



President's Column

Eve Carlson, PhD
President

Greetings members!

As we reach the mid-year mark, many members have been hard at work planning the annual meeting in Los Angeles in November. Submissions to the meeting were up an incredible 24 percent this year!

Program co-chairs Debra Kaysen and Wietse Tol are overseeing a massive review effort with 24 deputies and more than 200 reviewers conducting multiple reviews of 955 abstracts. The good news is that there is a tremendous amount of high quality work being submitted to the meeting. For regular sessions (not counting posters, media sessions, and PMIs), we had enough submissions to fill more than 300 rooms. The bad news is that with only about 150 available rooms, we can only accept about half of the submitted proposals for oral presentations.

Abstracts were categorized by primary keyword for review and available slots were allocated in proportion to the submissions for each keyword. So the content offered at the 2012 meeting will match the interests of those who submitted. We have planned four keynote addresses relating to the theme of the meeting – “Beyond Borders: Innovations to Expand Services and Tailor Traumatic Stress Treatments.” We have also invited two Master Clinicians and two Master Methodologists. Keep an eye on the website for information on the speakers and topics over the next few months.

We will try a few new things at the meeting this year. In response to the universal unpopularity among presenters of 8 a.m. sessions, we will have the same number of sessions, but try starting sessions at 9 a.m. and ending a little later in the day. We are also planning more ways for members with common interests to connect at the meeting. We've grown so much that in some events, such as receptions, it can be hard to connect with people, especially if you are new to ISTSS.

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This year, we will create gathering places at the reception for Special Interest Groups. We are also working to plan some opportunities to meet informally with the board and committee chairs so that members can find out about how to get involved with ISTSS committees and task forces.

There also are some changes in the wind in the U.S. that may be of interest to members. Read more about these here:

- Upcoming changes to U.S. regulations governing protection of human subjects (Issues 9-19 are of particular relevance to behavioral research): <http://www.hhs.gov/ohrp/humansubjects/anprmc/hangetable.html>
- A mandate for U.S. providers to begin using the ICD diagnostic system in 2014. (This change may be relevant to those in the U.S. who have been using the DSM diagnostic system and to those in other countries who use the ICD): <http://www.apa.org/monitor/2012/02/disorder-classification.aspx>

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Lastly, although interest in traumatic stress has expanded greatly in the past decade, ISTSS membership has not grown. There are still many researchers, clinicians and policy makers with an interest in traumatic stress who don't know about ISTSS.

If you have colleagues who aren't members, tell them about ISTSS and about our terrific annual meeting. You

can forward one of the marketing emails about the meeting and suggest they check it out.

For a couple of years, I have been including a "consider joining ISTSS at www.istss.org" in email responses to requests for measures or article reprints, and people often write back and thank me for the suggestion!



From Our Website: Do You Know?



We now have a mobile version of the ISTSS website! This means that you can access the website anytime, anywhere on your mobile devices. We expect that ISTSS members and all website visitors will benefit from this extended access.

Visit the ISTSS website on your mobile device to browse the new mobile layout!

Preventing Burnout and Compassion Fatigue: Coping Strategies that Work

Dr. Taylor Plumb

George E. Wahlen Veterans Affairs Salt Lake City Health Care System

As an early-career psychologist working in a U.S. VA PTSD clinic, I frequently get questions from students asking, "How do you manage doing trauma work all day, every day?" or "Is this the career you knew you wanted to do when you were a (practicum student, intern, post-doc)?" In fact, these are questions that I remember asking my own supervisors, particularly when I was experiencing effects of compassion fatigue and starting to question my own commitment to trauma work. When students now ask me these questions, I see it as a valuable opportunity to discuss finding that will help them to sustain, maintain and flourish over the "long-haul" doing trauma work.

I frequently share my own process of identifying the importance for me to develop support, variety and creativity into my clinical work experience. My hope is that these ideas will provide a starting place, or springboard, to encourage students to identify their own factors that empower them to thrive in the demanding, but rewarding, field of trauma.

With the U.S. VA Healthcare System rolling out numerous manualized, evidenced based therapy (EBT) training programs, a general heightened awareness of the mental health consequences of war, and thousands of veterans' returning home from deployments, the demand for mental health treatment is at an all-time high. While building supports into your training and work environments may sound like an obvious suggestion, it is an important part of sustaining one's own health and addressing the self-doubts and fears that inevitably creep in when doing trauma work.

Finding and maintaining safe and supportive outlets can help assuage feelings of isolation and normalize questions of self-competency that arise. Within the clinic where I work, I am part of group of clinicians that meet on a semi-weekly basis over lunch to provide support, encouragement and a listening ear as we each wrestle with the effects

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of trauma-focused work. While this level of support may not always be available (or supported), I would encourage students and trainees working in the trauma field to make a conscious effort to foster and develop forums where additional support is available.

The second element I find is an important factor in maintaining health when doing trauma work is to build variability into daily activities and duties. I am of the mindset that meaningful trauma work can happen on a number of different levels in a variety of settings and modalities. Finding methods and activities to “mix-it-up” is an important way for me to stay fresh and gain perspective from the easily confining nature of trauma work. One example of how this is done in our clinic is by providing outreach to returning veterans at Post-Deployment Health Reassessments (PDHRA), and holding educational outreach events in the community. Even something as simple as working with clients from diverse backgrounds, with varying trauma content, levels of engagement in treatment and readiness for change can help build variability into trauma-focused work.

The third idea I have for students considering careers in the trauma field is the importance of integrating creativity and the sharing of creative ideas into your work. When creativity is encouraged and supported it can provide an increased level of meaningfulness, excitement and energy into any work setting. Without creativity and the development of new ideas, the daily tasks can become the mundane and may contribute to compassion fatigue and eventually burnout. The work and energy put into fostering creative ways to connect with clients, engage people in EBT, develop new programs and contribute to the trauma field can help keep trauma work fresh, flexible, and dare I say...even fun.

As the demand for trauma work shows no signs of letting up and our understanding of compassion fatigue and burnout increases, it becomes even more important for students and clinicians doing trauma work to take a proactive role in identifying and recognizing factors that can buffer the effects of trauma-heavy work. My hope is that these simple, yet important, factors I have discussed can be used to provoke self-exploration and discussions will that may contribute to the continuous change in the culture of trauma work.



Two New Expert Training Recordings Available!

Start learning and earning credits today!

ISTSS expert trainings are audio and video recordings from well-known experts on important and timely topics in the traumatic stress field. Starting learning today with these two new recordings:

[Treating Trauma: Helping the Entire Human Organism Feel Safe and Live in the Present](#)

with Bessel van der Kolk, PhD

[Using Compassion-Focused Therapy to Work with Same-Based Flashbacks in PTSD](#)

with Deborah Lee, PhD

Both recordings are available for purchase with or without CE and ISTSS members receive 50% off all expert training recordings!

[Learn More](#)

Book Review: *Triggers* by Robert J. Sawyer

Fred Lerner
U.S. National Center for PTSD

It's a few years in the future, and some things are depressingly unchanged. Americans live in fear of terrorist attacks: Chicago, San Francisco and Philadelphia have suffered bombings in recent weeks, and an attempt on Los Angeles International Airport was averted only 10 days ago. Political leaders are vulnerable, too. Despite the stringent precautions of agent Susan Dawson and her Secret Service detail, President Seth Jerrison's speech at the Lincoln Memorial is interrupted by an assassination attempt. He is rushed to Luther Terry Memorial Hospital, where surgeons try to save his life.

There's another thing that's unchanged. Posttraumatic stress disorder (PTSD) is still with us. Kadeem Adams, an African American veteran of the war in Iraq, has a bad case of PTSD. He's willing to try anything to end the flashbacks that plague him. "They came all the time: when he was out for a walk, when he was in the grocery store, when he was trying to make love to his girlfriend." So he's sitting in Ranjip Singh's office at Luther Terry, his head enclosed by a latticework sphere fashioned from steel tubing. Professor Singh will use this device to transmit laser pulses that will stimulate the neural net within Kadeem's brain, with the goal of removing whatever glitch in its circuitry was triggering the flashbacks.

Susan Dawson has a lot on her mind. The assassination attempt appears to have been the work of a rogue agent within the Secret Service. A bomb discovered on the roof of the White House could not have been placed there without the participation of someone on the Secret Service Countersniper Team. And before her eyes Dr. Eric Redelop is leading a surgical team cutting into the torso of the President of the United States. Then the lights go out.

The bomb at the White House has gone off. There were no casualties: everyone had been evacuated. But the bomb-disposal robot couldn't defuse it in time. The White House is in ruins, panic is spreading in the city, and an electromagnetic pulse has disrupted the hospital's infrastructure.

That's not the only thing that has been disrupted. Professor Singh's experimental attempt to modify Kadeem Adams' memory processes had been running at the time, and it produced some unexpected results. Instead of his traumatic memories of the Iraq war Kadeem is now reliving the experiences of someone else entirely: Agent Susan Dawson. And he isn't the only one.

Everyone within range of Professor Singh's lab seems to have been affected. That's a sphere about 32 feet in diameter, so it takes a while to work out precisely how many people are affected, and who they are. It isn't a reciprocal process. Kadeem Adams can read Susan Dawson's memories.

Susan Dawson can read Ranjip Singh's. But that's not her main concern. Presumably there is somebody who can now read President Jerrison's memories, and as Secret Service agent in charge Susan Dawson desperately needs to find out who that might be.

And there's one other thing. Kadeem Adams came to Luther Terry Memorial Hospital in a desperate attempt to free himself from his traumatic memories. Now there is someone else who shares those memories with him.

Robert Sawyer is a Canadian science fiction writer with a reputation for crafting exciting stories based on scientific speculation. In *Triggers* he gives us a nail-biting thriller based on an understanding of posttraumatic stress disorder and the implications of experiencing and treating it. As someone who spends his days reading and indexing literature on PTSD I try to avoid the subject in my leisure hours, but this was a book that I couldn't put down. More accessible than many science fiction novels, *Triggers* should appeal to anyone who enjoys a science-oriented thriller.

Reference

Sawyer, Robert J. *Triggers*. Ace Books, April 2012.





Trauma and World Literature: Poetry from an ISTSS Member



In our January issue, we shared a profile of Elspeth Cameron “Cam” Ritchie, MD, MPH, a longtime member of ISTSS who recently retired as a U.S. Army colonel. He also served as director of the Proponency of Behavioral Health in the Office of Army Surgeon General and became Chief Clinical Officer of the District of Columbia's Department of Mental Health.

The article ended with a poem from Dr. Ritchie's 2010 collection, *Tearing Through the Moon: Poems and Prose of an Army Psychiatrist* (The Wineberry Press, Washington, DC). This volume distills 24 years of experiences and insights in the life of a military psychiatrist and poet.

Here, with permission of the author, we offer one of two new poems from Dr. Ritchie as examples of how trauma and art continue to inform one another. Stay tuned to the next issue for the second poem.



St Elizabeth's Hospital 2011 Washington, DC

History, both darkness and glory, rests
upon this hilltop overlooking the shining
white Capitol Dome of the Federal City.

Union and Confederate Soldiers, wounded, thirsty,
Were treated, bathed, legs amputated,
recovered or died. Soldiers of both Armies
were buried together overlooking Anacostia.

Doratheia Dix founded a sanctuary, an asylum,
The Government Hospital for the Insane.

Whites and coloreds with tuberculosis and psychosis,
tended gardens of leafy kale, cabbages, and apples,
recovered or not, and also were laid here.

7,000 of them filled 113 buildings, famous and
Infamous Americans, Ezra Pound, Reagan's shooter.

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Darker days followed the earlier enlightenment.
Patients sequestered for years. Cruelty, deaths.

Finally law and society intervened, after a
dead lady was found in a laundry chute;
Receivership, the Dixon lawsuit, Department of
Justice oversight, Olmstead, other Supreme Court cases.

A new hospital rose, with a Butterfly Hall.
The barred Howard Pavilion (for the
criminally insane) closed and pulverized.
The gorgeous old buildings are now festooned with colorful weeds.
Now, this Saint Elizabeths' shines.
Indoor courtyards boast labyrinths.
Murals of bright Washington
landscapes line curving corridors,
with monuments and children and flowers.
Purple iris and pink lotus flowers are painted by patients.
The old brick buildings are shuttered with yellow tape
Weeds festooning their entrances.

Here local politics always link with federal missions.
Military forensic fellows rotate with residents from across the globe.
The Department of Homeland Security revitalizes the West Campus.

What slice of history will be laid next, on the East Campus?
Therapy, wounds, healing or death?
Only we can decide what the gravestones will show,
What flowers will bloom; red poinsettias in the
Bitter winter, and golden daffodils in the spring.



Contribute to *StressPoints* Trauma and World Literature Feature

Passages from literature can capture truths about trauma and its survivors.
ISTSS members are invited to share a favorite passage or quote from literature that might not be well known, but which offers insight about the psychological effects of trauma or path of healing.

Send submissions to Howard Lipke and Harold Kudler at HLipke@aol.com.

ISTSS Honors Lisa Bernhardt with Public Policy Award



At the 2011 ISTSS Annual Meeting, the **Public Advocacy Award**, given for outstanding and fundamental contributions to advancing social understanding of trauma, was awarded to **Lisa Bernhardt**, senior public policy professional in the U.S. Congress and the U.S. Department of Health and Human Services (DHHS).

Ms. Bernhardt was unable to attend the meeting, but happily accepted the award at her office in Washington, DC.

We thank Lisa for her dedication and service to children and adults who have survived traumatic experiences.



ISTSS 2012 Board Elections: Voting Opens August 2012

The ISTSS Nominating Committee, chaired by board member and Past President Marylène Cloitre, has nominated the individuals listed below.

ISTSS nominees for President-Elect:

- Nancy Kassam-Adams, PhD
- Arieh Y. Shalev, MD

ISTSS nominees for Board Members (electing six):

- Bekh Bradley, PhD
- Diane Elmore, PhD, MPH **
- Julian Ford, PhD **
- Vanessa Kelly, PsyD
- Yoshiharu Kim, MD, PhD
- Harold Kudler, MD **
- Lyndia Matthews, PhD
- Candice Monson, PhD **
- Yuval Neria, PhD
- Miranda Olf, PhD

***Current board member running for re-election*

Note: With the exception of the president, individuals are typically limited to two consecutive terms on the board. This year, ISTSS members will elect six board members to serve three-year terms beginning November 2012. Members will also elect a president-elect who will assume the office of president in November 2013.

Mail ballots will be distributed to members without email addresses.

Results will be announced in November.

Watch your email for more information regarding the election and for instructions for voting.



Examining Resilience Through an Eriksonian Perspective

Daniel Kaushansky, MA

The Chicago School of Professional Psychology and John H. Stroger, Jr. Hospital of Cook County

Beyond the risk of physical injury, medical problems, and common grief, the psychological traumas children face when exposed to war are multiple, chronic and severe. As Judith Herman (1992) writes in her seminal book, *Trauma and Recovery*, “traumatic events involve threats to life or bodily integrity, or a close person encounter with violence and death.” (p. 33).

Whereas some children unwillingly succumb to the development of psychopathology, most notably posttraumatic stress disorder, some children are able to evade the encroaching damage, and some individuals even becoming strengthened through the experience – we aptly identify these children and adolescents as ‘resilient’.

Although decades of research have explored the specific risk and protective factors associated with children who develop resilience in wartime, studies concerning age differences are inconsistent, and there is little general agreement whether children of certain ages handle traumatic experiences better than others. Some research has found that younger children are more susceptible to posttraumatic stress, anxiety and other reactions, whereas other studies have suggested that older children and adolescents have a more developed and sophisticated array of coping abilities than younger ones.

To resolve this dilemma, is there an alternative means by which to comprehend and potentially predict children of differing ages’ response to trauma?

As Alkhatib, Regan, and Barrett (2007) initially proposed, understanding traumatic reactions through the lens of Erik Erikson’s psychosocial theory of development may facilitate a more qualitative appreciation of the experience of child trauma.

Alkhatib and colleagues (2007) determined that basic trust (vs. mistrust, the first Eriksonian stage encountered) is particularly difficult when parents are psychologically unavailable, as they often are when victims of war and trauma themselves. Growing up in a war zone may disrupt attachment relationships between child and parent and lead to emotional exhaustion due to the repeated exposure to fear. Consequently, regression is a common response among affected children, with associated toileting and speech problems, irritability, sleep difficulties and frequent somatic illnesses.

In contrast, if parents are able to provide a secure attachment, this can be critical in helping the child cope with difficult circumstances as well as to build resilient characteristics. The benefits of secure attachments among young children have been demonstrated in a multitude of empirical studies. Most pertinently, it has been shown that a child’s secure attachment to a caregiver buffers and/or prevents elevations of stress hormones in situations that typically elicit distress in infants (Gunnar et al., 2000).

Moreover, individual differences in the reactivity and regulation of both the limbic and sympathetic nervous systems are related not only to temperamental characteristics but also quality of caregiving that children receive (Gunnar & Davis, 2003).

At preschool age (the Eriksonian stage of initiative vs. guilt), children need to become confident about testing the limits of their individual freedom and group responsibility and understanding the difference between fantasy and reality. Intellectual skills also become increasingly complex and language is mastered. War may undermine these processes by disrupting culturally prescribed relationships and dramatically altering normative social structures.

On the other hand, if these children are successfully encouraged and supported to accomplish tasks on their own, they can develop not only independence but self-efficacy. Resilience research consistently demonstrates that children’s perceived self-efficacy to regulate positive and negative affect is related to their belief that they can manage emotional aspects of their lives—for example, a traumatic event.

Finally, during the school ages (the stage of industry vs. inferiority), children begin to gain a sense of competence and pride in their own skills, as well as primary feelings of accomplishment.

Unfortunately, at a time when children should be learning academic and social skills, traumatic experiences provoke regression and problem behaviors associated with PTSD, as well as prolonged fears of being alone, preoccupation with danger, and safety concerns.

Furthermore, academic-related difficulties and issues are common among traumatized children, including school refusal, defiant behaviors, and an inability to concentrate on the work at hand.

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Resilience during this stage may be fostered through relationships with parents and teachers characterized by supportive, warmth, and caring attitudes. High levels of social support, family cohesiveness, and communication all have been found to protect children from the negative effects of war. Further, an early return to educational activities has been proposed as an important means of restoring predictability and social supports to children's lives.

The opportunity for children to return to their studies may instill a sense of hope and allow them to develop the tools necessary for future success. Educational programs can also serve a protective function in permitting children's mental health to be monitored and assessed as needed, thus allowing for early awareness and subsequent intervention for any behavioral or emotional problems that emerge (Betancourt & Khan, 2008).

Whereas viewing trauma and resilience from an Eriksonian perspective facilitates a more holistic understanding of a child's development, one of its greatest benefits lies in the fact that it is epigenetic. Thus, if a child is unable to resolve the crisis of a given stage due to war and traumatic exposure, he or she may go back and work on his or her past issues at a later time.

For those of us who have the experience of working directly with traumatized children, this makes simple sense. We see this every day, children whose experiences have interfered with the formation of a balanced or cohesive sense of themselves.

As clinicians, what then matters is that we can aid these children to successfully master their earlier stages, assisting in the development of healthy, whole, adult human beings.

References

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Members on the Move

Do you know of ISTSS members who have been recognized for significant achievements?

Please send announcements to Editor Patricia Kerig, p.kerig@utah.edu, for the *Members on the Move* feature.

PTSD in the Elderly: An Update on Prevalence, Symptom Presentation, and Clinical Implications

Tobias Glück, MSc

Department of Psychology, University of Zürich, Switzerland

Andreas Maercker, MD, PhD

Department of Psychology, University of Zürich, Switzerland

Does posttraumatic stress disorder (PTSD) differ in its presentation in old age to that in middle or young adulthood? Is it rarer in old age, due to spontaneous recovery or other reasons? These and other questions have been increasingly investigated in recent years—starting from a point of almost non-existent systematic research ([Hiskey, Luckie, Davies, & Brewin, 2008a](#); [Lapp, Agbokou, & Ferreri, 2011](#); [Owens, Baker, Kasckow, Ciesla, & Mohamed, 2005](#)). However, research on the aftermath of World War II in Europe has contributed to these investigations (e.g. [Bramsen, van der Ploeg, & Boers, 2006](#); [Glaesmer, Gunzelmann, Braehler, Forstmeier, & Maercker, 2010](#); [Spitzer et al., 2008](#)). In this update we will provide some recent findings concerning the epidemiology of PTSD in the elderly, discuss age-differential symptom patterns, and report on the relationship between PTSD and age-related morbidity. We will also illustrate why knowledge on PTSD is important in gerontological care.

PTSD Prevalence and Symptom Presentation in the Elderly

When comparing prevalence trends of PTSD across age groups in the United States and Europe, most studies reported a lower prevalence of PTSD in the elderly compared to younger persons with respect to both, 12-month and lifetime prevalence ([Darves-Bornoz et al., 2008](#); [Kessler et al., 2005](#)). However, in societies with a history of World War II (WWII) trauma, two independent population-based epidemiological studies found higher current prevalence of PTSD ([Maercker, Forstmeier, Wagner, Glaesmer, & Braehler, 2008](#); [Spitzer et al., 2008](#)) in elderly persons compared to younger age groups. These representative samples, together with other data from clustered samples of war-affected elderly exhibiting PTSD, indicated prevalence from 5 percent up to 20 percent (cf. [Lapp et al., 2011](#)). Methodologically, it has to be taken into account that lifetime prevalence may be biased by recall problems in the elderly.

Do PTSD symptom patterns vary between older age and younger adulthood, such that intrusive recollections are more common and thought avoidance less common in the elderly? And is 'subsyndromal' or 'partial PTSD' more common in the elderly or in younger age groups? A related question concerns the validity, prevalence and time frame of 'delayed PTSD'. These topics are meaningful with regard to theory and clinical practice.

Two long-term longitudinal studies compared PTSD symptom profiles across 15 or 20 years. [Solomon and Mikulincer \(2006\)](#) investigated Israeli veterans in a 20-year follow up and found an increase of sleep and memory difficulties over time. Similarly, [Maercker, Gäbler, and Schützwohl's](#) (in preparation) investigation of former political prisoners of the German Democratic Republic in a 15 years follow-up found that hyper arousal symptoms increased (irritability, startle response) and intrusive symptoms decreased (intrusive recollections, vivid flashbacks). Although these studies were not conducted in samples of exclusively elderly persons, this kind of analysis provides meaningful findings concerning symptom trajectories over the life-span. More primary data analyses, as well as meta-analytic investigations, could lend more clarity to this issue in the future.

Several studies on PTSD in the elderly report quite substantial prevalence rates of subsyndromal PTSD, ranging from 3.8 percent in a population-based survey ([Glaesmer et al., 2010](#)) to 25.0 percent in former WWII refugees ([Teegen & Meister, 2000](#)). A recent investigation in elderly persons with a history of WWII trauma revealed that individuals with full or subsyndromal PTSD neither differed regarding the severity of their individual symptoms, nor regarding their distress levels ([Glück, Tran, & Lueger-Schuster, submitted](#)). In their review, [Owens et al. \(2005\)](#) pointed out that PTSD symptoms in the elderly are more likely accompanied by somatic symptoms and particularly hyper-arousal symptoms (cf. [Mainous, Smith, Acierno, & Geesey, 2005](#)), which may lead to a misinterpretation, or even a failure to detect posttraumatic symptoms in aged persons.

Delayed-onset PTSD has also been differently conceptualized as "trauma reactivation" in old age (e.g. [Bramsen et al., 2006](#); [Heuft, 1999](#); [Hiskey et al., 2008a](#)). However, this mainly describes the same phenomenon of later emergence of PTSD related to earlier life events. According to reviews and meta-analyses, this phenomenon is prevalent in up to 7 percent of all traumatized individuals and may also be related to particularities of somatic symptom presentations in old age ([Hiskey, Luckie, Davies, & Brewin, 2008b](#)).

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PTSD and Morbidity in Older Age

As already outlined, if PTSD or posttraumatic symptoms are present, this adds significantly to the burden of distress experienced in later life. Furthermore, these symptoms do not have to agglomerate to a full-syndrome to impair and limit health. There are robust findings that link negative health outcomes—psychological and physiological (e.g., hypertension, myocardial infarction, arthritis)—to previously experienced trauma and PTSD (Qureshi, Pyne, Magruder, Schulz, & Kunik, 2009; Sledjeski, Speisman, & Dierker, 2008). McFarlane (2010) linked these processes to the ‘allostatic load’, which can be regarded as a core process of stress-related dysregulations across the lifespan. In addition to physiological changes, negative mental health outcomes after adversity also seem to influence general morbidity in older age, ranging from trauma-related psychotic symptoms to the most severe depressive states (Böwing, Schmidt, Juckel, & Schröder, 2008; Strauss, Dapp, Anders, von Renteln-Kruse, & Schmidt, 2011). Furthermore, PTSD has also been associated with cognitive impairment and the clinical course of dementia in old age. There are two main explanations for this relationship: first, PTSD itself impairs cognitive functioning. Second, with age-related deterioration of cognitive functions, the barriers for re-emergence of pre-existing traumatic memories and PTSD symptoms are lowered (Cook, Ruzek, & Cassidy, 2003). The reoccurrence of traumatic memories may then worsen or exacerbate dementia-related behavioral and psychological symptoms, like wandering or angry outbursts.

A very recent issue, which has seen considerably little attention in the discussion on PTSD in old age, is epigenetic changes and their influence on health outcome and aging. Schmidt, Holsboer and Rein (2011) state that there is mounting evidence that traumatic life experiences cause changes in the chromatin (this is a complex of DNA and proteins packaged into nucleosomes which then form the chromosomes). Not only may these epigenetic modulations be seen as a pathogenic factor for PTSD if a “biological predisposition coincides with a traumatic stressor” (Schmidt et al., 2011), but they also may be seen as a factor for later adverse outcomes of the disorder itself, caused by changes in the HPA-axis and the sympathetic nervous system. Furthermore, there is evidence that multiple adverse or traumatic events in childhood and adolescence are associated with short age-adjusted leukocyte telomere length, a marker of accelerated cellular aging, and thus increased risk for age-related morbidity and mortality (O’Donovan, Epel, et al., 2011). Such changes in telomere length attributed to (traumatic) stress may also be linked to dysregulation in the HPA-axis (Tomiyama et al., 2011) and to elevated inflammation (O’Donovan, Sun, et al., 2011), further contributing to an increased risk of inflammatory disorders, such as arthritis.

In their review on broader implication of PTSD for the elderly, Lapp et al. (2011) also argue that PTSD must be “superimposed onto the normal biological, psychological, and social changes that are seen concurrently with aging” (p. 2). They summarize that PTSD may lead to accelerated aging and suggest that PTSD in the elderly is thus to be understood in developmental terms. Yet, it must be considered that potentially traumatic events are almost ubiquitous and it seems impossible to establish unique and systematic relationships or pathways between PTSD and morbidity, bearing in mind that the persons most affected by morbidity may not live to see the days of senescence.

Implications for Practice and Research

Although there have been various attempts to improve mental health related knowledge in both primary care (e.g. Hodges, Inch, & Silver, 2001) and long-term aged care (Hsu, Moyle, Creedy, & Venturato, 2005), there still remains need for improvement. As previously outlined, cognitive decline and increasing morbidity in old age pose numerous challenges—especially for dedicated personnel in residential and care settings for the elderly. Consequently, knowledge on PTSD and trauma in the elderly is important in care and residential settings.

Although most of the studies cited in this article claim that integration of psychotraumatological knowledge into gerontological care is needed, it appears somewhat difficult to identify clear operating procedures. Indeed, it seems that no attempts have been made so far to deduce such from the existing evidence. Consequently, future research should not only focus on prevalence and symptom presentation, but also on when it is best to assess trauma in the care process of elderly persons, e.g. as a standard procedure when entering care settings or when screening for dementia. Also, more research is needed concerning how to support and educate dedicated professionals on best managing elderly patients with a history of trauma and how this may reduce distress for both patient and caregivers. For example Hiskey et al. (2008b) report in a study on the phenomenology of reactivated trauma that, during reliving, body-related physical memories are the strongest, followed by emotional aspects felt during the past trauma. This aspect may be highly relevant, such as in situations where care personnel are performing genital hygiene on patients with a history of sexual violence, triggering strong and aggressive defense reactions against the carer (Heuft, 1999). This aspect may be particularly salient for patients with dementia, whereby while cognitive symptoms may be absent, somatic symptoms persist during the course of mental decline. If carers are educated about such

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possible reactions, they may not only be aware of how to interpret these actions (i.e. not as hostile actions against themselves, but as expressions of a traumatic memory), but they may also be instructed on how to handle such patients, to reduce the likelihood of triggering such memories. In this context, it may be helpful to imagine an average residential facility for the elderly with up to 300 residents. The prevalence of PTSD in the elderly (full and subsyndromal) in many countries ranges between 5 and 25 percent. As such, a cautious estimation leads to 15 persons in the best and more than 60 persons in the worst case, suffering of trauma-related symptoms. These persons are likely to need more attention in the form of specialized care and treatment. With an expected increase of over 50 percent in the world population aged over 60 years by 2050 (UN, 2011) there is an urgent need to continue to upgrade our knowledge in this area.

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NEW! “Paper in a Day” Program for Early Career Researchers

Did you finish your dissertation fewer than five years ago or are you about to submit it for publication? Are you planning to attend the 2012 ISTSS Annual Conference in Los Angeles? If so, join other ISTSS members for *Paper in a Day!**

The idea of *Paper in a Day* is to gather together approximately eight early career, international researchers and write a short report within one day. This will be a speedy process with a number of goals:

- To get to know colleagues from around the world
- To exchange ideas about traumatic stress and recovery
- To develop a collaborative manuscript

This is intended to be an intensive, pleasant and productive day, with the potential to develop into an ongoing yearly event. Because this event will take place prior to the ISTSS conference on Tuesday October 30, you will also be able to introduce yourself to new colleagues and continue conversations with them in the days that follow.

Program and Commitments Required

The program will run from 8:30 a.m. until about 8:30 p.m. at the conference venue, the JW Marriott Los Angeles at L.A. Live, and will include plenary discussions, writing time in subgroups, and breaks. Because one day is very short, the following commitments will be required from participants to make the event a success:

- To prepare in advance of the meeting, involving eight hours in the two weeks prior
- To be present during the full day
- To contribute to the final editing and referencing after the event, approximately a four-hour commitment.

Contributing Data for the Paper

Do you have data that have been collecting dust? Perfect! These can be data in any form, including de-identified patient data, epidemiological data, review data, etc. The only requirement is that the data be designed to answer a simple research question; therefore, a very basic dataset would be ideal. The contribution of data will determine first authorship and also will require the additional commitment of completing data analyses prior to October 16 to inform the write-up at this event. If no members of the group have data to contribute, that won't be a problem as there are back-up data and paper topics available.

Organizer

Dr. Eva Alisic is a trauma psychologist and research fellow at Monash Injury Research Institute of Australia. She also is affiliated with the National Psychotrauma Center for Children and Youth in the Netherlands and has both set up and participated in multidisciplinary networks of young academics and think tanks. Her blog www.trauma-recovery.net showcases the work of early career researchers.

How to Participate

If you would like to participate, please send an email to eva.alisic@monash.edu by July 15, 2012, with the following information:

1. A short CV listing your publications and main research interests, to allow a choice of topic consistent with the group's shared interests.
2. A statement that you commit to the required preparation, attendance and follow-up activities as described in this invitation.
3. A note as to whether you have data available and, if so, a short description of what you have in mind for the paper.

A brief selection process conducted by two senior academics will determine the data to be used and the topic if several participants would like to contribute data. Participants will be notified as to the outcome by August 1, 2012.

Looking forward to seeing you in Los Angeles!

** Please note: This is not an official ISTSS event, but rather an ISTSS members' initiative.*

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July 3 – 16, 2012

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August 2 – 5, 2012

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