



# Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD

## Specific Populations and Trauma Types PTSD in older people

This *PTSD in older people* information sheet addresses background issues and provides presentation, assessment, and treatment advice for practitioners working with older people who have PTSD.

### Background issues

In 2011, 14 per cent of Australians were aged 65 or over, compared to just four per cent a century earlier.<sup>1</sup> As the Baby Boomer generation ages and life expectancies continue to increase, this figure is likely to rise significantly, reaching up to 25 per cent by midway through this century.<sup>2</sup> Thus, older Australians represent a rapidly growing and often overlooked population of trauma survivors.

Older people with PTSD may be categorised into two broad classes. The first is those who experienced a traumatic event years or decades earlier, including subpopulations such as war veterans from conflicts such as Vietnam, Korea, and WWII, Holocaust survivors, and former refugee children (e.g.,<sup>3,4</sup>). Older people who experienced trauma earlier in life may have chronic PTSD, or find that the ageing process exacerbates pre-existing PTSD symptoms. For example, medical illness or reduced physical ability may mean the individual is unable to manage PTSD symptoms using his or her previous coping strategies. At the same time, retirement from work and fewer family responsibilities mean less distractions from PTSD symptoms.<sup>5</sup>

The second group of older people with PTSD is those who have experienced trauma relatively recently, as older adults. A number of factors may put older people at greater risk of trauma exposure. For example, they may be less likely to be able to escape quickly from dangerous situations, and decreased reaction times may make it difficult to avoid motor vehicle or other accidents. In the event of a natural disaster, older people may be less likely to receive early warnings through automated text message systems. This group may also be more likely to sustain physical injury in an accident or disaster, and to experience serious medical complications.

In understanding traumatic memories in this population, it is important to consider the influence of the ageing process on cognitive functioning. The majority of people are unlikely to develop cognitive deficits (in areas such as cognitive flexibility, concept formation, goal setting, planning, and organisation) until at least their eighties.<sup>6</sup> Dementia most commonly affects people who are aged 65 years and older, and is generally caused by Alzheimer's disease. It is estimated that around nine per cent of Australians aged over 65, and 30 per cent of those aged 85 years and over, suffer from dementia.<sup>7</sup> There is some evidence from veteran samples that dementia is more common in older

people with PTSD, although the nature of this relationship is not clear; it is possible that PTSD increases the risk of dementia,<sup>8</sup> or that a shared risk factor drives the development of both disorders.<sup>9,10</sup> Research with other trauma-exposed populations, such as ageing Holocaust survivors, has shown similar rates of dementia to non-trauma exposed groups.<sup>11</sup> Regardless, the presence of cognitive impairment has implications for the assessment and treatment of PTSD, as discussed below.

## Presentation

While it may be expected that cumulative exposure to trauma over the lifespan would result in high rates of PTSD in older people, in fact PTSD tends to be less common in older adults than their younger counterparts.<sup>12,13</sup> In an Australian community study, four per cent of men and six per cent of women aged 18 to 24 were diagnosed with PTSD, compared to just 0.4 per cent of men and even fewer women aged 65 and over.<sup>14</sup>

As in younger populations, research with older adults supports the existence of separate avoidance and numbing PTSD symptom clusters.<sup>15,16</sup> There is some evidence that PTSD tends to be less severe in older adults, with a decline in re-experiencing symptoms but an increase in avoidance symptoms.<sup>17</sup> Nonetheless, for many older people, traumatic memories remain highly disruptive, and have been found to be a significant barrier to good sleep among nursing home residents.<sup>18</sup> It may be speculated that age-related deterioration in cognitive functioning makes it harder to control or suppress painful memories of past trauma. Older people with PTSD are also at significantly higher risk of developing other mental health problems, particularly depression and anxiety,<sup>19</sup> and misdiagnosis often occurs.<sup>17</sup>

Among older veterans in particular, denial or avoidance of psychiatric symptoms is common, as is alcohol abuse.<sup>5</sup> Anecdotal reports suggest that, particularly in older males, an increase in agitated and aggressive behaviour may be associated with the emergence of PTSD; if so, this has implications for management of the behaviour.

While as a general rule older people are less likely to develop significant mental health problems after trauma, natural disasters may pose a particular risk to their mental and physical wellbeing.<sup>20,21</sup> Older survivors of natural disaster are more likely to experience grief reactions and survivor guilt than younger survivors, particularly if younger family members perished. Older people may be less likely to relocate following a disaster, preferring to remain in their own community, and there is some evidence that those who do relocate are at greater risk of developing PTSD.<sup>22</sup> Other risk factors for more severe symptoms include female gender, higher levels of disaster exposure, and the use of behavioural or avoidant coping styles.<sup>21,23</sup> Despite many experiencing significant distress in the aftermath of disaster, older people may be less likely than younger survivors to present to health or general support services.<sup>21,24</sup>

## Assessment

As a general rule, standard screening and assessment measures are appropriate for use with this population, although lower cut-off scores have been recommended than are used with younger adults.<sup>16</sup> Given the potential for a long history of trauma exposure, it may be useful to enquire about lifetime exposure, as well as the immediate antecedent event that prompted the presentation for

treatment. Interestingly, despite the predicted ‘accumulation’ of traumatic events over the course of a long life, the elderly actually tend to report fewer events than younger people.<sup>14</sup> The reasons for this are unclear, but probably comprise several explanations including simple forgetting, reappraisal (in the context of their whole life, the event is no longer considered distressing), and shame (especially, for example, older woman reluctant to acknowledge earlier sexual abuse). In the context of shame, older people can be concerned about the stigma of mental health and therapy and may be reluctant to disclose their trauma history. Providing a clear rationale for the assessment and treatment can facilitate disclosure.<sup>17</sup> Importantly, a range of other physical and social issues may be present that could impact upon the individual’s presentation, quality of life, and ability to engage in trauma-focussed therapy. Comprehensive assessment of not only PTSD symptoms but also the person’s broader biopsychosocial wellbeing is therefore important.

Assessment should include a comprehensive history, including developmental (e.g., pregnancy, birth, and milestones), medical, psychiatric, substance use, and educational/ occupational history. If possible, the use of a cognitive screening tool is recommended with a view to establishing both past and current cognitive functioning. Cognitive screening tools are not, and do not, replace the need for a comprehensive diagnostic assessment. They will however, give a broad indication as to whether a person’s cognition is intact or whether it requires closer examination. Widely used screening tools include the Mini Mental State Examination (MMSE),<sup>25</sup> the Rowland Universal Dementia Assessment Scale (RUDAS)<sup>26</sup> developed in Australia for multicultural populations, and the General Practitioner Assessment of Cognition (GPCOG),<sup>27</sup> also developed in Australia for cognitive screening in general practice. Patients who show signs of experiencing difficulties or a decline in cognitive functioning should be referred for further assessment to a specialist such as a clinical neuropsychologist, geriatrician, neurologist, or psychiatrist with special expertise in the elderly to provide a diagnosis and identify underlying causes of the cognitive impairment.

## **Treatment**

Evidence supports the use of standard PTSD treatment approaches with older patients, although some modifications may be necessary. For older people with PTSD, fatigue can pose a barrier to engaging in treatment.<sup>28</sup> Therapy sessions may need to be shortened, or held earlier in the day, to improve alertness.

Consultation with the patient’s GP can help establish any physical condition that may impact upon the patient’s ability to engage in therapy.<sup>17</sup> Although some authors advise caution in using exposure therapy with older patients who have cardiovascular disease (due to the potential danger posed by high physiological arousal), others suggest that when graded appropriately and done at the client’s own pace, exposure can be highly beneficial (and safe) even for patients with significant cardiovascular illness.<sup>28</sup> Exposure has also been shown to be effective in treating older veterans with chronic PTSD.<sup>29</sup>

For older patients with some level of cognitive decline, the following suggestions may be helpful:

- As with many PTSD clients, behavioural interventions such as relaxation and other arousal reduction techniques, or activity scheduling, are often easier to understand than the cognitive

elements of cognitive behavioural therapy (CBT). Introducing these early in treatment can help build the person's confidence and engagement with the CBT approach.

- Practical solutions to the presence of trauma reminders may be more effective than attempting cognitive restructuring in relation to the significance of the trigger. For example, cognitively impaired Holocaust survivors for whom showers serve as a reminder of concentration camps may be reassured by the use of a hand-held shower head.<sup>30</sup> Naturally, the education and involvement of care providers is critical in developing and implementing such interventions.
- Use the strengths and weaknesses identified by neuropsychological assessment to adapt therapy delivery. For example, use diagrammatic representations to explain concepts with clients who have good visual memory.
- Slow down the therapy process by focussing on only a couple of concepts each session, and make the most of review and repetition.
- Utilise memory aids where possible. For example, provide the client with recordings of relaxation exercises, provide diagrammatic representations or written summaries, use calendars/diaries or cue cards that can be carried in the person's wallet, and make the most of technology, for example, phone reminder alerts.
- It may be helpful to enlist the support of a 'therapy partner' (i.e., a family member or close friend) who can help to reinforce the therapy techniques in between appointments. It is important to encourage repeated practise of skills in naturalistic settings, and a therapy partner can be helpful in implementing strategies.

### **Directions for future research**

Although a few studies have appeared recently, there remains a dearth of good quality research on PTSD in the elderly. Any well designed studies that further our understanding of the nature and treatment of PTSD in the elderly will be useful, especially as our population continues to age. Some specific research areas to consider include:

- What is the relationship between cognitive decline (particularly dementia) and the onset or exacerbation of PTSD? What are the mechanisms involved and to what extent are traumatic memories likely to surface for the first time (or the first time in many years)?
- Is PTSD a risk factor for dementia? If so, how does it affect the manifestation of dementia and what are the implications for early intervention?
- What is the relationship between PTSD and the emergence of behavioural management problems such as agitation and aggression? If there is a relationship, what does that suggest about intervention approaches?
- In what ways should evidence-based psychological approaches be adapted for the elderly and is there evidence to suggest that one type of trauma-focussed approach is more appropriate than another for this group?
- Which pharmacological approaches are most effective in the treatment of PTSD in elderly populations?

## Source and contributors

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