Uploaded to VFC Website

March 2013

This Document has been provided to you courtesy of Veterans-For-Change!

Feel free to pass to any veteran who might be able to use this information!

For thousands more files like this and hundreds of links to useful information, and hundreds of "Frequently Asked Questions, please go to:

Veterans-For-Change

Veterans-For-Change is a 501(c)(3) Non-Profit Corporation
Tax ID #27-3820181

If Veteran's don't help Veteran's, who will?

We appreciate all donations to continue to provide information and services to Veterans and their families.

https://www.paypal.com/cgi-bin/webscr?cmd=_s-xclick&hosted_button_id=WGT2M5UTB9A78

Note: VFC is not liable for source information in this document, it is merely provided as a courtesy to our members.

PTSD 101
www.ptsd.va.gov/professional/ptsd101/

COURSE TRANSCRIPT FOR:
PTSD in Older Veterans: Emerging Issues
Course Instructor(s): Robyn D. Walser. Ph.D.

Slide 1: PTSD in Older Veterans: Emerging Issues

Welcome. I'm Dr. Robyn Walser from the National Center for Posttraumatic Stress Disorder and today I'm going to be talking about PTSD in Older Veterans: Emerging Issues.

Slide 2: Goals of the Presentation

The goals of this presentation are to increase awareness of PTSD in older adults. I'd also like to talk about the current state of research and knowledge in terms of this particular issue. We'll examine the relationship between PTSD and the elderly. And then we'll spend a bit of time discussing some treatment implications.

Slide 3: What is PTSD?

I'd first like to start by talking about what is PTSD or posttraumatic stress disorder. PTSD is an emotional disorder caused by exposure to traumatic events. And these kinds of events can include everything from combat, sexual assault and rape, child physical and sexual abuse, motor vehicle accidents, and other kinds of accidents. It can also include violence, such things as street crimes, spousal abuse, and elder abuse may all fall under traumatic events and can lead to a diagnosis of PTSD if the individual experiences continuing mental health problems.

Slide 4: Veterans

In addition to the above veterans may also experience a number of other traumas that involve actual or threatened death. These include captivity or POW experience, fire fights, seeing mutilated bodies or atrocities, witnessing death or other people dying, doing medical care in the field, sexual assault or torture.

Slide 5: What is PTSD?

So given these traumatic events there is particular things that need to happen in order to receive a diagnosis of PTSD. One is that the traumatic event must involve actual or threaten death or serious injury to self or someone else. And it must include a response of intense fear, helplessness or horror. So if an individual doesn't meet this initial criteria they wouldn't be diagnosed with PTSD. In addition to these criteria there are three clusters of PTSD symptoms including re-experiencing, avoidance and arousal, and in order to receive the diagnosis you have

to have at least one re-experiencing symptom, three avoidance symptoms, and two arousal symptoms. Let's explore each of these symptom categories.

Slide 6: PTSD Symptoms

Let's start by looking at the re-experiencing symptoms. These include recurrent and intrusive distressing recollections. So these are unwanted memories of the trauma. It includes recurrent distressing dreams of the event. So individuals will often report having a dream about the trauma that's almost as if the trauma is recurring again, the dream is very similar to the trauma. The individual may be acting or feeling as if the event were recurring in real time so they're reliving the event. There's intensive psychological distress when exposed internal or external cues or reminders about the trauma. And then it also includes physiological reactivity when exposed to reminders. And once again you need at least one of these symptoms in order to be diagnosed with PTSD.

Slide 7: PTSD Symptoms

One of the avoidance symptoms are efforts to avoid thoughts, feelings or conversations associated with the trauma. Others include efforts to avoid activities and places that might remind the individual of the trauma. Also included is an inability to recall important aspects of the trauma so the individual might be able to say that they can remember when it first happened or right after it happened but not be able to recall specific things related to the trauma. They also experience diminished interest in significant activities. They may feel detached or estranged from others. Their affect may also be restricted so they begin to feel numb or just few emotions instead of the rich range of emotions that we generally feel. And they can report a sense of foreshortened future. And here again you want to have three of these symptoms in order to meet criteria for PTSD.

Slide 8: PTSD Symptoms

And the final set of PTSD symptoms includes increased arousal. Here the individual may report difficulty falling or staying asleep. They may feel irritable or have outbursts of anger. Often they'll report difficulty in concentration and the sense that they need to be on guard or super alert, which we call hypervigilence. And then they may also experience an exaggerated startle response. So a small noise that may cause individuals who don't have PTSD to give a small start will cause individuals with PTSD to give a very large or exaggerated body movement in response to the sound that they may hear. And here you want to have at least two symptoms in order to meet the diagnosis for PTSD.

Slide 9: Impact on Survivor

When an individual is diagnosed with PTSD there is a large impact on the survivor. Symptoms can cause significant distress or impairment in social occupational and other important areas of functioning. It is linked to increased rates of physical illnesses and it causes reduced quality of life.

Slide 10: Course of PTSD

There are several models for the course of PTSD. The first includes the stress evaporation model. This model suggests that the effects of trauma dissipate over time. So symptoms decrease as time passes. The second model is the residual stress model. This model suggests that the effects of trauma are long lasting with symptoms lasting perhaps a lifetime and can be exacerbated under increased stress. And finally there is the delayed onset and fluctuating patterns course. This model suggests that PTSD can lie dormant for long periods of time and then resurface under conditions of stress or loss and it also asserts that PTSD symptoms can fluctuate, waxing and waning depending on the situation.

Slide 11: Studies

So with respect to PTSD in the elderly there are no epidemiological studies using a representative sample of older adults investigating rates of PTSD. In addition estimates of traumatic exposure of PTSD can vary depending on definitions, the population studied, and symptoms assessed. So at this time we don't really know what the rates of PTSD are but in a few moments I'm going to talk about the approximations of trauma exposure in the general population and in the elderly and give some information about rates that we do have.

Slide 12: Lifetime Traumatic Exposure

We do have epidemiologic information for the general population about trauma exposure and rates of PTSD based on figures from the National Comorbidity Study and the Detroit Area Survey Study. And I'll review those at this time.

Slide 13: Rates of PTSD

A National Comorbidity Study found that lifetime traumatic exposure for American women was about fifty percent and for American men about sixty percent. So there is at least half to more then half of the population being exposed to trauma at some time during their life. The Detroit area survey found that seventy-five percent of individuals will be exposed to some event in their lifetime that meets the stress or criteria for PTSD. So rates of trauma exposure are relatively high, however actually receiving a diagnosis of PTSD is much lower then these rates.

So if we take a look at the same studies the rates of PTSD and the National Comorbidity Study are about 7.8 percent. And that's prevalence across the lifetime. And for the Detroit area survey they found that rates were about 9.2 to 9.8 percent. And again that's prevalence of PTSD across the lifetime.

Slide 14: Trauma Exposure in the Veteran Population

Now that we've taken a look at exposure in the general population I also have some information to present on trauma exposure in the veteran population. Approximately eighty-five percent of male veterans have been exposed to trauma in the past. Rates of combat exposure include fifty-two percent of World War II veterans and thirty-five percent of Korean War veterans. Of these

about twenty percent screened positive for PTSD. Hankin and company also found that if there is a trauma exposure depression is three times more likely and an alcohol disorder is two times more likely. They also noted in their study that the rates are higher among veterans than primary care private sector patients. So here you can see that trauma exposure is relatively high and if we think about our World War II and Korean War era veterans we could be looking at a population that is still struggling with PTSD or PTSD may be affecting their life functioning.

Slide 15: PTSD and the Elderly

So as noted the exact prevalence of PTSD in the elderly is not known. We do have some estimates in combat veterans and that's about three to fifty-six percent get diagnosed with PTSD. It does as I mentioned happen to be lower in community samples then in psychiatric or medical in-patient samples. And the National Vietnam Veterans Readjustment Study found that about fifteen percent of all Vietnam theatre veterans are diagnosed with PTSD and thirty-six percent of those exposed to high levels of combat have received a diagnosis of PTSD. The estimates in POWs range from thirty to seventy percent. So as we start to look at these figures we can see how the elderly may be impacted by PTSD. Given these figures and the course of PTSD the models that I discussed earlier we really need to be thinking about how trauma may be impacting the elderly. Unfortunately, it's not a well understood population in terms of PTSD and its impact on functioning.

Slide 16: Graying of Veteran Population

There is a growing need for understanding and research with respect to PTSD and its interplay with the aging process especially if we take a look at the figures about the graying of the veteran population. Thirty-eight percent of male veterans are over the age of sixty-five. There is about 5.9 million World War II veterans and 4.1 million Korean War veterans. Our largest service group, the 8.1 million Vietnam veterans are about to move into the older age group. Within the veteran population the sixty-five or over age trend is occurring. In 1990 twenty-six percent of the male vet population was over the age of sixty-five. In 2010 about forty percent will be over the age of sixty-five. And in 2020 fifty percent will be over the age of sixty-five. So we have a very large population of veterans moving into old age. Again pointing to the importance of understanding and research about PTSD and its effect on the aging process or how aging might actually affect PTSD symptomatology. There are a few studies that have begun to investigate this issue and I'll take a few minutes to go over these findings.

Slide 17: Current State of Research and Knowledge

Falk, Hersen, and Van Hasself found that there's generally symptom stability across the decades. In a literature review they found that older adult survivors of combat, natural and manmade disaster, and the Holocaust met diagnostic criteria as many as forty-five years after the trauma. Port in a recent investigation suggest that symptoms are highest after exposure declined for years and then can be followed by an increase in late life.

Slide 18: Normative Aging Study

In their Normative Aging Study Spiro, Schnurr, and Aldwin found that World War II and Korean vets with traumatic exposure were 13.3 times at greater risk for PTSD symptoms decades after the initial exposure to trauma. However, Bramsen and van der Ploeg looked at a community sample of survivors of World War II who had withstood bombardments, persecution, resistance and combat and they found that they did not meet diagnostic criteria for PTSD; however, many did suffer negative long term effects. Here it's important for us to be thinking about the continuum of PTSD symptoms and it may be that many of our older veterans are experiencing sub-threshold PTSD. This points to a strong need for assessment which I'll talk about in just a few minutes.

Slide 19: Current State of Research and Knowledge

In addition to the above studies, Schnurr and colleagues investigated older male military veterans with PTSD and found that they had increased onset of arterial disorders, lower gastrointestinal disorders, dermatological disorders, and muscular skeletal disorders. And they found these after controlling for PTSD symptoms, age, smoking, alcohol use, and body weight. So here again we want to be thinking about the impact of the trauma symptoms or experience of trauma in undetected PTSD on older male military veterans.

Slide 20: Current State of Research and Knowledge

In a study conducted by myself and other colleagues at the National Center for PTSD we looked at trauma and health in older female veterans. What we found is as the number of different types of trauma increased female veterans were then more likely to be symptomatic as measured by the PTSD checklist and the trauma symptom checklist. We also found that as scores on the trauma measures increased reports of physical health decreased and reports of pain increased. Additionally as trauma symptom severity increased on the Trauma Symptom Checklist, it was more likely that subjects screened positive for alcohol abuse. Here again, we can begin to look at the relationship of trauma and its impact and functioning in older life. It is important to also be assessing females for trauma and PTSD symptoms.

Slide 21: PTSD and the Elderly

Given this brief review of the literature and the potential for large numbers of veterans moving into long term care and assisted services as they age again it will be important for us to respond to the needs of this growing cohort.

Slide 22: PTSD and the Elderly

Unresolved distal or recent trauma may interact negatively with the age related changes. These changes may uniquely effect physical and mental health functioning in later life. And age related changes may contribute to the waxing and waning of PTSD symptoms. Research can help us further understand the long term effects of PTSD and its relationship with aging.

Slide 23: Aging and PTSD

Given what we know I'd like to now spend some time looking at the relationship between PTSD and aging focusing more generally on issues to be alerted to and then making suggestions about what kinds of steps providers can take to work with this population.

Slide 24: Developmental Stressors Due to Age

Let's first take a look at the developmental stressors that may be due to aging. There is diminished sensory capacities, decreased mobility, physical frailty, income shrinkage, financial limitations, loss of friends and social status, isolation, changes in housing, loss of control.

.

Slide 25: Developmental Stressors Due to Age (cont.)

The elderly may be taking multiple medications and have complex medical problems or ill health. Retirement and widowhood can be stressors. There is also cognitive impairment or loss. Impaired self-care and more time for reflection. All of these different stressors can either interact with PTSD symptoms or be mistaken as a PTSD symptom or be missed as a PTSD symptom. So there's a combination here that makes it difficult to really understand the picture of PTSD in the elderly population. So you'll want to be careful in considering differential diagnoses. For instances the elderly may isolate due to age related processes, but isolation is also one of the key symptoms of PTSD. So you want to know if trauma is impacting current functioning. Doing a thorough assessment to fully understand what these symptoms are about. In addition these stressors may actually trigger trauma reactions and symptoms. So as the elderly's capacity to cope diminishes PTSD symptoms may begin to arise. So although they may have been able to cope for years later in life they may begin to struggle with trauma and its impact.

Slide 26: Other Considerations

Other things to consider include how physical problems might be associated with PTSD and may be even difficult to distinguish from those associated with the aging process. For instance some veterans report gastrointestinal problems or pain that maybe related to PTSD symptoms and not to the aging process or may be related to both. A thorough assessment may help in distinguishing this unique set of problems. In addition the trauma survivor may not recognize the problem as attributable to PTSD. They may just come in with a somatic complaint not recognizing that PTSD may be what they're experiencing. And finally the clinician may not think to ask about traumatic events that occurred many years ago. It may not be in their mindset as something that would actually be impacting functioning this many years later.

Slide 27: Phenomenology

In addition to this, there's a phenomenology that distinguishes younger vets and older vets. This phenomenology may include younger vets reporting more PTSD, more depression and hostility, more guilt, more impairment at work and derealization and suicidal tendencies whereas older veterans may just focus on somatic complaints.

Slide 28: Why higher rates of psychological distress in younger?

These types of distinctions may be due to cohort issues. For instance younger vets may admit to more symptoms because there are fewer stigmas as with older veterans. Younger vets may be also better able to identify psychological problems. A younger age at the time of services may be a factor on reporting and experiencing symptoms. There are large differences between the wars experienced. And our assessment tools and nosology were developed under younger veterans. Given this phenomenology, it will be important to see how PTSD may be underlying other problems seen in primary care.

Slide 29: PTSD May Underlie Other Problems Seen in Primary Care

So the clinician may want to be alerted to some of the following kinds of complaints in terms of thinking about trauma and its relationship to these or PTSD and its relationship to these. So older individuals may be reporting somatic complaints such as pain syndromes, GI problems, headache or pelvic problems. They may be reporting alcohol or substance abuse. Acute or chronic stress related medical conditions and complaints. Clinicians might also want to look at high utilization or problems in living such as poor social support, marital problems, and work related problems as possibly related to PTSD. Here again, it's important to take a trauma history and to assess PTSD symptoms to see if they might be impacting some of the things that the individual is coming to see the doctor about. Remember, elderly patients often do not associate complaints with PTSD.

Slide 30: Traditional Primary Care Setting

Other things to consider in the traditional primary care setting include that survivors may not talk about trauma unless they are prompted to do so, and providers generally may not ask… as mentioned. So professionals and patients will mutually fail to identify many problems. And this is based on lack of information or time or perhaps embarrassment and discomfort about talking about the trauma. The elderly may have a lot of discomfort or embarrassment and may see it as something that you don't talk about or something that you don't share with others. It's over and done with. There's no need to rehash old things that are no longer happening. In addition the provider may be worried about talking about the trauma and perhaps triggering other kinds of problems, however, undetected PTSD that's gone untreated can increase and potentially cause greater difficulties. Not only will it be important for the provider then to appropriately diagnose PTSD and provide treatment but it also can impact other providers care of a PTSD patient. So if PTSD goes unrecognized multiple problems can occur.

Slide 31: Possible Impact of PTSD on Care Providers

So for instance if the elderly are moving into long term care units or are needing higher levels of care due to medical issues relationship difficulties can arise that are related to PTSD. For instance the patient may have difficulty trusting others. The patient may be on an emotional roller coaster or angry and irritable or the anger that they may be experiencing is more intense

and out of proportion to the current situation. The patient may have negative feelings about the VA and they may not form a therapeutic relationship.

Slide 32: Impact on Care Providers

In addition PTSD may cause particular management difficulties. So for instance the patient may avoid sleeping. They may be seeking medications or losing their temper. They may not be motivated or impulsive. And they may not appear to learn from the provider's care. So the patient behavior becomes a stressor to the provider and then the provider may find it difficult to feel empathy with the PTSD patient. So in these kinds of settings you can have an interaction of patient PTSD with provider care that can complicate or worsen the problem. Here again assessment of trauma and understanding of PTSD can be helpful in resolving some of these issues.

I do have a few examples of things that providers can do to promote healthcare. But first let me also mention traditional mental health treatment.

Slide 33: Traditional Mental Health Treatment

Traditional mental health treatment requires help seeking behaviors, acceptance of a mental health label, and usually high levels of distress. If you think about our elderly, they don't tend to seek help from mental health professionals. They tend to handle the problems on their own. If you talk with our older veterans, they largely see these kinds of issues as something that they can deal with. It's seen as a weakness should they need to seek help from others. It's also very difficult for them to accept a mental health label. These kinds of issues and problems are generally not talked about among this particular cohort so what we might see then is that many of these elderly individuals will show up in the primary care setting with somatic complaints, bodily complaints that are the problem and may not, and they may not even be thinking about mental health as an issue that is related to the struggles that they're currently experiencing. Here the provider can be of the best help.

Slide 34: Action Steps to Avoid or Minimize Problems

There are a number of action steps that providers can take to avoid or minimize problems. First is the staff need to be educated. They need to understand the disorder of PTSD so that they can work more effectively with patients who have been diagnosed with this disorder. It will also be important to see how the symptoms may be impacting functioning or how the symptoms may be playing a role in their medical conditions. Another action step that can be taken is to teach staff behavioral methods for working with difficult patients who may be acting out. For instance if the patient is symptomatic and acting out in anger, it'll be important for the staff to differentially reinforce the behaviors that they like to see. They may also want to consider removing triggers from the room such as loud noises, unexpected visitors, people dressed in military uniforms. All of these kinds of things might be triggers for the older veteran and if the staff understand just some behavioral interventions or some easy changes in the way they approach the patient then it may make for smoother treatment.

Also it'll be important for the staff to get help when needed. Call in mental health professionals to help guide treatment and to give suggestions about how to manage PTSD symptoms. Also it would be important for staff who are working directly with these individuals to take breaks when needed and to be patient.

Another action that can be taken especially in the setting of long term care is to form an alliance early. Take a little bit more time to find out about a patient's history rather then just treating the medical problem. Sometimes with busy schedules nursing staff or other providers may be wanting to rapidly move through procedures that need to be done. Here if you can form alliance and take a little bit more time with the patient who has PTSD you may have greater success in treatment.

Finally, there are several action steps that can be taken in both long term care settings and in mental health settings. Take a trauma history and screen for trauma. If the individual screens positive you may want to do further assessment to find out if the individual actually has PTSD. You can use the Clinician-Administered PTSD scale or the PCL, the PTSD Symptom Checklist. If you discover that the individual has symptoms of PTSD, or is fully diagnosed with PTSD, it'll be very important to ask about the symptoms and to educate about PTSD symptoms. And you'll want to treat the PTSD whenever possible and appropriate. In addition you want to make efforts to communicate respect and work with the individual and medical professionals to help decrease anxiety, improve sleep, and other problems associated with PTSD.

Slide 35: Action Steps to Avoid or Minimize Problems

PTSD in the elderly population is not well understood. We need more research that can provide information and guide us in best how to approach resolving PTSD symptoms or a full diagnosis of PTSD in the elderly. We also need to further investigate assessment and learn more about how PTSD interacts with aging. We do have a very large group of veterans who are moving into old age and many of them have been exposed to trauma. Future needs and appropriate treatments will be key in treating this population.

If you have any questions about the presentation please feel free to contact me at robyn.walser@va.gov. The email is provided on the slide. And then also you can take a look at the references on the last slide if you'd like to read more about how we understand PTSD and its effects on the elderly. Thank you.