



Assessing, Intervening, and Treating Traumatized Older Adults

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4th BIENNIAL TRAUMA CONFERENCE

Addressing Trauma across the Lifespan: Integration of Family,
Community, and Organizational Approaches

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Program Objectives

Describe how existing physical and mental conditions - sensory impairment, physical disability, dementia, psychiatric disorders, and medical illnesses greatly increases risk for poor outcomes, resulting in higher rates of morbidity and mortality among older adults.

Describe how evidence informed practices can be modified for geriatric populations and implemented in various settings that serve older adults.

Program Objectives

Overview of techniques use to Intervene and Treat Trauma in older adults –

- * Psychological First Aid
- * Skills for Psychological Recovery
- * Cognitive Behavioral Therapy

Identify barriers to behavioral health treatment at the personal, provider, and system levels.



Colored Card Exercise

Yellow – 3 thing you love

Blue/green – 3 people/pets you love

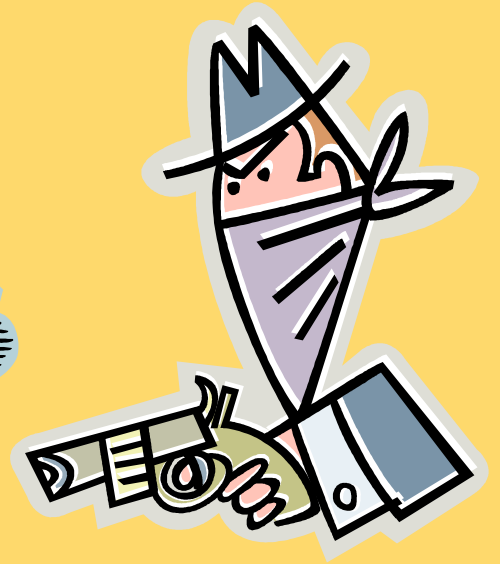
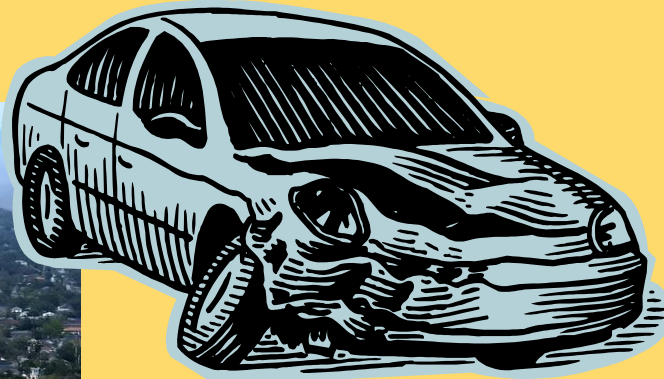
Pink/orange – 3 places you love

Traumatic Stress

“Traumatic stress refers to the emotional, cognitive, behavioral and physiological experiences of individuals who are exposed to, or who witness, events that overwhelm their coping and problem solving abilities”

(Lerner & Shelton, 2001)

Traumatic Events



Potentially Traumatic Events

- A potentially traumatic event (PTE) is any powerful incident that affects a person's daily life
- An event is considered **potentially** traumatic because it may not affect two people in the same way
 - Some may be severely affected while others may not feel any type of discomfort and may actually thrive on the experience.

Prevalence of Potentially Traumatic Events

- In 2009, 10.8 million motor vehicle accidents occurred in the U. S.
- In 2009, over 1.4 million violent crimes occurred in the U. S.
- Other types of PTEs include natural disasters such as hurricanes, which affect up to 1.1 million Americans each year.



New Definition of a Traumatic Event From DSM-5

- Actual or threatened death, serious injury or sexual violence in any of the following ways:
 - Direct exposure
 - Witnessing, in person
 - Learning of events occurring to a close friend or family member (must be violent or accidental)
 - Repeated/extreme exposure to aversive details of trauma (e.g., fire and police officers)

Traumatic Events

- Combat
- Physical and sexual abuse
- Motor vehicle and other accidents
- Natural and Human-made disasters
- Violence
 - Street crime
 - Domestic abuse

Older Adults and Traumatic Events

- Age in and of itself does not make a person vulnerable
- Some older adults may be a valuable resource
- A constellation of factors makes it more or less difficult for elders before, during, and after traumatic events
 - Impaired cognition, mobility, or senses
 - Decreased social network or unavailable social support, limited finances, low literacy
 - Mental or medical problems – acute or chronic

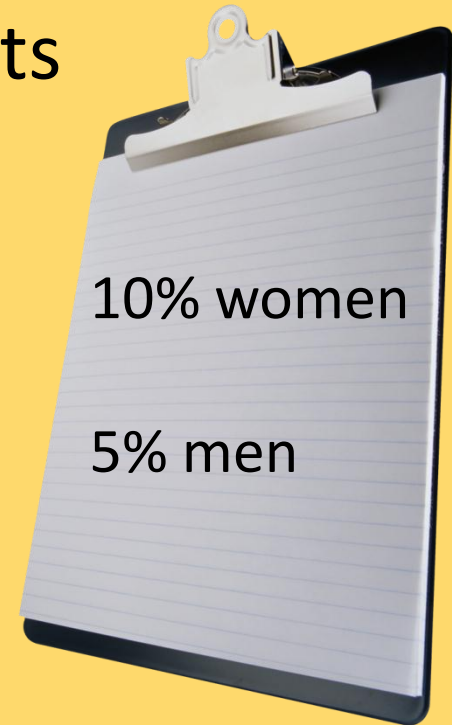
Prevalence of Acute Stress Disorder

- Survivors of motor vehicle accidents
 - 13%-21%
- Survivors of violent assault
 - 19%
- Victims of robbery
 - 25%
- Victims of mass shootings
 - 33%



Prevalence of PTSD

- The National Comorbidity Survey (NCS) 2001-2003 estimates lifetime prevalence of PTSD to be 7.8% among American adults



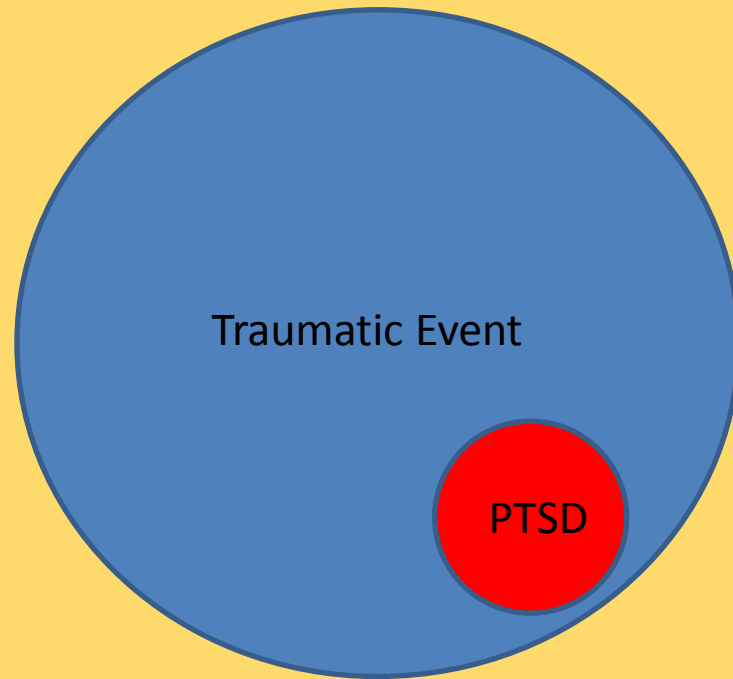
Prevalence of Subsyndromal PTSD

- No numbers but researchers are looking to classify and define subsyndromal/partial PTSD



The good news is.....

- This percentage is a small proportion of those who have experienced a traumatic event at some point in their lives
 - 61% men
 - 51% women



Course of PTSD

- 40% of people with PTSD recover within the first year after trauma exposure.
- 1/3 to 1/2 of those with PTSD do not recover, even after many years.
- Duration of PTSD varies according to severity of traumatic stress exposure.
- Duration of symptoms is shorter for survivors who obtain treatment.

Risk Factors for Developing PTSD

Severity of trauma (dose-duration) is one of the best predictors of:

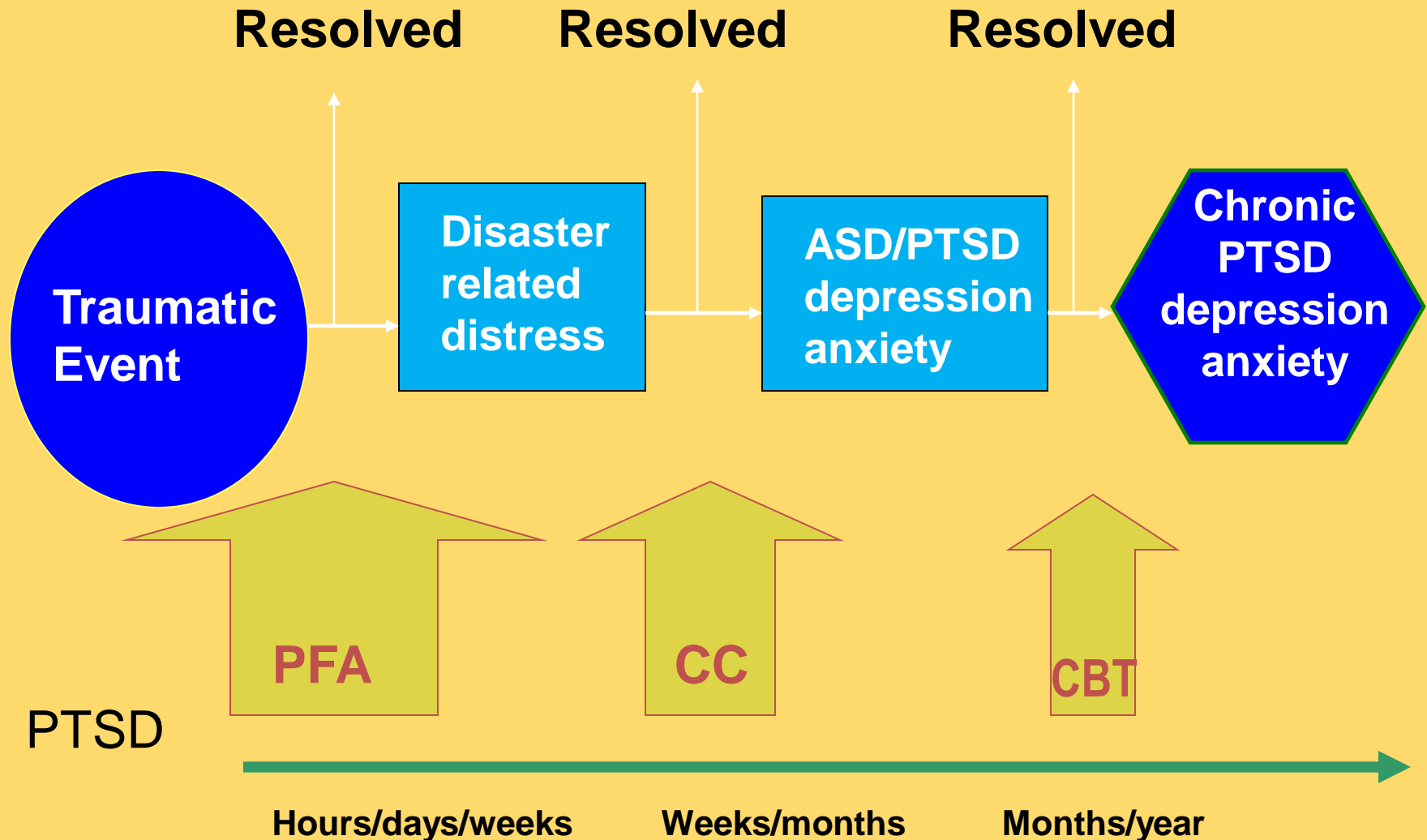
- Likelihood of developing PTSD
- Severity of PTSD
- Chronicity of PTSD

Barriers to Care



- The ability of people to adjust and cope after a trauma is mitigated by their capacity to access tangible support and assistance.
- People requiring assistance may be confused about who to call for assistance and unsure about which organizations are available to provide help
- People may not understand what crisis counseling and therapy can and cannot do to help them recover

Delivery of Behavioral Health Services





Elders at Increased Risk for Adverse Consequences

- Socially isolated
- Frail
- Chronic illness
- Cognitively impaired
- History of exposure to an extreme traumatic stressor
- Substance Abuse
- Low SES
- Language and cultural barriers
- Severe mental illness
- People at ground zero
- 1st responders and media

Disaster Needs of Older Adults Are Not Based on Age - Consider Where They Live

- Community dwelling older adults
 - Senior communities – planned or naturally occurring
 - Aged in place – may be surrounded by younger families in their community
 - Homebound older adults
- Institutionalized older adults
 - Nursing homes
 - Assisted living facilities

A one size fits all approach with older adults does not work for preparedness or recovery

Community Dwelling Older Adults

- Many older adults, especially those age 85 and older, have chronic physical illnesses or disabilities, which affects their ability to prepare and recover from a disaster
- Many older adults may be a caregiver to a spouse who has a chronic physical illness or disability, which affects their ability to prepare and recover from a disaster

Community Dwelling Older Adults - Preparedness

- A 2005 national survey of disaster preparedness found that people 65 years and older were the least prepared for a disaster despite having the highest morbidity and mortality post-disaster.
- Despite representing only 15% of the population, 71% of those who died during Hurricane Katrina were age 60 years and older

Community Dwelling Older Adults - Recovery

- Are less likely to complain, ask for support, and receive services or resources after a disaster
- If not affiliated with a community organization prior to the disaster, are at risk for not receiving services
- May be worried about who is trustworthy – need to identify pre-disaster who will provide information
- May be concerned if the “help” provided will really be helpful

Homebound Older Adults - Preparedness

- Homebound elders may not possess the knowledge or information to make informed decisions and take adequate steps to prepare for disasters
- Homebound adults may not have the ability to access public or private transportation to purchase supplies, pre-enroll in special needs shelters
- Formal and informal caregivers may need to provide assistance

Homebound Older Adults - Recovery

- Impaired physical mobility, confinement to a bed or wheelchair, vision or hearing problems further compounds disaster-related stress
- Outreach programs will need to locate older adults who may not possess sufficient knowledge to access services or the physical ability to leave their homes and stand in line for assistance

Homebound Older Adults - Recovery

- Probability of home health aid service interruption is high - home health aide is dealing with personal or family issues after a disaster and may not be able to work
- May require care in an assisted living facility or nursing home
- If local LTC facilities are damaged or destroyed, person may have to move from the area

Institutionalized Older Adults - Preparedness

- Nursing home residents may fare best during disasters if staff has taken part in planning and drills
- Nursing home residents are provided with continuity of care whereas assisted living facility (ALF) residents may not have the same level of coverage
- It is critical that ALF residents read the fine print in their contract prior to a disaster
- Some ALF residents were dropped off at special needs shelters

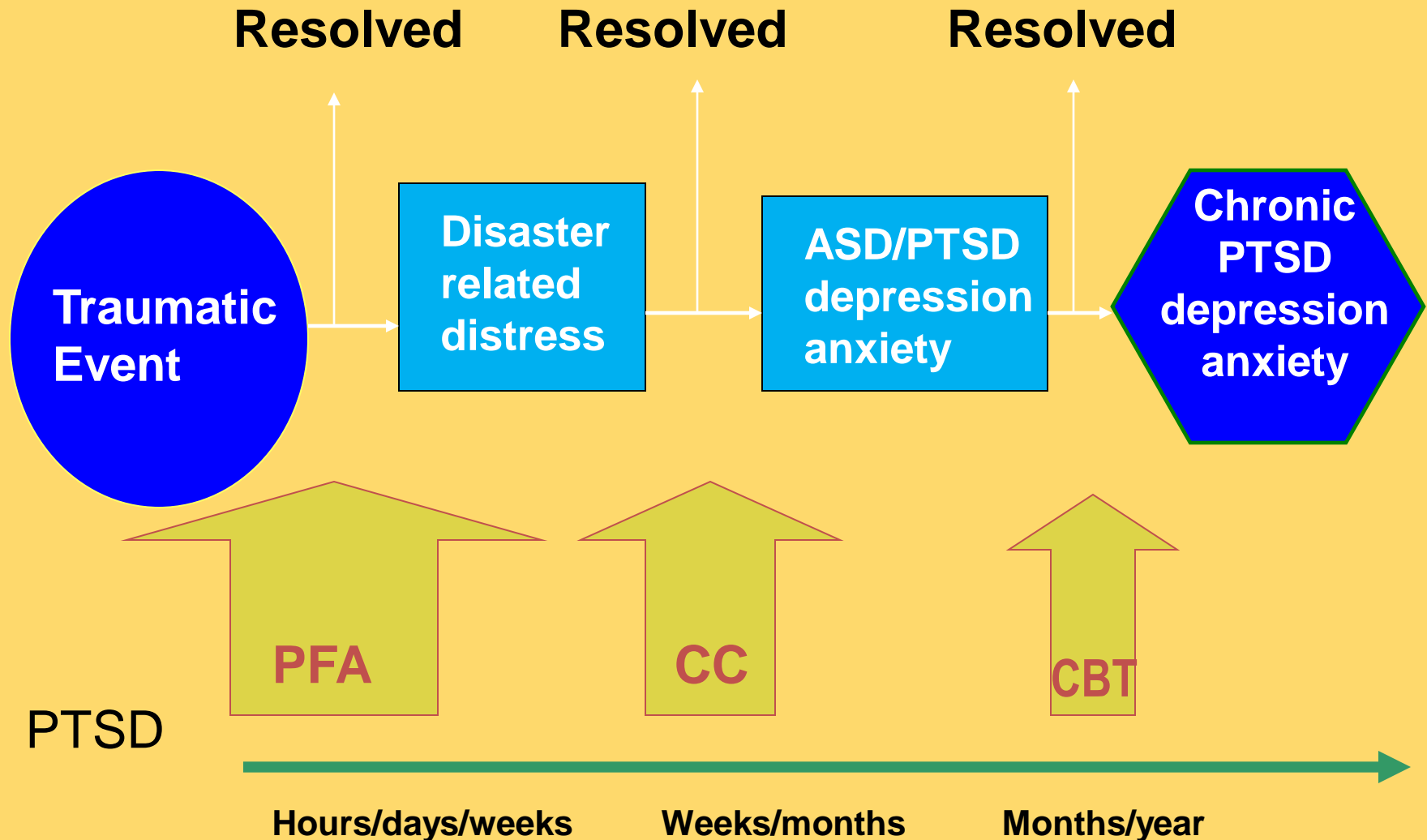
Institutionalized Older Adults - Recovery

- Institutions that are closed for an extended period of time force residents to receive shelter and care outside their community
- Nursing home staff have relationships with their residents – not the same as a hospital nurse with a short-stay patient - disruption of social network occurs

Institutionalized Older Adults - Recovery

- Emergency relocation of persons with significant cognitive impairment presents a unique set of challenges and can result in increased morbidity and mortality
- Older adults with cognitive impairment are especially vulnerable in disaster situations.
- Excess morbidity mortality was found at 30 and 90 days post-Hurricane Gustav

Delivery of Behavioral Health Services



Assessment of Trauma and PTSD

Diagnostic Criteria for PTSD

- Duration is more than one month.
- Causes significant distress or impairment in social and/or occupational functioning.
- Not caused by physiological effects of substance use or a medical condition.

Assessment of Subsyndromal PTSD

- Subsyndromal, subthreshold, or partial PTSD, is more common than PTSD
- People are often not treated or diagnosed because there is no consistent definition or proven treatment

Assessment of Acute Stress Disorder

- The Acute Stress Disorder Interview (ASDI) is the only structured clinical interview that has been validated against DSM-IV criteria for ASD.
- The Acute Stress Disorder Scale (ASDS) is a self-report measure of ASD symptoms that correlates highly with symptom clusters on the ASDI. It has good internal consistency, test-retest reliability, and construct validity.

Assessment of PTSD

- Thorough assessment of trauma exposure
 - Was the trauma a DSM-defined stressor?
 - Combine objective and subjective reports
 - i.e. public records and self-report
 - Record detailed narrative
- Assessment of comorbid conditions
 - Depression, anxiety, etc.
 - Other features such as guilt associated with the trauma, dissociation, etc.
 - Assessment of response bias

Assessment of PTSD

- Diagnostic structured interviews
 - Clinician-Administered PTSD Scale, the PTSD Symptom Scale-Interview, the Structured Interview for PTSD, the PTSD Interview, and the PTSD Module from the Structured Clinical Interview for the DSM



Diagnosis of PTSD

- DSM-IV Criteria for PTSD
 - Criterion A: stressor
 - Criterion B: intrusive recollection
 - Criterion C: avoidant/numbing
 - Criterion D: hyper-arousal
 - Criterion E: duration
 - Criterion F: functional significance



PTSD Symptoms

- Re-experiencing (1+)
 - Intrusive distressing recollections/thoughts
 - Recurrent distressing dreams
 - Dissociative reactions (flashbacks) in which event feels like its reoccurring
 - Distress when exposed to “triggers” symbolizing or resembling trauma
 - Intense physiological reaction to trauma triggers

PTSD Symptoms

Avoidance (1+)

- Efforts to avoid thoughts and feelings associated with trauma
- Efforts to avoid activities, people and places associated with the trauma or which provoke distressing thoughts/feelings about trauma

PTSD Symptoms

Negative Alterations in Cognition or Mood (2+)

- Inability to remember important aspects of trauma
- Extreme negative beliefs/expectations (e.g., “I am always in danger”)
- Persistent negative emotions (e.g., fear, shame)
- Diminished interest in significant activities
- Perceived detachment/disaffection from others
- Inability to feel positive emotions

PTSD Symptoms

Arousal and Reactivity (2+)

- Irritability and angry outbursts without provocation
- Recklessness/self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Difficulty concentrating
- Sleep disturbances

General Assessment Considerations

- Inquire in a physically private and safe setting.
- Avoid the common pitfalls:
 - Negative inquiries and labeling words/phrases.
- Echo the patient's words or concerns.
- Normalize. But don't minimize.
- Validate, validate, and validate.

Introducing the Line of Questioning

“Because most people have had difficult experiences at some point during their life, I’ve begun to ask about them routinely.”

“Some people have told me about difficult experiences they had during their lifetimes, such as being threatened or . Has anything like that ever happened to you?”

How To Respond to Traumatic Disclosure

- It is appropriate to express your care and concern:
“I am sorry that this has happened to you.”
- You may need to allow a few extra moments now to listen to her/him.
- Maintain eye contact with the veteran and be at eye level with her/him. Remain relaxed and empathic in your manner. A nonjudgmental attitude is essential.

How To Respond to Traumatic Disclosure

- Normalize reactions and responses:
 - “You are not alone.”
 - “I know that this has happened to others.”
 - “Many people have had these experiences and are deeply affected by them. They often feel angry, embarrassed, and fearful for some time afterwards. It is an understandable reaction to a very frightening experience.”
- Validate the experience and its effects :
 - “That must have been very frightening.”

How Not To Respond to Traumatic Disclosure

- Do not appear to doubt or disbelieve the person's account of what happened.
- Do not inquire about details of the trauma episode at this time.
- Do not ask questions or make statements that suggest that you hold the person responsible for this incident like:
 - “What were you doing in a place like that?”

PTSD Often Co-Morbid With Other Psychiatric Conditions

- 80-90% have additional psychiatric disorders
- Often multiple psychiatric disorders including:
 - Depressive disorders
 - Other anxiety disorders
 - » Panic disorders/agoraphobia
 - » Generalized anxiety disorder
 - Substance abuse/dependence
 - Personality Disorders

PTSD and Addictions

- Complex relationship between PTSD and substance use.
- PTSD can lead to substance abuse
 - Escape or access feelings or memories
 - Get through the day or night
 - Compensate for pain
- Between 11% and 38% of men in substance abuse treatment endorse PTSD symptoms
- Rates of PTSD in women substance abusers between 30-59%

Suicidality and PTSD

- If PTSD, 12X greater risk of suicidal ideation
- Even greater risk if person has PTSD and Major Depressive Disorder

(Lish et al., 1996)

Special Considerations When Assessing Older Adults

- Age-related factors and PTSD symptoms may interact in older adults so it is important to take some special considerations when assessing the elderly.
- A full Mental Status Examination, including a cognitive screening, is recommended when assessing an elderly patient
 - Need to consider cognitive impairment such as dementia or delirium
- Assessment of trauma and related symptoms should be routine.
 - Older adults may fail to report or minimize traumatic experiences

Special Considerations When Assessing Older Adults

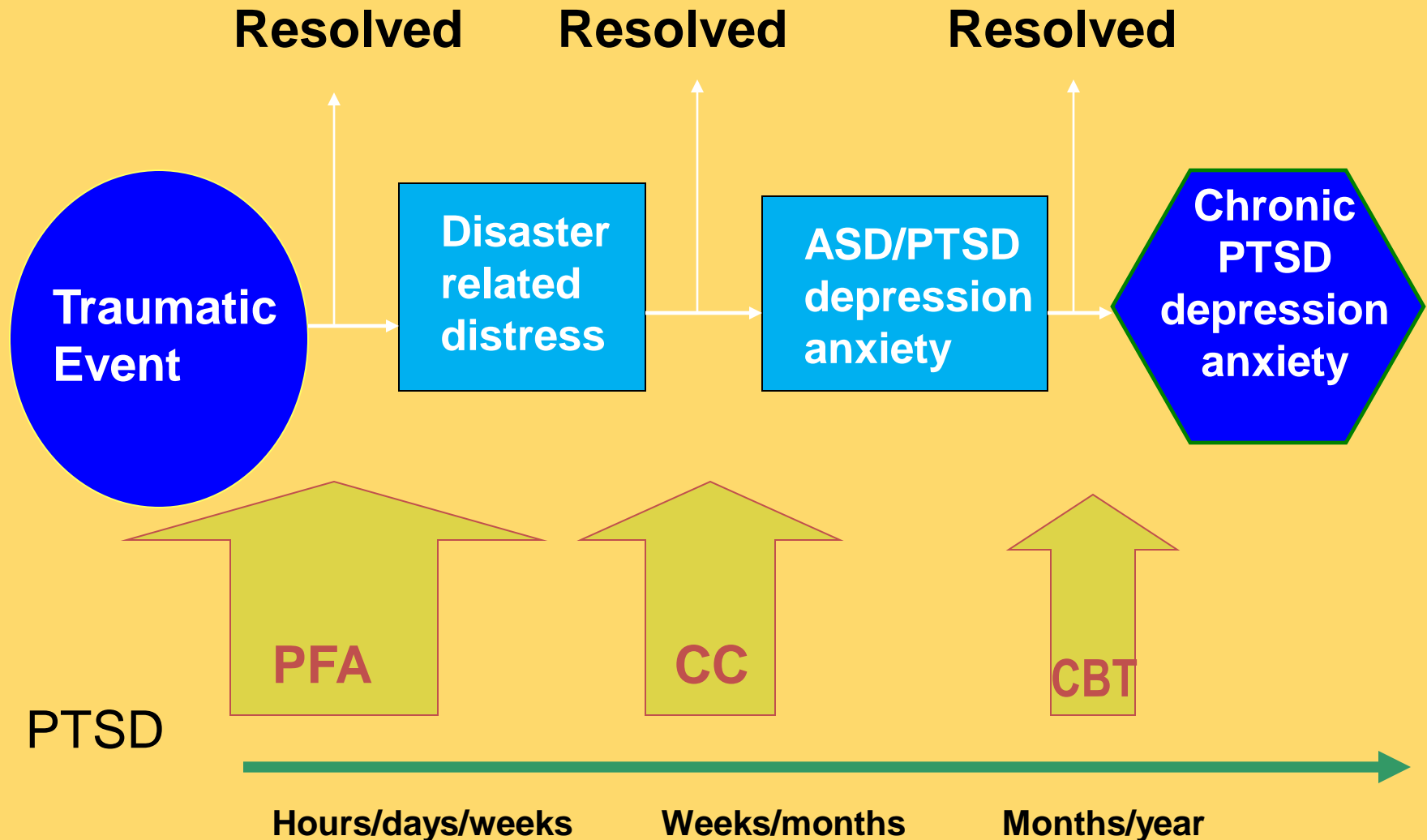
- Older patients may talk about problems or respond to questions differently than younger people.
 - Focus on physical rather than emotional symptoms
- Suicide assessment is particularly important in older patients.
 - Older males are at greater risk for death by suicide



You have successfully negotiated
these first few moments.

What comes next?

Delivery of Behavioral Health Services





Crisis Counseling vs. Traditional Psychotherapy

Psychotherapy

- Self-identified or court ordered to obtain treatment because of emotional, interpersonal, or mental illness
- If you build it, they will come

Crisis Counseling

- Self-identified as having disaster related distress
- Setting (where the individual lives) and existing infrastructure affects ability to access resources

Psychological First Aid

- An evidence based approach designed to reduce the initial stress caused by traumatic events and to foster short and long-term adaptive functioning.
- Developed by the National Center for PTSD and the National Child Traumatic Stress Network and used by American Red Cross and the Medical Reserve Corp.

PSYCHOLOGICAL FIRST AID PFA™

**Field Operations Guide
2nd Edition**

**National Child Traumatic Stress Network
National Center for PTSD**



Psychological First Aid



- PFA is used during and immediately after trauma/disaster
- PFA is an approach that can be used with everyone
- PFA is like medical first aid, it can be used by non-clinicians
- PFA may be used anywhere
- The program is in the public domain – you can download a copy of the manual for free
- Considered the gold standard for immediate intervention
- PFA can act as a crisis intervention for people who experience potentially traumatic events just as medical first aid is a crisis intervention for medical emergencies

Medical First Aid and Psychological First Aid Implications



Medical first aid is often easier to administer.

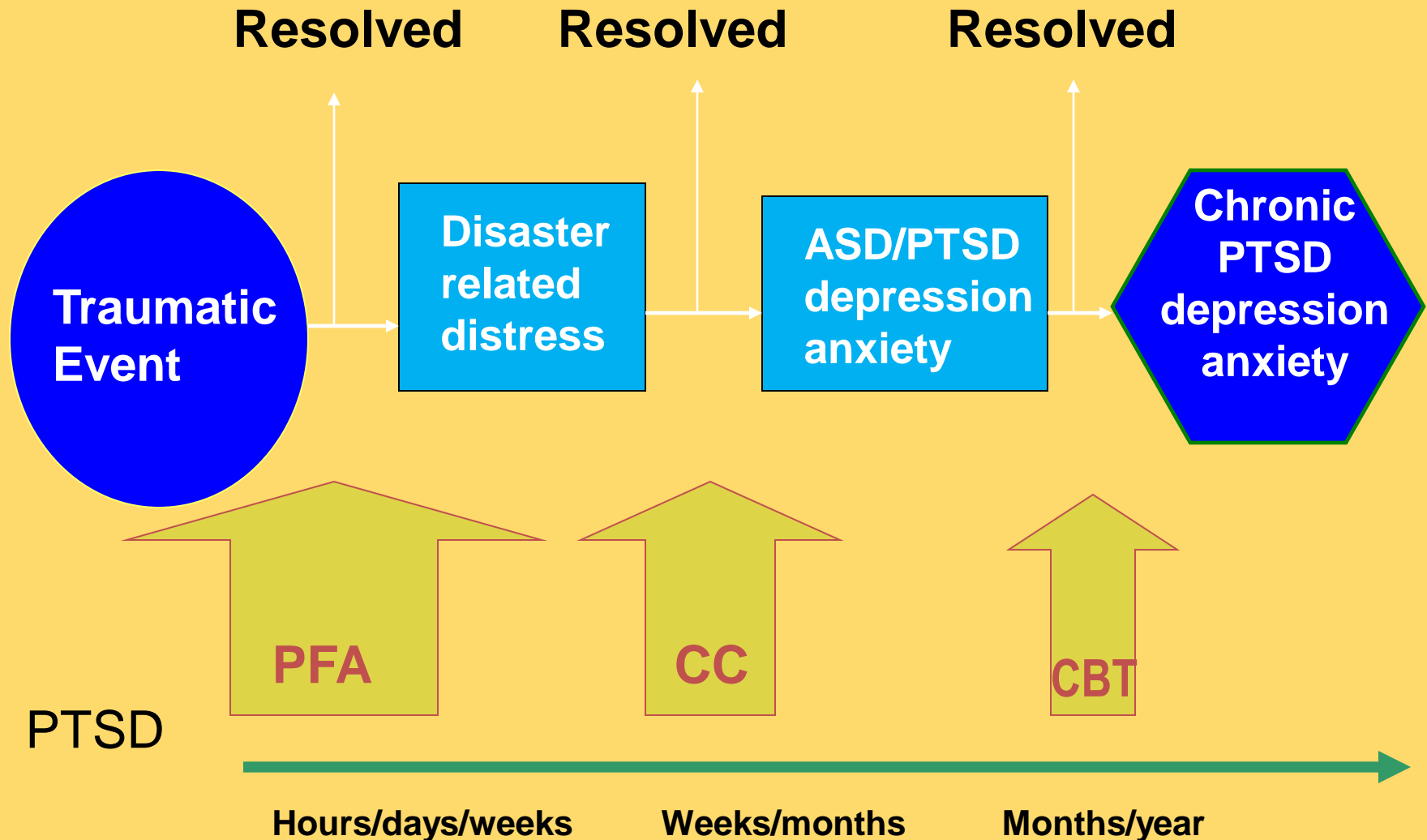
PFA training should be given to all who are involved in disaster response – not just health and behavioral health responders.

Psychological First Aid Components

- 1) contact and engagement
- 2) safety and comfort
- 3) stabilization
- 4) information gathering:
current needs and concerns
- 5) practical assistance
- 6) connection with social
supports
- 7) information on coping
- 8) linkage with collaborative
services



Delivery of Behavioral Health Services



Skills for Psychological Recovery

- Provide information about common physical and psychological reactions to crisis
- Provide education about stress and coping
- Help restore the individual's sense of control
- Encourage networking and reestablishing contact with informal and formal support, providers, and clergy



Recovery Considerations



If the person is safe and their medical needs are appropriately met, what is most important to the individual?

SPR Section 4 - Promoting Positive Activities

- Make the survivor feel more in control and that life is more “normal”
- Help the survivor feel less sad, hopeless, fearful, or low in energy
- Remind survivors who feel overwhelmed to make time to do things that improve their health and well-being

Rationale for Promoting Positive Activities

- People stop doing rewarding things because:
 - They are too busy coping with other problems
 - They just don't feel like it anymore
 - They are avoiding reminders of the disaster
- People become sad, down, or apathetic when they no longer engage in rewarding or meaningful activities
- Everything feels effortful

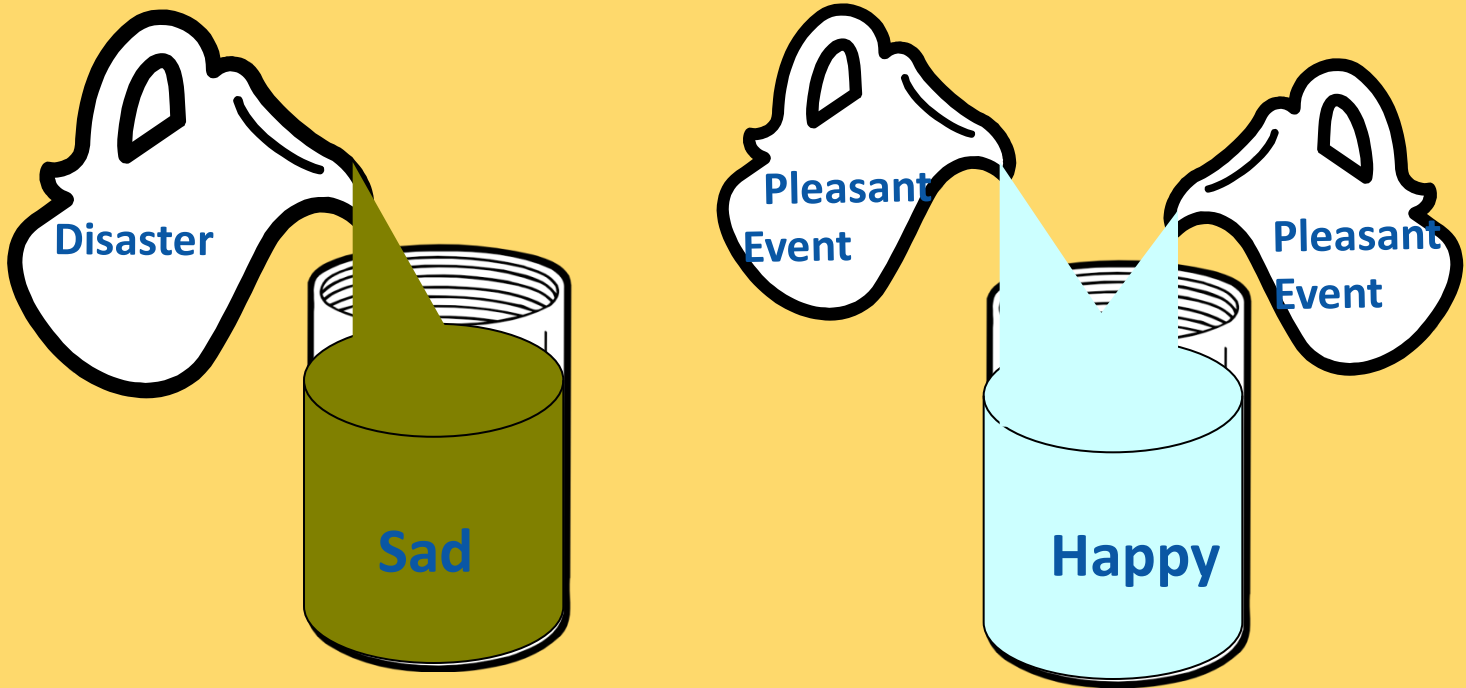
Rationale for Promoting Positive Activities

Problems with Focusing on Changing Feelings:

- Feelings are very difficult to change
- Telling yourself to feel good does not work
- It is easier to change your behaviors, which will change feelings



Rationale for Promoting Positive Activities



Anticipatory Pleasure



Steps of Promoting Positive Activities

After explaining rationale:

1. Identify and plan one or more activity
2. Schedule activities in a calendar

Provider Alert

Caution survivors:

- Activities may not be as enjoyable as before
- It's still important to do them
- Include activities that give a breather from everyday stress
- Validate that it has been a trying time

Step 1: Identify and Plan a Positive Activity

- Use the worksheet/handouts to:
- Review the list of activities – if person is depressed it will be difficult for them to generate a list of their own – easier to select
- Brainstorm to pick activities that provide:
 - ✓ “Downtime” or relaxation
 - ✓ A sense of safety
 - ✓ Feeling closer to loved ones
 - ✓ Coping with a new situation
 - ✓ Increasing social time with others

SPR Section 4 - Promoting Positive Activities

- Make the survivor feel more in control and that life is more “normal”
- Help the survivor feel less sad, hopeless, fearful, or low in energy
- Remind survivors who feel overwhelmed to make time to do things that improve their health and well-being

Step 1: Select Activities

- Identify at least 3 different activities to engage in this next week
- Help survivors choose activities that:
 - ✓ They think they would enjoy
 - ✓ They think they would actually do (achievable)
 - ✓ They can set up fairly easily (practical)

Step 2: Schedule Activities in Calendar

- Survivors can get “stuck” in a cycle
- Use the calendar & make a concrete plan so they don’t get caught up in this cycle



Review Promoting Positive Activities

- Look for successes
- Reward small steps
- Ask about lack of follow-through
- Make a new set of activities

Section 7 - Rebuilding Healthy Social Connections

- Increase connections to positive relationships and community supports
- Individuals may feel isolated due to:
 - Moving from their community
 - Loss of friends and family
 - Sadness, fear, and lack of motivation

Rationale for Rebuilding Healthy Social Connections

- Positive social support is a proven protective factor in disaster survivors
- Lack of social support or negative social support leads to worse outcomes
- Social support after a disaster helps survivors meet their emotional and practical needs

Rationale for Rebuilding Healthy Social Connections

- Positive social support can help survivors:
 - Feel understood and cared for
 - Feel like they fit in and belong
 - Feel needed and wanted
 - Feel like they are NOT alone or isolated
 - Build confidence that they can handle problems
 - Feel reassured that others will be there
 - Get good advice when facing a difficult situation

Steps for Rebuilding Healthy Social Connections

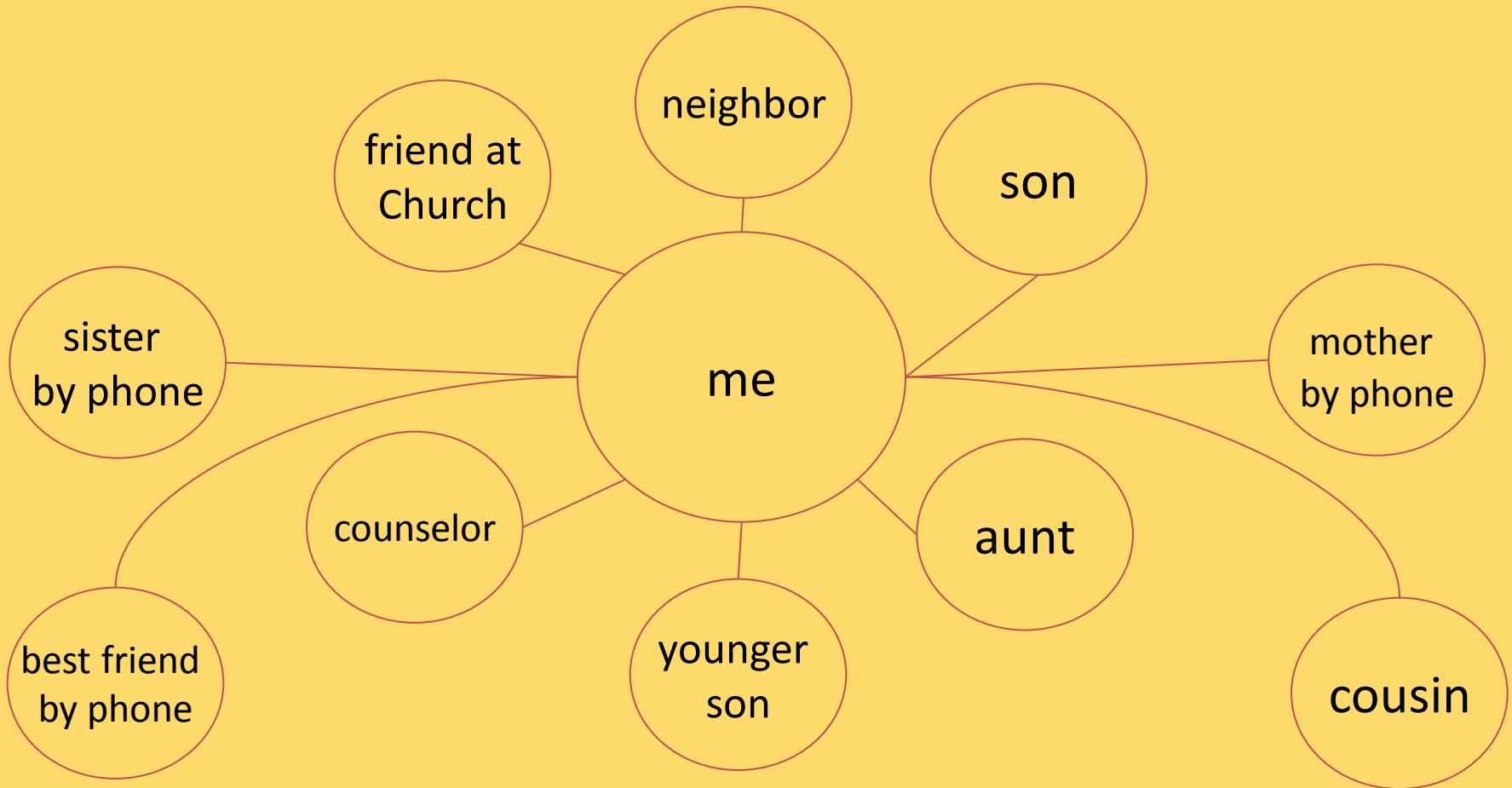
After explaining rationale, use handouts and worksheets to:

1. Develop a Social Connections Map
2. Review the Social Connections Map
3. Make a Social Connections Plan

Step 1: Develop a Social Connections Map

- Identify who is:
 - Currently in their network
 - Easily accessible
- A social connections map allows survivors to see the “big picture” of their social network
 - Move focus from who is lost to who is present

Example of Social Connections Map



Step 2: Review Social Connections Map

- Who are your most important connections?
- Who can you share your feelings with?
- Who can you get advice from?
- Who do you want to spend time with?
- Who might need your help or support?

Review Map: What is Needed?

- Are there types of supports that are missing?
- Are there those you are not connected with but want to be?
- Who do you want to spend more time with?
- Who do you want to spend less time with?
- Are there relationships that you want to improve?
- What ways do you want to help others?
- Do you want to join a community group?

Step 3: Make a Social Support Plan

- After identifying areas in need of improvement:
 - Identify one area to change
 - Make a plan that is concrete and specific
 - Review the plan to make sure it is understood

Review Rebuilding Healthy Social Connections

- What supports were used? What happened?
- Did you offer support to others? What happened?
- Revise plan based on experience

Practical Strategies

- Staying connected to family and friends
- Talking with others about feelings
- Writing a journal or diary
- Prioritizing problems
- Developing a concrete plan of what needs to be done, taking action one step at a time
- Volunteering; and examining personal strengths and finding personal meaning in the experience
- Material providing information and telephone numbers detailing steps to take should another tornado occur, should be developed and widely disseminated by government and non-profit agencies, the media, and other community-based organizations, such as churches and synagogues.

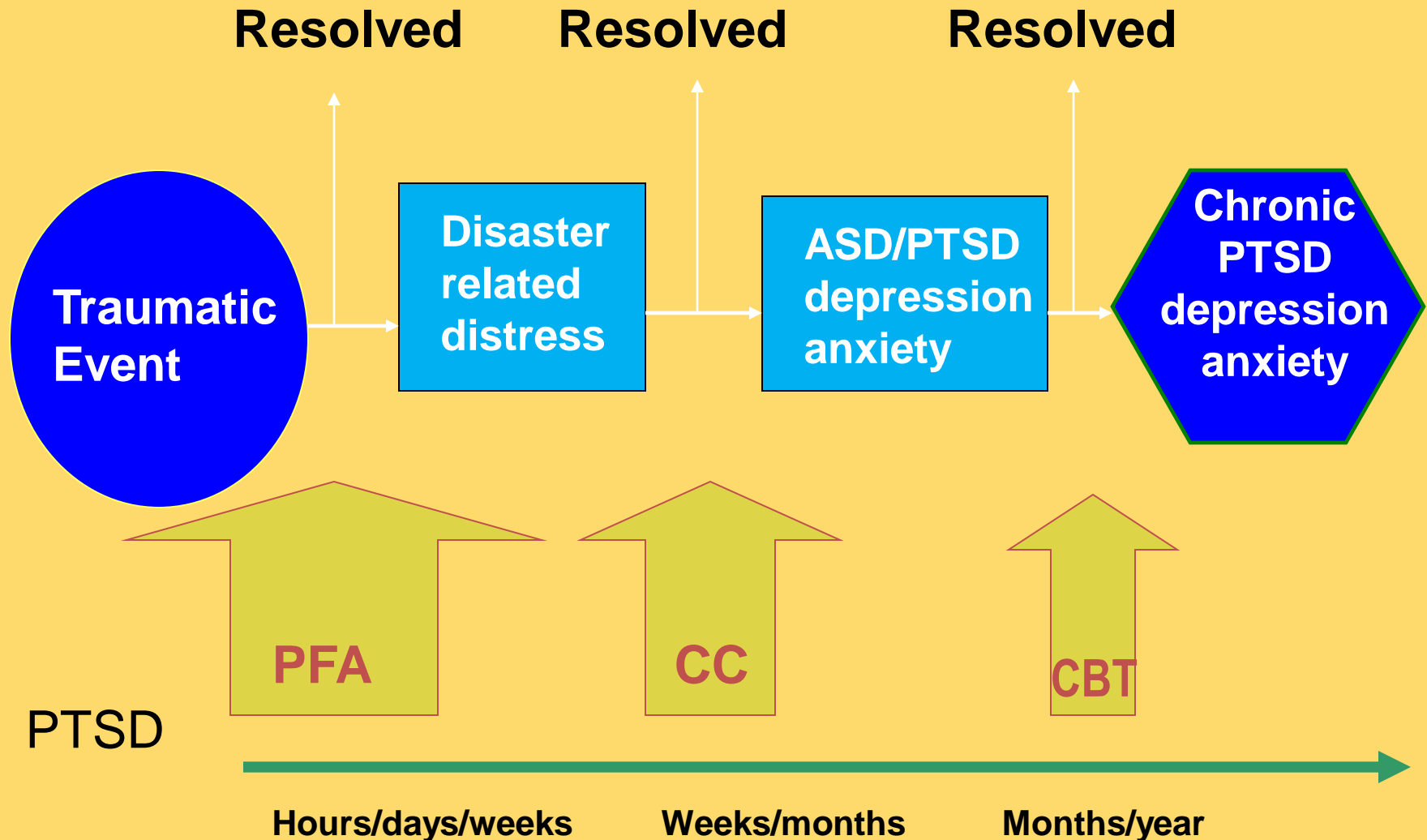
Social Connections Exercise

Mabel is an 84-year-old grandmother. Her husband died several years before the tornado. Her son and his family were forced to move out of town. Two of her closest friends have moved into an assisted living facility after their homes were destroyed. Mabel feels sad and lonely. She has stopped attending the senior group at her church. She is becoming increasingly isolated.

Group Exercise

- What are your main concerns?
- How will you proceed?

Delivery of Behavioral Health Services



A person has just informed you
of a traumatic event in her/his history.

How do you respond?

What do you do?

Core Principles of Trauma Informed Care

Trauma awareness through staff training, consultation and supervision.

Organizational restructuring to incorporate an understanding of trauma at the system level (e.g., adapting policy to prevent retraumatization).

Emphasis on physical and emotional safety for the person and provider (e.g., awareness of triggers, clear rules and boundaries, confidentiality).

Core Principles of Trauma Informed Care

Respect the person's choices and promote efficacy and self-control over their life.

Foster a strength-based approach (as opposed to deficit-oriented) focusing on skill building and future-oriented goals.

General Considerations:

- Establish rapport, trust (e.g., provide emotional safety).
- Remember the goal is not for the older adult to disclose any or all details but rather to feel safe, develop trust and ultimately become more functional

Trauma-Informed Case Management

- Provide empathy
- Normalize reactions to trauma (e.g., in session, handouts, videos)
- Educate elders about trauma and PTSD

You know the saying.....



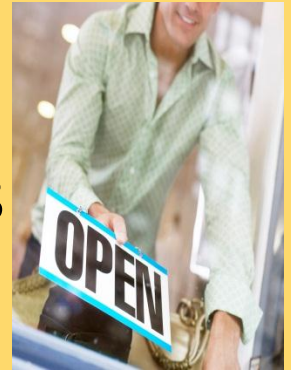
System Barriers to Trauma Informed Care



- Rural communities may have a smaller pool of local talent and fewer resources to support incoming temporary programs

Provider Barriers to Trauma Informed Care

- Have limited budget and limited timeframe to conduct outreach effort – trial and error
- No evidenced-based approved techniques for conducting outreach
- Outreach methods used in other settings and applied to Crisis Counseling have been criticized – i.e., bingo
- The model for delivery of Crisis Counseling is based on the model for delivery of psychotherapy



Provider Barriers to Trauma-Informed Care

- Discomfort in asking about trauma/PTSD
- Older adults have complex health and social needs
- Lack of information about referral services

Personal Barriers to Trauma-Informed Care

- Emotional pain
- Self-blame
- Shame
- Belief that talking about it will make it worse
- Belief that providers can't be trusted/past negative reporting experiences

Personal Barriers to Trauma Informed Care

Most older adults don't want to be known as needing mental health services

- ★ Stigma

"I'm not crazy, I have problems because of the tornado"

- ★ Social comparison

- ★ Preferences for location of services

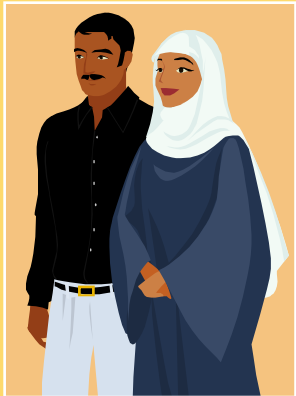
- ★ Practical barriers to treatment – no transportation



Personal Barriers to Trauma Informed Care



- Some people may be reluctant to accept assistance from government agencies or find completion of the paperwork required to receive aid daunting.
- Some people may turn to religious leaders, family members, informal social networks, or their personal physician for relief from their distress.



Personal Barriers to Trauma Informed Care



- Symptoms associated with PTSD, depression, and anxiety may motivate some older adults to ask for medication from their physician
- Primary care physicians have increased their efforts to screen for trauma among people who seek medical care for somatic complaints following disasters

Personal Barriers to Trauma Informed Care

Older adults are often reluctant to use disaster behavioral health services in traditional mental health settings due to a complex set of help-seeking factors:



- ★ Problem recognition
- ★ Symptom misattribution
- ★ Readiness to change

Disaster affected people don't self-identify as having a mental health problem

A Poor Match Between What is Offered and how Services are Marketed

Assumes people possess knowledge about services

- ★ Poor literacy/mental health literacy
- ★ Language barriers
- ★ A top-down approach is not used by commercial marketers
- ★ People may not understand what crisis counseling can and cannot do to help them recover



Barriers and Facilitators

15 minutes small groups and 15 minutes group discussion

- What barriers do you see for traumatized older adults in obtaining services?
- What can be done to reach older adults?
- How would you market services to older adults?

Increased Vulnerability for Older Adults After Disasters

- Access to age-sensitive health services may be limited
- Problems with the home environment
- Social isolation
- Exclusion from decision-making
- Delays in service delivery
- Separation from family and support systems
- Poor nutrition
- Assumptions that family will care them
- Low income

Intervention after Disasters

- Older persons with mental health problems are responsive to psychotherapies, group therapies, counseling, and psychotropic medications, when necessary (APA, 1998)
- Education to decrease misattribution of somatic symptoms and increase acceptance of mental health treatment should be provided

What comes next?

- Trauma survivors frequently decline referrals -- this may be especially true of older adults.
- Most people who have been traumatized just want to forget about it, hoping it will go away by itself.
- Older adults may not realize the connection between trauma and PTSD.
- They may not realize the toll trauma may have taken upon their emotional and physical health (e.g., depression, PTSD, chronic pain syndromes).

Formal Treatment for PTSD

- Eye movement desensitization and reprocessing
 - Focus on other stimuli when thinking or talking about memories from trauma
- Medications
 - SSRI
 - Increase serotonin levels



Other Types of Treatment

- Group therapy
 - Share experiences with others who have experienced similar traumas
- Brief psychodynamic psychotherapy
 - Learn how to deal with emotional conflicts due to trauma
- Family therapy
 - Helps family understand PTSD and improve relationships

Formal Treatment for PTSD

- Cognitive Behavioral Therapy
 - Most effective type of counseling for PTSD
- Not one single approach
- CBT includes (not an exhaustive list):
 - Behavior therapy (Lewinsohn)
 - Cognitive-behavioral therapy (Beck—the most widely used)
 - Rational-emotive therapy (Ellis)
 - Problem-solving therapy (Nezu)
 - Dialectical-behavior therapy (Linehan)
 - Acceptance and commitment therapy (Hayes)
 - Mindfulness-based cognitive therapy (Segal)

Therapeutic Relationship

- Supportive, empathic
- Work as *equal partners* to address the client's problems
- Importance of client activation from the beginning
 - Education
 - Develop treatment plan together

Education about the Problem

- Symptoms, diagnosis
- Causes
- What happens if goes untreated
- Interaction of problem with other illnesses
- Written, video and verbal education

Education about Treatment

- Treatment options
(medication/therapy, type of therapy)
- Treatment rationale (why it works)
- Treatment strategies (how it works)
- Treatment timeline (how long, how often, when start to improve?)
- Side effects

Working Collaboratively

- Go over information slowly
- Elicit client's view of their problems
- Allow time for discussion, questions
- Together, develop a treatment plan:
 - Concrete goals
 - Strategies
 - Timeline
- Let the client choose the treatment

Structure of Therapy

- Usually weekly, 50-minute sessions
- Usually brief (< 20 sessions)
- Together, therapist and client set an agenda at the beginning of each session
- Homework is crucial: goal is to apply new skills in daily life

Cognitive Behavioral Approach: Phases of Treatment

- Emotional and behavioral stabilization
- Trauma education
- Stress management
- Trauma focus
- Relapse prevention
- Follow-up and maintenance

(Keane, 1995)

Rationale Behind Cognitive Theory

- The interpretation of the trauma determines an individual's emotional state and dysfunctional thoughts lead to dysfunctional emotional states.
- Three steps:
 - Identification of dysfunctional thoughts
 - Evaluation of validity of thoughts and challenging those that are erroneous
 - Replacement of dysfunctional thoughts with more helpful ones

Cognitive Processing Therapy for PTSD

- Typically includes:
 - Exposure element
 - Cognitive therapy
- Emphasis on identifying “stuck points”

Manual: (Resick & Schnicke, 1993)

Examples of Cognitive “Stuck Points”

- I should have prevented the trauma
- I’m going crazy
- I’m weak
- My life is ruined
- I attract bad things
- I deserve bad things happen to me
- I cannot rely on other people

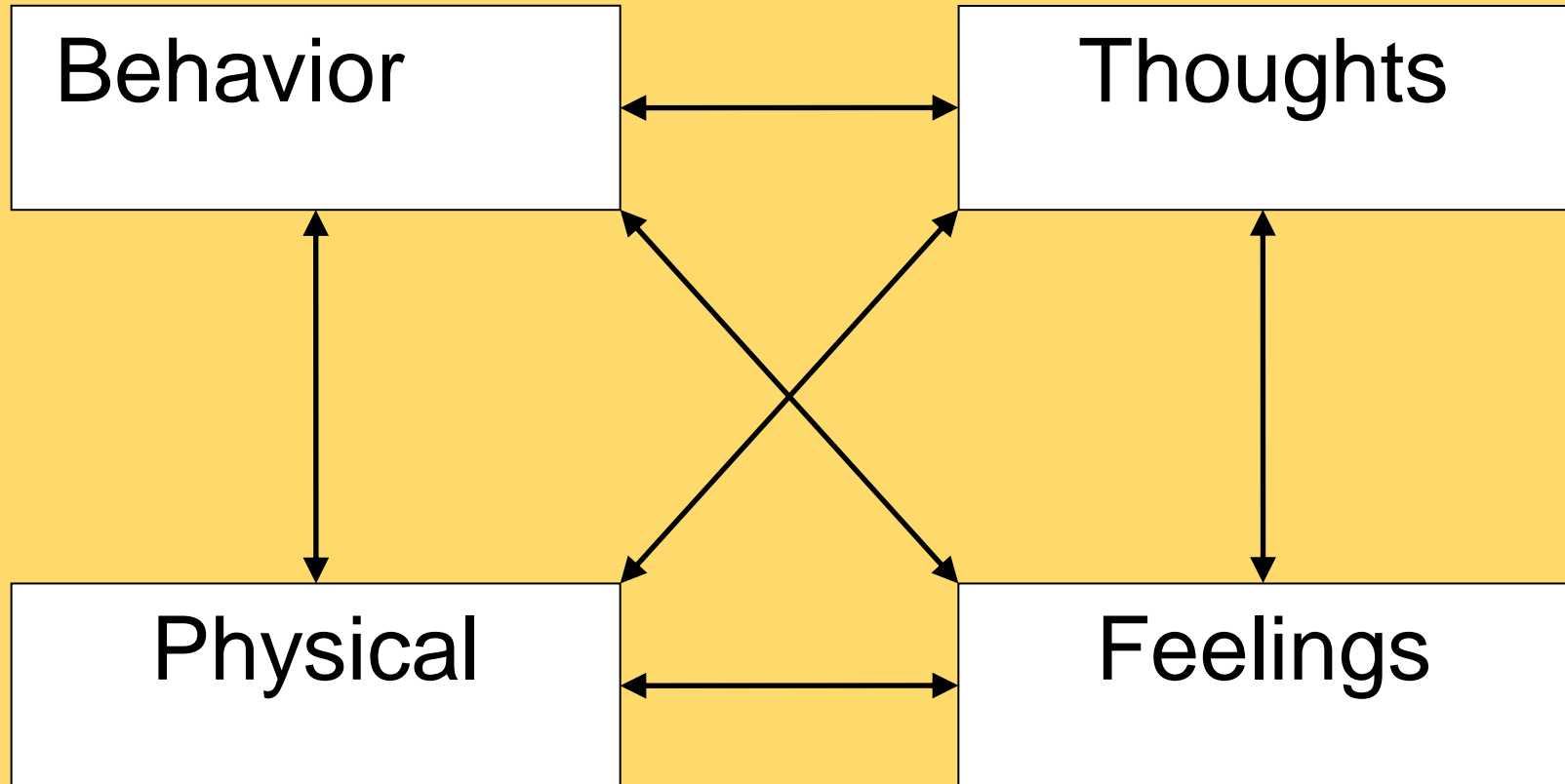
Mental health problems involve unhelpful behaviors...

- Unhelpful behaviors, such as
 - Withdrawal, isolation, avoidance
 - Aggression, risk-taking
 - Poor social skills
 - Poor health behaviors

...and thinking patterns

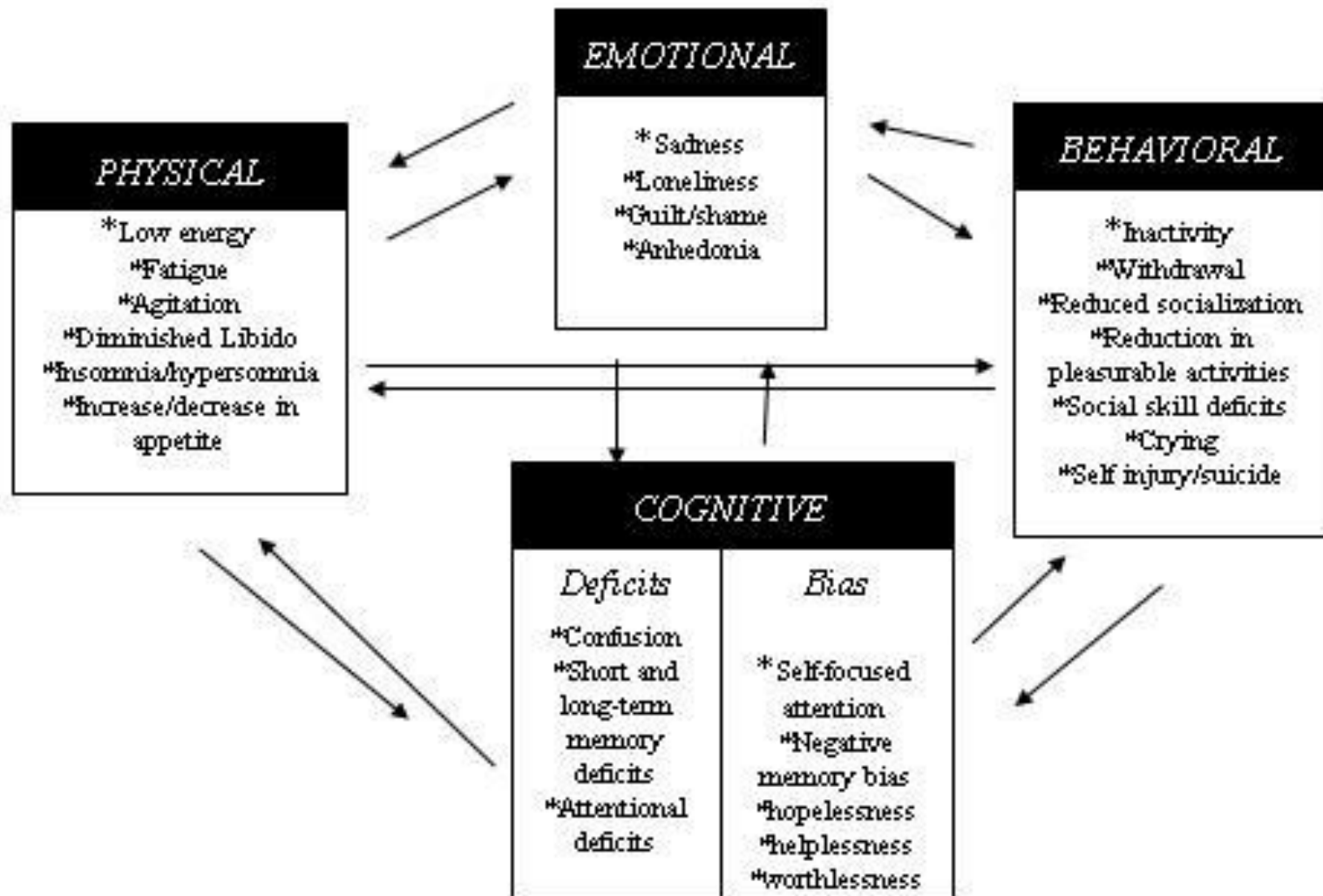
- Unhelpful thinking patterns (“cognitive distortions”), such as
 - Discount positive, focus on negative
 - Black and white thinking
 - All-or-nothing thinking
- These behavioral and thinking patterns can cause and maintain mental health problems

CBT Model



Example: Depression

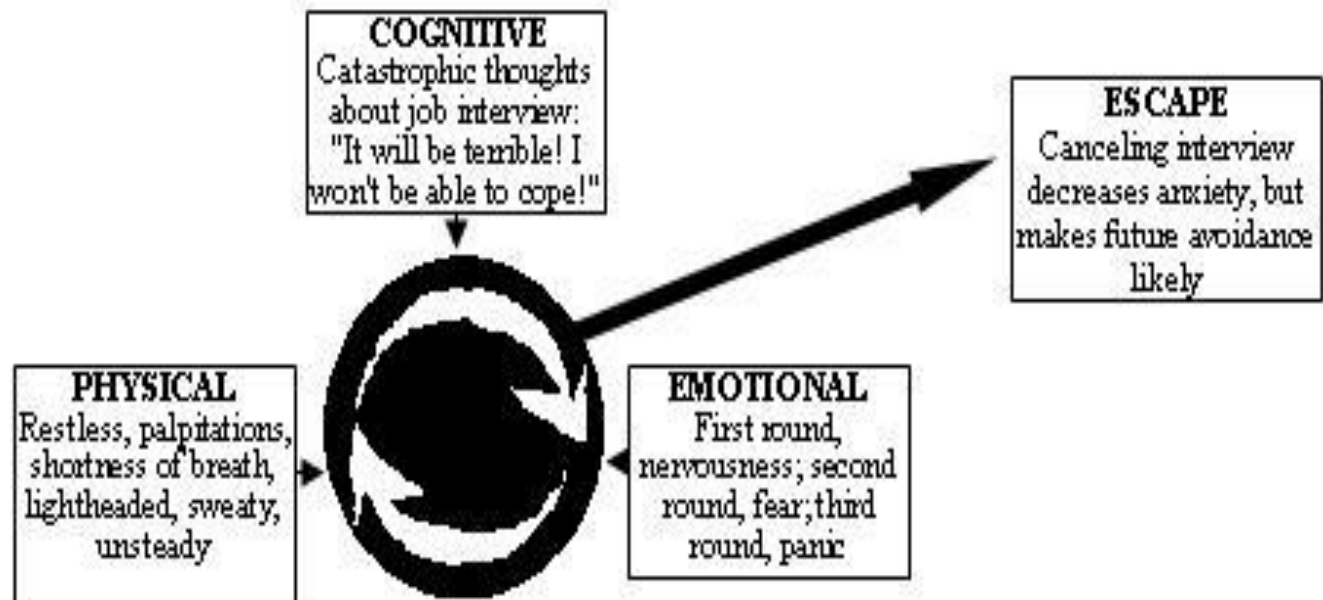
(www.habitsmart.com/dep.html)



Example: Anxiety

(www.habitsmart.com/dep.html)

THE SELF-FEEDING CYCLE OF ANXIETY



CBT Techniques Overview

- Change behaviors:
 - Skill-building (e.g., communication, problem-solving)
 - Mood regulation (e.g., behavioral activation, relaxation)
- Change thinking:
 - How one processes information from the psychosocial world (e.g., cognitive restructuring, mindfulness)

Behavioral Modification

- Chain analysis of antecedents, behaviors, and consequences (ABC)
- Environmental modifications to change antecedents and consequences (e.g., lighting, noise)
- Alter consequences to reinforce desired behaviors (e.g., reward desired behavior, ignore undesired behavior)

Cognitive techniques: Thought monitoring

- 3-column thought record (J. Beck, 1993)

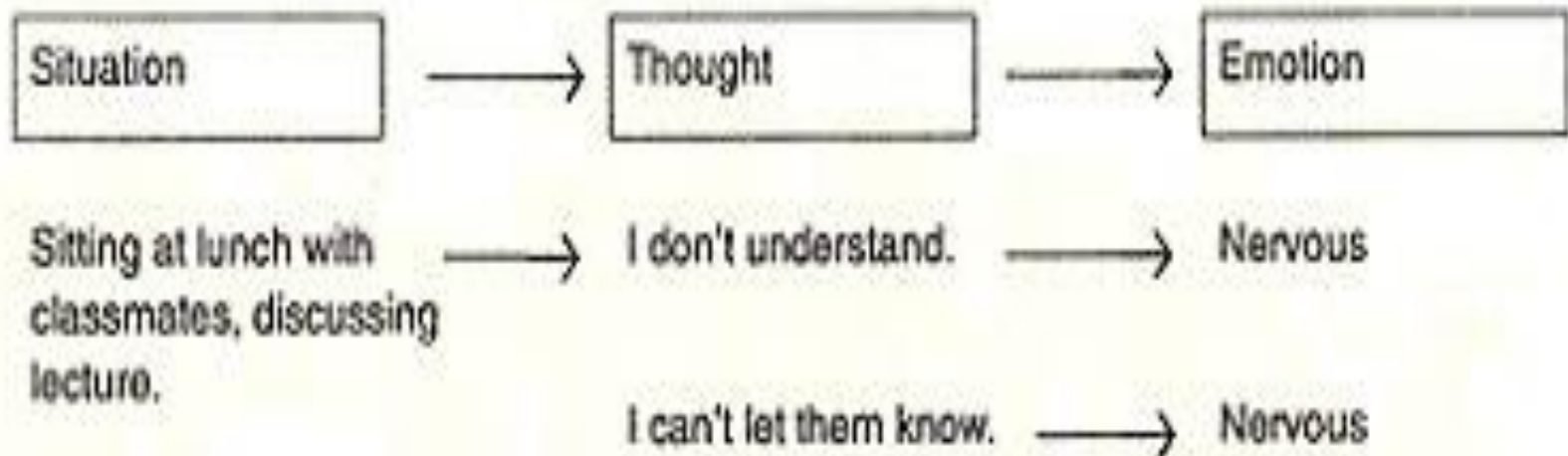


FIGURE 3.2. Sally's Session 1 notes: The cognitive model.

Cognitive Restructuring

- 5-column thought record: situation, thoughts, feelings, new thought, new feelings
- Challenge and replace unhelpful thoughts:
 - What's the evidence?
 - Alternative explanation?
 - What's the worst?
 - What should I do about it?
 - What would I tell a friend? (J. Beck, 1993)

Mindfulness

- Mindfulness meditation
- Mindfulness during everyday activities
- Observational, nonjudgmental perspective
- Believed to result in:
 - New insights
 - Acceptance of thoughts, feelings
 - Reduce ruminations of past/future (Kabat-Zinn; Linehan; Segal)

Validation

- 3 types (Linehan, 1994)
 - Active observing
 - Accurate reflection
 - Find and reflect whatever grain of wisdom or validity in client's statement or behavior
- Importance of balancing change and validation

Does CBT need to be modified for older adults?

- It depends
- More similar than different
- Many older adults will accept and engage in these techniques
- Older adults are very heterogeneous, must be flexible

Rapport

- Older adults may be less familiar with therapy, may need more time to educate and develop a treatment plan
- Be collaborative
- Older adults have many life examples – use them to illustrate CBT principles
- Use their language
- Periodically inquire about their satisfaction with therapy, progress

Strategies for cognitive decline

- Slower pace
- Repetition
- Use of personal examples, life review
- “Say it, show it, do it” (Gallagher-Thompson)
- Simplify
- Notebook to organize, remind
- Scheduling: shorter, more frequent, best time of day

Strategies for sensory impairments

- Assistive devices for hearing or visual impairments
- Can person read/write?
- Large print, large pen/pencil
- If not, may use recorder or just extra repetition

Strategies for physical impairments

- Shorter sessions for fatigue, pain
- Attend to environmental barriers (e.g., wheelchair navigation, rug, low chair)
- Scheduling: shorter, more frequent, best time of day
- Flexibility in meeting place

Using older adults' strengths

- Older adults “have a larger repertoire of experience from which to operate, use more effective strategies, and better integrate emotional information” (Blanchard-Fields & Chen, 1996)
- Life review:
 - Point out strengths, accomplishments, times client used CBT strategies on own
 - Restructure “mistakes” as learning opportunities, did the best they could
- Use emotional understanding to make sense of complex situations and feelings

Resources

- National Center for PTSD
 - <http://www.ptsd.va.gov/>
 - PTSD 101 courses
 - Clinician's trauma update-online
 - Pilots database
 - Assessment materials
 - Printable patient posters, brochures handouts

Resources

<http://www.nia.nih.gov/health/topics>

http://www.samhsa.gov/dtac/dbhis/dbhis_olderadults_bib.asp

<http://store.samhsa.gov/product/Psychosocial-Issues-for-Elder-Adults-in-Disasters/SMA99-3323>