Traumatic stress and aging—an interview with psychologist Joan Cook

October 7 2016, by Shaili Jain, Md

Dr. Joan Cook is a clinical psychologist and Associate Professor in the Yale School of Medicine, Department of Psychiatry. She has specific expertise in the areas of traumatic stress and geriatric mental health. Dr. Cook has served as the principal investigator on four grants from the National Institute of Mental Health, as well as grants from the Agency for Healthcare Research and Quality and Patient-Centered Outcomes Research Institute. She is a member of the American Psychological Association (APA) Guideline Development Panel for PTSD and is the

2016 President of APA's Division of Trauma Psychology.

Recently, I spoke with Dr. Cook about PTSD in older adults.

Dr. Jain: Can you comment on the unique methodological considerations for researchers doing PTSD research in the elderly?

Dr. Cook: There are a number of methodological considerations that researchers who want to study older traumatized individuals might want to think about beforehand. One issue in working with this current cohort of older (65 and above) adults is their potential denial or minimization of reporting of trauma and related symptoms. For some individuals in this current cohort, their traumas may have preceded the 1980 introduction of posttraumatic stress disorder (PTSD) into the official diagnostic classification. Thus they may associate more stigma or blame themselves for having experienced such event and/or having subsequent symptoms.

I think events such as the September 11th terrorist attacks, the wars in Iraq and Afghanistan, and Hurricane Katrina, have helped raise the national consciousness about trauma. But I still clinically come across older adults who lack an understanding of the potential effects of traumatic experiences or don't accurately label such events as "traumatic." In addition, there are also cognitive, sensory, and functional impairments that may affect the experience, impact, or reporting of trauma-related symptoms.

Dr. Steven Thorp, Heather Sonas and I (2011) provided some recommendations for conducting trauma and PTSD-related assessment and treatment with older survivors. This includes practical issues like the need for large, bold fonts in written assessment or therapy materials to increase readability and minimize frustration, using specific behaviorally

anchored questions to assess for traumatic events, and the benefits of using more than one method of assessment (e.g., self-report, observation, caregiver report, and structured interviews).

Dr. Jain: Can you discuss the findings of intimate partner violence (IPV) rates (and related PTSD) in older women versus younger women? How might these findings be explained (e.g. reporting bias, less public awareness, lack of resources to help older women)?

Dr. Cook: I'm so glad you asked this question! This is a topic that is near and dear to my heart. I've done a little research in this area but wish I had time and resources (grant support, interested collaborators) to do more.

In general, rates of IPV and related PTSD are lower in older as opposed to younger women. This may be due to more recent violent times in our society, for sure. But it also may be due to an interaction between reporting bias and cohort effects. The current cohort of older women may be less likely both to label IPV as such and to disclose such histories to health care providers. There also appears to be limited public awareness and fewer available services specifically designed for older IPV survivors compared to younger and middle-aged women.

A fairly recent systematic review that my colleagues and I conducted found that older women with IPV histories have greater psychological difficulties than older women who do not have these experiences. More specifically we also looked at data from a large nationally representative sample and found that one out of seven older women reported a history of physical or sexual assault, or both. And those who reported this type

of traumatic history were generally more likely to meet criteria for past-year and lifetime PTSD, depression, or anxiety than those without such a history. Although IPV does not appear to be a widespread phenomenon in older women, it should not remain a "hidden variable" in their lives. I'd love to see more public attention, research, and clinical endeavors with older traumatized women.

Dr. Jain: Much of the studies of PTSD in older populations have been done in Veterans—do you think these findings are applicable to other populations of trauma exposed adults?

Dr. Cook: You're right. The vast bulk of the empirical literature on older adult trauma survivors has been conducted on combat veterans and former prisoners of war. But there is a relatively decent sized research base on older adults who experienced Holocaust-related trauma earlier in their life and individuals who experienced natural or man-made disasters later in life. There is very little research on trauma in aging ethnic and racial minorities and, as explained above, less on physical and sexual abuse in older men and women.

I don't think this means that the findings from the literature can never generalize. That would feel too extreme, right? But I think we need to sometimes exercise caution in our interpretation and recognize the limits of what we can and should say. I'm a researcher. I'm always looking to widen the representativeness of my samples (e.g., men/women, assessing for all types of trauma and a range of mental health and quality of life type outcomes, looking at people from varying SES, racial/ethnic backgrounds, and disability statuses) and to dive more into the nuances or intersectionality of those variables.

Dr. Jain: Can you talk about the correlation between

PTSD and dementia? How robust are these findings? What other causal factors may be involved? What about the reverse—how does having dementia impact PTSD symptoms?

Dr. Cook: This is a hard one for me to answer. It's intriguing data for sure, but there's so much we don't know. We know that older adults with PTSD perform more poorly across a range of cognitive measures, particularly processing speed, learning, memory, and executive functioning compared to older adults without PTSD.

Over the years there have been several case reports indicating that dementia may exacerbate existing PTSD symptoms. However in the past few years data from two recent large veteran datasets relatively indicate some evidence for a link between PTSD and dementia. In a sample of 181,000 veterans age 55 and over, those with PTSD were more than twice as likely to develop dementia over a six-year follow-up. In another study, almost 10,000 veterans age 65 and older were categorized according to PTSD status (yes or no) and having received a Purple Heart medal (yes or no). There was a greater incidence and prevalence of dementia in the older veterans with PTSD.

Some, however, believe that PTSD and dementia may share a third variable, intelligence, which may account for the link.

Dr. Jain: With regards to PTSD and older adults—what do you think are the top 5 questions/priorities for researchers to address in the coming 10-20 years?

Dr. Cook: The older adult population is increasing rapidly, and that

changing demographic landscape will likely translate to an increased need for mental health services for older adults. Most randomized controlled trials investigating psychotherapy or pharmacotherapy for adults with PTSD do not typically include older individuals or sufficient numbers of them to examine age comparisons. A recent systematic review on psychotherapy for PTSD with older adults identified 13 case studies and seven treatment outcome studies. But this literature is disappointing in some ways. It has significant methodological limitations, including non-randomized research designs, lack of comparison conditions, and small sample sizes. One conclusion from this review was that select evidence-based interventions validated in younger and middle-aged populations appear efficacious with older adults. But while a number of the studies reported that older adults experienced a reduction of PTSD, depression, and anxiety symptoms, few experienced complete remission. It's currently unclear if those treatments were not delivered in sufficient dose (i.e., intensity and frequency) to produce full benefit or if chronic, severe PTSD is harder to treat in older as opposed to younger adults.

Over the past decade there have been several epidemiological studies both in the United States and in several industrialized countries using representative samples of community dwelling adults and examining the prevalence and impact of traumatic experiences and PTSD with sufficient numbers of older adults to examine late-life age effects. Needless to say, this is very exciting and a significant advancement for both the traumatic stress and geriatric mental health fields. Now that we've done that I'd love to see more on the experience of trauma and expression of any related distress in the least healthy and potentially most "vulnerable" older adults—those with, physical, emotional, or cognitive impairment; those who are homebound; and long-term care residents.

Although the prevalence of full PTSD appears to be relatively low, there

is some evidence to suggest that older adults may have clinically important PTSD symptoms. I think it would be great if we could invite subthreshold PTSD in the older adult population as well as trauma-related depression. There is a very robust literature on depression in older adults and only a handful of articles that look at the connection between depression and trauma.

Though older adulthood encompasses at least a 30-year age range, the vast majority of studies on older adult trauma survivors lump all of them into a generic older adult group. Ideally I would like to see more fine-grained analyses (even if they are exploratory) on young-old (65–74 years), middle-old (75–84 years) and old-old (85 years and older). This seems to be fairly low hanging fruit that most investigators could try to do.

I've also included other things in my wish list above.

This story is republished courtesy of PLOS Blogs: blogs.plos.org.

Provided by Public Library of Science