Purple Heart
  - Greater prevalence and incidence of dementia in older Veterans with PTSD
  - PTSD+/PH- group had almost twice the odds of developing dementia as the PTSD-/PH+ group or the comparison groups
  - PTSD may be a greater risk factor for dementia than just combat-related trauma

Qureshi et al., 2010
Provide Information on the Assessment and Treatment of PTSD in Older Adults
PTSD Assessment Instruments

• Most research on psychometrics properties of PTSD assessments in older adults has been conducted with older combat veterans or former POWs.

• For review and details on suggested cut-points, see Thorp, Sones and Cook (2011).
PTSD Assessment Instruments

• Clinician administered and patient self-report measures that have demonstrated good reliability and discriminative validity with older combat veterans or former-POWs include:
  – Clinician Administered PTSD Scale (Blake et al., 1995)
  – Mississippi Scale for Combat Related PTSD (Keane et al., 1988)
  – Minnesota Multiphasic Personality Inventory PTSD Scale (Keane et al., 1984)
  – Impact of Events Scale (Horowitz et al., 1975)
  – PTSD subscale of the Symptom Check List 90-Revised (Saunders et al., 1990)
  – PTSD Checklist (Weathers et al., 1993)
Psychotherapy for PTSD in Older Adults
Dinnen, Simiola, and Cook (2015) identified 13 case studies or case series which reported at least one outcome measure. Of these,

- Three on Eye Movement Desensitization and Reprocessing (EMDR),
- Three on cognitive behavioral therapy (CBT),
- Two on Prolonged Exposure (PE),
- One on imaginal exposure only,
- One on Life Review,
- One on brief eclectic psychotherapy,
- One each on supportive group therapy and supportive plus CBT group therapy.
13 Case Studies or Case Series

- Only two of these did not show a positive treatment effect on PTSD symptoms.
- Both were group interventions that did not include a trauma-processing focus.
Systematic Review of Treatment in Older Survivors

• Identified seven outcome studies:
  – Three uncontrolled pilots,
  – Two randomized controlled trials,
  – One non-randomized concurrent control study, and
  – One post hoc effectiveness study.

• Findings were equivocal: Four indicated positive effects, while the other three produced non-significant or mixed effects for PTSD symptoms.

• In all, few older adults experienced complete remission.
Empirically-Based Treatments for PTSD

• For the general population, PTSD treatments with the most empirical support are Exposure Therapy, Cognitive Processing Therapy (CPT) and EMDR.

• PE and CPT currently disseminated throughout the VA Healthcare System.
Special Considerations for PTSD Treatment in Older Adults

• To Do or Not To Do: Trauma Processing Therapy

• Effects of Cognitive Impairment
Are Trauma Processing Therapies Contraindicated for Older Adults?

• It has been suggested that intensive trauma processing therapies, such as exposure, are undesirable and counterproductive for older survivors of trauma because they lead to increased autonomic arousal and decreased cognitive performance.

(Boudewyns et al., 1997; Coleman, 1999; Hankin, 1997; Hyer et al., 1995; Hyer & Woods, 1998; Kruse & Schmitt, 1999)
Are Trauma Processing Therapies Contraindicated for Older Adults?

- Others suggest increased physiological arousal is expected in trauma processing therapies and can be tolerated by older adults.
- Closely monitor individuals who are at great risk from high arousal, such as patients with serious cardiac or respiratory problems.
- For a thoughtful review of the use of exposure therapy with veterans, see Thorp, Sonas and Cook (2011).
Exposure Treatments
Successful and Well-Tolerated

• For older adults with:
  – Panic disorder (Swales et al., 1996)
  – Phobias (Thyer, 1981)
  – Obsessive-compulsive disorder (Rowan et al., 1984)
In the Systematic Review

- All the case studies and treatment outcome studies utilizing exposure therapy (e.g., imaginal exposure only; in vivo exposure only; full, manualized PE) reported at least some effectiveness in ameliorating symptoms related to trauma.

- One of the larger treatment outcome studies showed a substantial benefit from PE for older male veterans treated nearly 40 years after combat.
Pilot Study: Exposure Therapy for Older Veterans with PTSD

- **Sample**: 11 older male Veterans with PTSD from military (mostly combat) traumas
- **Objectives**: Determine feasibility of recruitment, assessment, and treatment protocol; initial efficacy
- **Design**: Pre/post (“open label”) trial of 12 sessions of Prolonged Exposure

(Thorp et al., 2012)
Mean CAPS Scores
(Clinician-Administered PTSD Scale)

All $p < .05$; (Thorp et al., 2012)
RCT for PTSD in Older Adults

• First RCT of psychotherapy for U.S. older veterans with PTSD is complete.
• Analyses are underway.
• Compares 12 sessions of relaxation training to PE in older male veterans
• Trial includes extensive neuropsychological testing to examine performance on executive functioning tasks as a potential predictor of treatment outcome

(Thorp et al., in process)
Exposure and Cognitive Processing Therapies

• In a RCT of 145 sexual assault survivors with PTSD, older women in PE and younger women in CPT had best outcomes.

• Authors posit this is due to “long standing cognitions” in older group, but perhaps abstraction and written materials contribute

• Average participant age was only 32 (range 18-70) and there were less than a handful of participants aged 55 and older.

(Rizvi et al., 2009)
Cognitive Processing Therapy

Comparison of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans and Vietnam veterans before and after receiving CPT on an individual basis (Chard, Schumm, Owens, & Cottingham, 2010)

OEF and OIF veterans had lower posttreatment CAPS scores than the Vietnam veterans even after controlling for pretreatment CAPS score and number of sessions attended.
Psychotherapy with Older Adults

• Patient’s cognitive abilities must be considered before determining an intervention.

• In cognitively intact older adults with PTSD, interventions can be similar to those used with younger adults, including
  – Psychoeducation,
  – Relaxation training,
  – Development of coping skills
  – Cognitive and behavioral therapies.
PTSD, Cognitive Deficits and Psychotherapy

• Older trauma survivors with moderate to severe cognitive impairment may have lowered thresholds for responses to cues or “triggers.”

• The structure and setting of long-term care facilities can trigger traumatic memories.

• Certain sounds, sites, and even staff activities can serve as trauma-related stimuli.

(Cook et al., 2001)
Pharmacotherapy for PTSD in Older Adults
Pharmacotherapy Studies

• Currently, only paroxetine and sertraline are approved by the U.S. Food and Drug Administration for treatment of PTSD symptoms.

• Only two studies have been conducted specifically with older adults:
  – Prazosin (Peskind et al., 2003)
  – Quetiapine (Hamner et al., 2003)

Both were found to reduce PTSD symptoms.
Pharmacotherapy Can be Complicated

• By age-related changes and issues:
  – More sensitive to side effects
  – Probability of side effects increase because medications remain in the body for longer periods of time
  – Polypharmacy is common and complex drug regimens may cause confusion and lead to poor treatment adherence
Summary

• PTSD persists for many older adults for decades
• There are some differences between younger and older trauma survivors
• Both pharmacotherapy and psychotherapy have shown promise for ameliorating PTSD
• Dementia may exacerbate PTSD symptoms, and cognitive problems may limit response to psychotherapy
Summary Context

• The vast majority of the literature on traumatized older adults has centered on men, particularly veterans or former prisoner of war, and on Caucasian citizens of Western Nations.

• More investigation is needed to determine if these findings can be generalized to a broader older adult population including:
  – women, cultural, racial and ethnic minorities, the oldest old (85+), and those who are cognitively impaired.
PTSD Consultation Program
FOR PROVIDERS WHO TREAT VETERANS

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