PTSD in the Elderly

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“Lifespan Perspective” on Aging

Modern gerontological theories take a “lifespan perspective” on aging (Coleman, 1986; 1996) that individual reactions to the many challenges of aging differ according to personal life histories.

“The way in which we grow old and experience this process, our health and functional ability all depend not only on our genetic makeup but also on what we have done during our lives; what sort of thing we have encountered in the course of our lifetime, on how and where we have lived our lives” (Heikkinen, WHO Geneva, 1998).

Dual Reality

- Inconceivable experiences
- Incongruent with the here and now
- Continuous foreground/background interplay
Scene from “Because of That War”

Providing Healthcare for the Elderly

- Growing old involves reckoning with the finality of time and of the choices we made.
- This view can present a difficulty to the elderly individual, as well as to the healthcare provider’s sense of effectiveness and purpose (Knight, 1998).

PTSD: an Anxiety Disorder in DSM-IV TR

- Diagnosis requires a traumatic experience during which one felt helplessness, intense fear, horror.
- 3 symptom clusters:
  - Re-experiencing (1:5 required)
  - Numbing and avoidance (3:7 required)
  - Hyperarousal (2:5 required)
- Symptoms required for diagnosis are not unique to the particular configuration of symptoms and their relation to a specific traumatic event define PTSD.

The Response to Trauma

- Over the last few decades, it has become known that shocking events cause serious damage to physical and mental health.
- There is great individual variability in the response to trauma.
- Only 10% of trauma-exposed individuals respond with PTSD.
- One third of those recover spontaneously and one third show lasting post-traumatic effects (Kessler et al, 1995).
Course of PTSD

- The course of PTSD over the lifetime can be highly variable
- Accumulation of evidence suggests late onset in old age (Bramsen, 1995; Aarts et al, 1996; Yehuda, 2009; Lapp, Agbokou and Ferreri, 2011)

PTSD Well Described in General Population

- Estimated lifetime prevalence in USA population- 8% (Breslau, 2009)
- 9%-15% of Vietnam vets exhibited PTSD 15 years later (National Vietnam Veterans Readjustment Study, 1990)
- Gulf War veterans- 12.1% suffering from PTSD
- Operation Enduring Freedom/Operation Iraqi Freedom- 19% of veterans suffering from PTSD or depression (Gradus, 2007)
- In another study, 24% in WWII vets, Korean War and Vietnam (Rand Report, 2010)
- Higher for Holocaust survivors (Barack, 2005)
- Many others suffer from sub-threshold symptoms (Spiro, Schnurr & Aldwin, 1994; Qureshi et al, 2010)

PTSD in Elderly Scarcely Researched

- No population-based information
- Netherlands: 1% of the population 13% sub-threshold
- Growing public health issue as the number of persons living into older adulthood drastically increases (US Dep. Of Health and Human Services, 1995)

PTSD Comorbidity

- PTSD strongly comorbid with other disorders (Breslau, 2009)
- Anxiety in older adults is common (Kessler et al, 2005)
- Depression in older adults is not "normal" (Blazer, 2009) and can be treated
- Depression with PTSD is more difficult to treat (Chan, Ming-Yu and Unutzer, 2001)

Irit Felsen, PhD at ADHCC Annual Conference
PTSD is a Significant Issue for Older Adults

Elderly suffering full or sub-syndromal PTSD Show:

• Greater impairment in functioning
• Less satisfied
• Receive less optimal care (Marshall, Olfson, Helmann, Blanco, Guardino, Struening, 2001)

Sub-Threshold PTSD

• Large sample of community-dwelling, older survivors of WWII, including survivors of bombardments, persecution, resistance and combat who did not meet full criteria for PTSD were suffering long-term negative effects (Brams and van der Ploeg, 1999)
• Other studies of various trauma survivors render similar results, even 45, 50, and 60 years after the trauma (Falk et al, 1994; Trappler et al, 2007; Marshall et al, 2001)
Types of PTSD

- Due to a recent trauma in old age
- Chronic course of fluctuations of symptoms
- Delayed onset after years of no symptoms or low symptoms

- Chronic with enduring personality changes
- Chronic complex PTSD with multiple psychiatric disorders

Delayed Onset has been Observed in Elderly Survivors

- Explanations for delayed onset:
  - Decrease of physical and mental resilience - less able to “ward off”
  - Decrease of financial and social resources - less support
  - Interaction of trauma with normative processes of aging

Trauma and Normative Aging

- Ego Integrity versus Despair (Erikson, 1994)
- Life review: reminiscing, making meaning
- Continuity in the sense of self
- Coherence in the sense of self
- Accepting one’s unique path in life
- Awakening of earlier losses
- Longing for lost loved ones

Older Adults at Risk

- Victims of interpersonal violence, domestic abuse, childhood abuse, hate crimes, rape, assault, relatives of homicide victims
- Combat veterans and POWs, immigrants from conflict zones
- Victims of natural disasters and accidents
Risk factors for PTSD

- Severity of trauma
- Perceived support
- Peri- and post-traumatic factors very important for outcome prediction
- Prior adjustment, prior history of trauma, family psychopathology also important
  - Brewin et al, 2000; Ozer et al, 2003

Additional Risk Factors

- Female gender
- Lower social support
- Current level of PTSD in spouse
- Adverse events in childhood
- Attachment style
- Cognitive status

Inoculation or Vulnerability

- Inoculation hypothesis
- Vulnerability hypothesis
- Crisis-Resolution hypothesis
  - Hantman and Soloman, 2007
- Cognitive Aging
  - Floyd et al, 2002
- Neurodegenerative decline
  - Ruzich et al, 2005

Recognition of PTSD

- PTSD is often under-diagnosed
- Presents disguised as somatic/medical concerns
- Associated with real medical conditions and medication side effects
- PTSD is highly comorbid with depression and anxiety, which are also underrecognized and undertreated in the elderly (Davidson, 2001)
Assessment of PTSD

- Use mini-mental status exam when indicated
- Routinely include questions about trauma-related experiences and behaviors
- Follow up on physiological and medical complaints with questions about changes in mood and activities
- Use brief measures of PTSD, geriatric depression inventory, and geriatric anxiety inventory (Mehta et al, 2003; Davidson, 2001; Blazer, 2009)
- Use lower cutoff scores to diagnose older adults on the various screening measures

Treatment Indications

- Treatments of choice for PTSD include CBT, prolonged exposure, psychodynamic psychotherapy, and EMDR
- Trauma-focused treatments: processing of traumatic memories versus supportive treatments
- Supportive treatments develop coping skills for here-and-now stressors
- Assess competence for treatment of choice for PTSD: CBT (modified) (Friedman, 2003). No evidence that older adults cannot benefit from it.
- Assess for cardiac and respiratory problems if prolonged exposure is considered
- Modified delivery of treatments according to cognitive capacity
- Assess need for pharmacologic treatment
- Provide resources:
  - www.mindingourelders.com
  - www.thefamilycaringproject.com
  - National Center for PTSD Research, www.ptsd.va.gov

PTSD as Risk Factor for Dementia

- The odds for dementia diagnosis for patients with PTSD are two times as high as for those without PTSD
- Regardless of combat-related trauma, comorbid physical disorders and substance abuse
  - Qureshi et al, 2010
PTSD and Dementia

- Mild cognitive decline was associated with delayed onset of PTSD in war veterans (Mitall, 2001; Johnson, 2000) and in Holocaust survivors (Grossman et al, 2004; Dasberg, 1989)
- PTSD worsened cognitive impairments
- Bidirectional pathways: neurodegenerative decline can disinhibit trauma memories
  - Dallan, Mellman et al, 2011

PTSD is Associated with Cognitive Impairments

- Including:
  - Attention
  - Memory
  - Other executive functions (Moore, 2009)
- Altered stress hormones
- Neuro-anatomical changes in brain structure
  (Sutker, Vasterling, Brailey & Allain, 1995; Burns and Zaudig, 2002)

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Presentation of Posttraumatic Symptoms in Old Age

- While trauma can occur at any time in life, its presentation is different in old age due to developmental processes and cohort effects.
- PTSD in the elderly can be disguised by health-related complaints, comorbid health conditions, medication side effects, cognitive impairment
- Dissociative phenomena are less common in older adults
- Connection to index trauma might be lost

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<tr>
<th>PH</th>
<th>PTSD</th>
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<td>+</td>
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<td>PTSD+ PH-</td>
<td>3660</td>
<td>PTSD- PH-</td>
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*PH= Purple Heart decoration
Qureshi et al, 2010
Behavioral Problems in the Elderly

- More harmful than symptoms of cognitive decline (Gitlin, Kales and Lyketsos, 2012)
- Repetitive speech
- Wandering
- Sundown restlessness and anxiety
- Sleep disturbances (see video on next slide)
- Belligerence, enactment of trauma memories and flashbacks (Dallan, Melman, Bhatnagar et al, 2011)
Nonpharmacologic Approaches

- Non-pharmacologic management recommended because pharmacologic treatments are only modestly effective, have risks and do not treat some of what caregivers find most distressing
- Behavioral symptoms as expression of unmet need:
  - Attempt to get stimulation
  - Inadvertent reinforcement of wrong behavior
  - Mismatch between the patient and the physical and social environment (Pelletier and Landreville, 2007)

Pharmacologic Treatment of PTSD in the Elderly

- Pharmacologic treatment of PTSD in the elderly not sufficiently studied
- Clinical experience suggests up to 60 mg/day Fluoxetine or 200 mg/day Sertraline for optimal effect
- Trazadone may be effective but can cause sedation
- Mirtazapine/Venlafaxine/Duloxetine might be useful, but not enough studied in geriatric population for this indication
  - Only modestly effective and have side effects
  - (Jacobson et al, 2007)

**Table 1. Potential Nonpharmacologic Strategies Targeting Abnormal Behavior**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Evaluate capacity for taking medications independently</td>
<td>40 mg/day Fluoxetine or 200 mg/day Sertraline for optimal effect</td>
</tr>
<tr>
<td>Supervise medication taking and ensure medications are taken</td>
<td>Trazadone may be effective but can cause sedation</td>
</tr>
<tr>
<td>Cognitive stimulation</td>
<td>Mirtazapine/Venlafaxine/Duloxetine might be useful, but not enough studied in geriatric population for this indication</td>
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<td>Physical activity</td>
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Consensus Treatment for Depression in the Elderly

• Dan Blazer, 2003

<table>
<thead>
<tr>
<th>Table 2. Diagnostic Workup of the Depressed Older Adult</th>
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<tr>
<td><strong>Rule</strong></td>
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<tr>
<td>Screening for significant depressive symptoms using a standardized screening scale such as the CES-D or GHS</td>
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<tr>
<td>Present and past history, including</td>
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<tr>
<td>family history—include assessment of additional states and functional status and</td>
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<tr>
<td>current medications</td>
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<tr>
<td>Screening for cognitive function</td>
</tr>
<tr>
<td>Routine laboratory tests, e.g. chemistry</td>
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<tr>
<td>and electroencephalograms if antipsychotics are to be</td>
</tr>
<tr>
<td>prescribed</td>
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</tbody>
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Note: CES-D = Center for Epidemiologic Studies Depression Scale; GHS = Geriatric Health Scale; MRIs = magnetic resonance imaging; TSH = thyroid-stimulating hormone.

Consensus Treatment for Depression in the Elderly

• Dan Blazer, 2003

<table>
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<th>Table 3. Consensus Treatments of Late-Life Depression</th>
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<tbody>
<tr>
<td><strong>Diagnosis</strong></td>
</tr>
<tr>
<td>Major depression</td>
</tr>
<tr>
<td>Unipolar psychotic major depression</td>
</tr>
<tr>
<td>Dysthymic disorder</td>
</tr>
<tr>
<td>Minor depression</td>
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Note: From Kocopoulos et al. (2009). SSRIs = selective serotonin reuptake inhibitors; ICFR = electroconvulsive therapy.

PTSD at End of Life

• Virtually no research addresses PTSD at the end of life
• Psychiatric symptoms highly prevalent in patients near the end of life
• 25% develop PTSD, often comorbid with depression and anxiety
• Specific strategies of pharmacotherapy according to the expected lifespan of the patient
• Physicians might respond to the patient’s impending death with their own avoidance

(Feldman and Periyakoil, 2006)

Gladys Wilson and Naomi Feil

http://www.youtube.com/watch?v=Cr2Xz10FcVM
Testimonies of Trauma Survivors

- http://www.youtube.com/watch?v=sCvQpS-pfb0
- http://www.youtube.com/watch?v=RKUvRZXOiqc
- http://www.youtube.com/watch?v=NHTr7O9C_A
- http://www.youtube.com/watch?v=h9IdSEsECQU
- http://www.library.yale.edu/testimonies/