

PTSD: National Center for PTSD

Older Adults and PTSD

Anica Pless Kaiser, PhD, Eve Davison, PhD, Jennifer Moye, PhD, Avron Spiro, PhD, and Sadie Larsen, PhD

In the U.S. and worldwide, people are living longer and healthier lives, leading to a growing proportion of the population being older adults (sometimes considered to be age 65 and older, other times 50 or 55 and older). Older adults with PTSD may have unique presentations and issues related to their PTSD symptoms. Although PTSD in some older adults will be chronic, other older adults may experience an emergence or exacerbation of PTSD symptoms as they age, and some may experience a late-life trauma that leads to a new onset of PTSD. This article will describe the presentation of PTSD in older adults as well as implications for assessment and treatment.

It is important to note that much of the research on PTSD in older adults has been conducted with military Veterans, and as such, the information and suggestions below may be most applicable to older, often male, Veteran samples.

PTSD and Aging

Prevalence

The prevalence of both current and lifetime PTSD is found in most studies to be somewhat lower in older adults than in younger adults (1). For instance, the National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III) found that lifetime prevalence of PTSD in the general US population was 7% for adults below 65, but 3% for adults ages 65 or older (2). Likewise, among Veterans, the prevalence of PTSD generally decreases in older age groups (3).

Although full PTSD may be somewhat less common in older adults, there is some suggestion that subthreshold PTSD may continue at similar rates into older age. Therefore, those who are older may be equally as likely to have subthreshold as full PTSD (4) or perhaps more likely (5). People with subthreshold PTSD carry higher risk for poor functioning and comorbidity than those with no/minimal PTSD (though lower than those with full PTSD; 5).

Definitions of subthreshold PTSD vary widely across studies, making it challenging to compare prevalence rates. A large study in Veterans used an empirically-derived definition of subthreshold PTSD including a specification of symptoms for at least 1 month as well as symptom-related distress or functional impairment. Subthreshold PTSD was as common in older Veterans (aged 65 and above) as full PTSD, whereas in younger cohorts, full PTSD was more prevalent (noting both full and subthreshold PTSD were less prevalent in older than younger Veterans; 6).

Why might PTSD prevalence be lower among older versus younger adults? Some possibilities include:

- **Resilience:** Older adults may have developed better methods of coping. Decreasing PTSD severity may be partially explained by theories of aging, in which older adults adopt more of a focus on the present in order to maximize meaning and nurture positive emotions in the shorter time remaining in their lives (7). In part, this may entail de-emphasizing the role of past traumas in their identities (8).
- **Risk factors:** PTSD is related to a range of negative health outcomes (see below). Although findings are mixed, in general, PTSD is associated with increased mortality (9). As such, there may be fewer people living

with PTSD at older ages.

- **Period effect:** Because PTSD was not an official diagnosis until 1980, with the release of DSM-III , it is possible that generations of current older adults were less likely to be diagnosed with PTSD in the past, or to seek a diagnosis later in life (10).
- **Cohort effects:** Older adults may share unique cultural norms that affect their awareness of or willingness to report mental health difficulties. For example, older adults may be:
 - More likely to express mental health difficulties as somatic concerns
 - Reluctant to acknowledge mental health difficulties due to stigma or stoicism
- **Lower mental health care utilization:** Older adults may have lower rates of mental health care utilization (11). Although this is unlikely to fully explain differences in PTSD prevalence as measured by standardized interviews, it is supported by research suggesting older adults are less likely to be referred to mental health treatment by providers (12).

Is the experience of PTSD different in older adults?

Over the years, some have suggested that in addition to lower prevalence, the presentation of PTSD may be different in older adults (13), even necessitating a different set of criteria for diagnosing PTSD in older adults (14). That said, there have been very few studies, mostly small, with no consistent findings of differences in symptom presentation across studies.

Research does suggest there are some ways in which PTSD and aging interact to make for a different experience of PTSD for some in older age:

- **Comorbidity and accelerated aging:** For older adults who have had PTSD much of their lives, the effects of other mental and [physical health](#) comorbidities can accumulate meaningfully in older age. A review of the literature indicated that for those with PTSD, there is an increased risk of early or accelerated aging, of increased morbidity of aging-related conditions (e.g., cardiovascular disease, diabetes, and dementia), and of early mortality (15). Further, [chronic pain](#) is a common comorbidity of PTSD, and the relationship between pain and PTSD may strengthen with older age (16).
- **Delayed onset and LATR:** Some older adults will have new-onset symptoms or an exacerbation of symptoms in older life. For those with delayed-onset PTSD, there are likely to have been at least some symptoms present that are then exacerbated at a later point (17,18). In older adulthood, developmental changes and aging-related challenges such as retirement, loss of loved ones, increasing loneliness, poor physical health, or disability may trigger feelings of loss, helplessness, or burden may lead to some re-emergence of symptoms. Loneliness and poor social connection itself may be related to PTSD bidirectionally (19,20). And for some, having additional time to think (e.g., post-retirement or post-illness) can foster increased thoughts about past traumatic events. There has been some suggestion that it may be normative for older Veterans to reengage with earlier unresolved wartime experiences, a process called later-adulthood trauma reengagement (LATR; 21), which can lead to either distress or growth depending on the ability to make meaning.
- **Age, cohort, period, and intersectional factors:** Our understanding of older adults and PTSD will shift over time as new cohorts grow older. Older generations are more likely to downplay symptoms, but this may be

a generational effect that will change as current young people grow older. Another example would be war experience—older adults who were deployed in World War II versus Vietnam versus the Persian Gulf will all have very different experiences based on their wartime, homecoming, and general cultural experiences (20). Moreover, experiences of isolation and discrimination will be different for women, people of color, and LGBTQ+ Veterans who served in earlier versus later conflicts.

Evidence and Considerations for Assessment and Treatment in Older Adults

Assessment

In terms of assessment, a few studies have found that standard assessment measures perform similarly in older adults as in younger adults. For instance, the PTSD Checklist for *DSM-5* (PCL-5) shows excellent psychometric properties in older adults (22). Both the Primary Care PTSD Screen (PC-PTSD-5) and the PCL-5 appear to differentiate those with and without PTSD equally well in older versus younger adults, with similar cutoffs (23). Thus, evidence to date points to using symptom measures similarly with older and younger adults. One consideration is to assess for subthreshold as well as full PTSD in older adults, as subthreshold PTSD may be at least as common and still linked to functioning and health deficits.

Psychotherapy

In terms of psychotherapy, two systematic reviews indicate that there have been relatively few studies of PTSD psychotherapy that included or studied older adults (24,25). The more recent review focused on individual trauma-focused psychotherapy in older adults and found that trauma-focused psychotherapy was well-tolerated, showed positive effects on symptoms, and had relatively low dropout (ranging from 0% to 19%; 25). More recently a report of Eye Movement Desensitization and Reprocessing (EMDR) in a non-controlled sample of older adults with significant comorbidities also showed a positive effect (26). Finally, two non-randomized studies have compared psychotherapy outcomes in older versus younger adults, in one case finding no differences between matched samples of older and younger adults (EMDR; 27) and in the other case finding that both benefited, but younger adults had greater changes in PTSD despite attending fewer sessions on average (Cognitive Processing Therapy [CPT]; 28).

In summary, there is nothing in the existing treatment literature to contraindicate using a first-line psychotherapy with an older adult with PTSD. The available evidence indicates that older adults do benefit from trauma-focused psychotherapy, with some indicating that perhaps they benefit slightly less, while others find no difference between older and younger adults with PTSD. Likewise, although older adults may be less likely to seek or receive therapy (29), once they do attend, they are less likely to drop out (30). Despite the studies above including participants with a variety of physical and psychological comorbidities, none systematically modified therapies, and none identified contraindications. There are, however, some important limitations of the existing, small evidence base for psychotherapy among older adults, including few adults in the treatment literature older than 75, no randomized trials comparing younger to older adults, fewer civilian than Veteran samples, and few studies specifically including older adults with medical illness or cognitive changes.

Pharmacotherapy

Although specific psychotherapies are recommended as first-line PTSD treatment, [specific medications](#) are also effective for PTSD and should be considered for older adults as well. Unfortunately, medication studies are also likely to exclude older adults or have not examined whether safety or effectiveness are affected by aging. (See table below for considerations in prescribing with older adults.)

Considerations for tailoring assessment and treatment to older adults

In general, an evidence-based approach to assessment and treatment of older adults can look similar to assessment and treatment of all adults, not modifying unless it seems necessary. Of note, randomized controlled trials including older adults have generally not made any universal modifications, though case studies with older adults often note specific modifications made to tailor the treatment to a given individual (31). Below are some considerations that may affect assessment or treatment with specific older adults, although providers should be careful not to assume that modifications are needed without assessing (32).

Age-Related Findings	Clinical Implications
<p>Current cohorts of older adults may be more stoic, more likely to focus on somatic complaints, or less likely to identify symptoms as trauma related. Providers may be more likely to recognize comorbidities than to identify PTSD. One study found that older adults in VA were less likely to receive therapy after a new PTSD diagnosis (29).</p>	<ul style="list-style-type: none"> • As in VA, universal screening for trauma and PTSD (e.g. using the PC-PTSD-5) may be more helpful than expecting a patient to raise the issue of trauma or PTSD on their own. • It may also be helpful to avoid psychological jargon and be mindful of potential stigma around mental health (e.g., describing being “on guard” vs “afraid”; 33), or describing Prolonged Exposure without using the word “prolonged.” • It is best to assume that older adults may be as likely to benefit from therapy as younger adults.
<p>Older adults may be less likely to have full PTSD but may still have subthreshold PTSD that is impairing.</p>	<ul style="list-style-type: none"> • Consider whether a PTSD treatment may still be helpful even if a full diagnosis of PTSD is not met.
<p>Older adults may be more likely to have decreased mobility, transportation challenges, and sensory (hearing, seeing), changes.</p>	<ul style="list-style-type: none"> • As needed, use written materials with larger, bold font. • When indicated, make sure to speak directly to the patient in a clear voice, louder and slower only as necessary. • Consider consults to audiology or to blind and visual impairment rehabilitation services, which can help with assistive technologies (e.g., screen readers). Have devices (magnifying glass, pocket talkers—or personal sound amplifiers) on hand in office. • Consider including caregivers or family members as appropriate for purposes of transportation, reinforcing messages from the treatments, or facilitating treatment (but be careful to always address the patient first). • Consider telehealth to help with transportation barriers.
<p>Pain is often comorbid with PTSD, and this relationship can be exacerbated with age (16).</p>	<ul style="list-style-type: none"> • See Chronic Pain and PTSD
<p>PTSD can also affect care at end of life.</p>	<ul style="list-style-type: none"> • See PTSD and End of Life: Clinical Considerations for PTSD in Palliative or Hospice Care

Age-Related Findings	Clinical Implications
<p>Not all older adults will have neurocognitive impairment, but PTSD does increase risk for neurocognitive disorder (NCD), and vice versa.</p>	<ul style="list-style-type: none"> In general, mild and moderate NCD are not contraindications for PTSD treatment. If there is a concern about NCD (e.g., inattentive to appearance, a poor historian, or forgetful during interview), a cognitive screening is warranted (standardized options include the MOCA [34] and the less validated but free SLUMS [35]). If NCD is suspected, a referral for a comprehensive neuropsychological exam can be helpful. If delirium is suspected, or there is a question about medication interactions, a medical evaluation can be considered. See Assessment and Treatment for PTSD with Co-occurring NCD
<p>Clinicians may have concerns about exposure therapy leading to increased physiological arousal among older adults, especially those with cardiovascular conditions.</p>	<ul style="list-style-type: none"> There is no evidence that this concern should contraindicate evidence-based psychotherapy (EBPs) for PTSD. The 2 systematic reviews noted above included various forms of exposure and trauma-focused therapies for PTSD, none with exclusions for any comorbidities. None of the included studies reported long-term adverse events in this population. One study of imaginal exposure in patients with PTSD due to a life-threatening cardiovascular event found no adverse effects or “cause for worry” after monitoring changes in heart rate and blood pressure during treatment (36). On the other hand, untreated PTSD contributes to worse physical health outcomes, and daily symptoms already cause cardiac strain—whereas treatment may improve cardiometabolic disease severity or lower risk (37). If there are particular concerns, clinicians can consult and collaborate with medical providers. In cases of higher risk, medical providers can clear patients for treatment and monitor cardiac status during treatment. Shared decision-making can be used to think through potential risks and benefits of various options, including first-line PTSD EBPs and non-trauma-focused treatments.

Age-Related Findings	Clinical Implications
<p>There has been relatively little research on medications in older adults with PTSD. However, in general, older adults may be more susceptible to side effects due to slower metabolism. And for those taking other medications there is an increased risk of drug-drug interactions.</p>	<ul style="list-style-type: none"> • Consider the side effect profiles of various medications. • Be cautious about polypharmacy and drug-drug interactions. • “Start low and go slow,” adjusting one medication at a time. Older adults often respond to lower doses of medications than younger adults. • Benzodiazepines are not recommended in general for PTSD and they are particularly to be avoided with older adults given that they can cause cognitive impairment, sedation, respiratory problems, and fall risk.
<p>Social support is generally an important buffer against PTSD symptoms, and role changes or losses of key loved ones later in life may constrain social support.</p>	<ul style="list-style-type: none"> • It can be helpful to assess for changes in roles (e.g. retirement, changes in living situations) along with social connectedness (loneliness, bereavement). If relevant, helping problem solve to address isolation may help to buffer PTSD symptoms.

Summary

Older adults may be somewhat less likely to have PTSD than younger adults. However, full or subthreshold PTSD can contribute to accelerated aging in older adults. Emerging evidence indicates that assessment and psychotherapy can generally proceed similarly with older and younger adults, though we have provided some considerations (e.g., pharmacotherapy, co-occurring conditions) to optimize care for older adults with PTSD.

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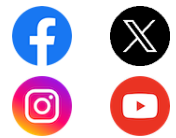
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PTSD and End of Life: Clinical Considerations for PTSD in Palliative or Hospice Care

Sadie E. Larsen, PhD

Patients receiving health care at end of life (EOL) may receive palliative and/or hospice care for their medical conditions. One task of end-of-life care is to help patients have a death that involves minimal pain and suffering, optimal emotional well-being, and quality of life as defined by the patient (1,2). For patients with pre-existing PTSD, some may have had chronic symptoms, and others may experience a flare of symptoms during EOL, either of which can complicate the dying process for patients and their loved ones. Although there has been very little research on PTSD specifically at EOL, clinical guidelines are emerging that may support clinicians and point to areas for future research.

This article is designed for an audience of clinicians who primarily work with patients at EOL (considered roughly a life expectancy of one year or less, though definitions vary) and may also be helpful for PTSD specialists whose patients become seriously ill or injured. Most writing and research on this topic involved Veterans—largely older male ones—and discussed combat-related trauma; it will be important for future work to consider the experiences of women and civilians, and other trauma types (e.g., sexual assault, racial trauma).

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End-of-Life Care: Palliative and Hospice Care

For many medical diagnoses, particularly those that are life threatening, patients have the option of receiving palliative care (also referred to as supportive care). **Palliative care** is a holistic approach that focuses on promoting quality of life as well as providing patients with relief from the symptoms, pain and stress of a serious illness, regardless of diagnosis. Palliative care can be delivered in conjunction with treatment designed to cure disease, or, in cases where patients face incurable illness, palliative care may be the primary offering. **Hospice care** is somewhat more specific, in that it is generally available as an insurance benefit when the prognosis of an illness is 6 months or less. Thus, palliative care is a broader umbrella term. It can take place in a hospital, nursing

home or a patient's home. The palliative care team is a coordinated and interdisciplinary one, composed of medical doctors and nurses, and can include other therapists as called for by the needs of the patient and family. In VA, core palliative team members also include social workers, mental health providers and chaplains. Close loved ones and family are often considered part of the team and the unit of care since the goal of palliative care is to relieve suffering and support quality of life for the patient and the whole family. Goals of care are collaboratively determined by the care team and the patient and family.

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How might PTSD affect end-of-life care?

There has been very little empirical research on PTSD at EOL, including prevalence, presentation or effect on other aspects of care. Therefore, much of the knowledge about how PTSD can present in palliative care is based on case reports and clinical writing, as well as informed by what we know of related populations (e.g., [older adults](#), those with [neurocognitive disorders](#)). Clinically, PTSD may be missed in EOL care for a number of reasons, including lack of psychiatric expertise within the treatment team, the fact that patients often don't talk about trauma unless asked, possible dementia making it challenging for patients to talk about symptoms or trauma directly, and PTSD symptoms being expressed as, or covered up by, other symptoms (e.g., irritability not being recognized as due to PTSD, dissociative flashbacks being mistaken for delirium) (3).

Clinical literature and case studies have documented that Veterans with PTSD may have an increase in symptoms while in palliative care, even if symptoms were well controlled prior to change in health status (3,4). Although this exacerbation is most likely the case for civilian trauma as well, such a finding has been less commonly discussed.

Two studies asked family members of deceased Veterans whether the Veteran had "reexperienced the stress and emotions that they had when they were in combat". They found that 9 to 17% had experienced such combat-related stress in their last month of life (4,5). One study found that these posttrauma symptoms were associated with more discomfort than dyspnea (shortness of breath) (4). The other found that these posttrauma symptoms were worse for those who were younger, male, Black, and with more comorbidity, but were improved for those who had a palliative care consult and felt listened to or had their emotional needs met (5). These studies did not use diagnostic interviews and only asked about combat, so they cannot indicate true prevalence of PTSD. However, they do concur with other clinical literature in indicating that PTSD may complicate EOL outcomes for Veterans and their families.

Another study found that Veterans at EOL who had PTSD had increased health care utilization and antipsychotic prescriptions than those without PTSD, suggesting that PTSD likely increases symptom burden. Veterans with PTSD possibly experienced greater terminal delirium than patients without PTSD (6). Indeed, we know that PTSD increases risk for dementia, which can also complicate the clinical picture at end of life by making it more challenging to identify the source of behavioral symptoms or the most appropriate treatment approaches.

There are multiple reasons that PTSD symptoms may be present or exacerbated at EOL:

- Life-threatening illness or injury itself may constitute a trauma, either leading to PTSD or exacerbating existing PTSD (7). Further, studies have found elevated rates of PTSD in intensive care units related to the treatment itself (8).
- Earlier trauma may be evoked by other aspects of the treatment or dying process, such as receiving intimate care (i.e., being touched by a provider), a sense of lack of control, or being reliant on others.
- For those who have experienced sexual assault, racial trauma or other interpersonal trauma, the appearance, cultural traits, sex or race of a provider may be a trauma reminder. There is some indication that PTSD at EOL may be worse for Black Veterans (5), whether because of disparate trauma experiences or disparate health care.
- Trauma reminders may be more salient if a patient is experiencing a neurocognitive disorder; single stimuli (whether a machine beeping or the touch of a hand) may be perceived in isolation of medical care and easily

misinterpreted as a current danger given heightened arousal response (9)

- A process of spontaneous life review can be common later in life (10) and especially when living with a life-limiting illness; this process may be complicated if a person has not found a way to make sense of trauma(s) they experienced, leading to potential for guilt, shame, regret, or a loss of meaning or faith. Life review may be particularly painful in the case of traumas that also involve [moral injury](#) or implicate patients' spiritual beliefs.

When present, the symptoms of PTSD may complicate care for patients in palliative or hospice settings, thus interfering with the potential for as much quality of life as possible at EOL. See Table 1 for examples.

Table 1. PTSD Symptoms and End-of-Life Care

PTSD Symptom Criterion	Implication for End-of-Life Care
Criterion A: Stressor	Current symptoms may increase, or subclinical cases may emerge after new medical stressors or when death seems imminent. Life-threatening medical emergencies or events that evoke imminent death are themselves traumatic (<i>DSM-5-TR</i> ; 11).
Criterion B: Intrusions	The life review process may lead to heightened intrusive recollections of trauma along with distress. PTSD-related nightmares can also contribute to poor sleep.
Criterion C: Avoidance	Medical problems and the dying process can be (re)traumatizing. Patients may cope by avoiding—not engaging in decision making processes, becoming more withdrawn and isolated, avoiding talking about what they are experiencing or about death—resulting in poorer doctor-patient relationships, less social support, and difficulties in treatment planning (12). PTSD may have eroded social support earlier in life, leaving patients lonelier or without caregivers in the dying process.
Criterion D: Negative Alterations in Cognition and Mood	Patients with PTSD may have negative beliefs and expectations about treatment (e.g., "What is the point?") or mistrust of providers (13). PTSD (or moral injury)-related changes in cognition and mood may also lead to an increased sense of blame, guilt or shame. Increased anhedonia or detachment from others may also be present.
Criterion E: Alterations in Arousal and Reactivity	Significant anger or irritability may lead to problems with family members and the treatment team (especially when not recognized as stemming from PTSD). Significant anxiety, including panic attacks, as well as agitation and sleep problems may occur.

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Palliative and Hospice Care for the Patient With PTSD and Their Family

When appropriate, the palliative care team can help family and loved ones as well as patients to understand why PTSD symptoms may (re)emerge at EOL when coping mechanisms are challenged. This reemergence can be surprising for family and members of the patient's support network, especially if PTSD symptoms had previously been well-controlled or if the patient had avoided revealing symptoms. If patients have not previously spoken about trauma(s), loved ones may feel uncertain about how to respond. Both families and patients themselves may need to come to terms with the status of their relationships if PTSD has interfered with their interactions with others. Some individuals with PTSD might experience a sense of guilt related to perceived shortcomings in their relationships if, for instance, PTSD symptoms led to withdrawal that was hurtful to loved ones and now feels too late to repair.

Thus, at many points in EOL care, the team may want to help both the patient and the family (or close support network) to better understand and to manage PTSD symptoms more effectively. Initial education, screening and management can take place within the team itself, with the opportunity to connect family or patient with a mental health specialist if initial efforts are not sufficiently helpful, or if there is not sufficient mental health expertise on the team itself.

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Special Considerations Regarding Assessment of PTSD at End of Life

An accurate diagnosis of PTSD or at least recognition of PTSD-related symptoms can be helpful in guiding treatment. It can also help caregivers to accurately attribute symptoms and therefore experience more empathy rather than blame toward patients related to these symptoms (3). To date, no studies have specifically validated any assessment methods for PTSD at end of life. Therefore, guidance is based on clinical writing and extrapolation from what is known about [PTSD assessment](#) in related populations.

When considering best practices for assessment and treatment of PTSD at EOL, the goals of care must be carefully considered. Some questions to guide assessment are:

- Is it possible PTSD is part of the clinical picture for this patient?
- How much is PTSD interfering with quality of life?
- What are the patient's and family's goals in relation to symptom alleviation?
- How much time and energy does the patient have to devote to a PTSD assessment?

The first of those questions can be answered by screening for trauma and PTSD, which can be conducted by any member of the care team. Screening is indicated if providers notice symptoms that may indicate the presence of trauma and may be interfering with quality of life.

On the other hand, universal screening may also be helpful given that patients will often not spontaneously disclose trauma without being asked, and that PTSD symptoms can masquerade as other common EOL symptoms (e.g., flashbacks may look like delirium or agitation, insomnia may be due to nightmares instead of pain). This conversation might be opened with patients by asking such questions as:

- "As people live with serious illnesses, they sometimes experience reminders of prior scary or upsetting events. Has this happened to you?"
- "Have you felt guilty or bothered about events that previously happened in your life?" (14)

Such questions can be followed by a brief screen for PTSD. The [PC-PTSD-5](#) is validated in a primary care setting and has the benefit of being brief enough to be easily implemented in a clinical setting (though, like other PTSD measures, it has not been validated in this population). If desired, other validated measures may be used: the [Life Events Checklist](#) (LEC-5) to assess for a range of traumas, or the [PCL-5](#) to get a sense of severity of symptoms. But again, these need only be used as appropriate to the patient's goals for care, and as possible given the patient's energy level, concentration and cognitive level.

There may be times when a patient is unwilling or unable (due to dementia, etc.) to give a trauma history. Lack of desire to discuss trauma should be respected. Assessment can be supplemented by a chart review or by discussion with the patient's family (3), though it is possible that this will not help if the patient has not previously discussed PTSD or is having a late-life emergence of PTSD for the first time. Providers might ask family members whether their loved one has a history of trauma, as well as whether they have noticed particular situations that cause irritation, distress or withdrawal in their loved one. If there is a potential for PTSD that cannot be confirmed, many of the following recommendations for management of PTSD can be followed "as if" the patient has a history of trauma if symptoms appear to be present (15). Indeed, for some patients, a

suggestion of a mental health diagnosis may be difficult to accept given general societal stigma, and in these circumstances, it may be preferable to talk about "the challenges of adjusting to your difficult situation" rather than about mental health per se.

Finally, given the prevalence of comorbidity, consider also assessing for depression, anxiety, suicidality, and alcohol or substance use.

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Treatment Considerations for Management of PTSD at End of Life

As with assessment, there is no empirical research—including randomized controlled trials—on PTSD treatment at EOL. Therefore, recommendations are based on the general PTSD treatment literature, with modification based on evidence from clinical writing and consideration of goals of care relevant to EOL. Again, providers might benefit from considering:

- How much is PTSD interfering with quality of life or of dying?
- Is symptom alleviation a prominent goal for the patient or family?
- How much time and energy does the patient have to devote to PTSD treatment or management?

Standard treatments for PTSD often include psychotherapy and/or medications, but these standard approaches may not be the most appropriate at EOL (3). For instance, both antidepressants and trauma-focused psychotherapy are very effective but often take weeks to begin to work and may involve side effects or increased distress in the short term. If life prognosis is short, cognitive reserve is decreased, or addressing PTSD is not a central goal for the patient, then a course of PTSD treatment may not be the best fit. Instead, in line with easing suffering, environmental modifications might be undertaken to increase patient comfort. (See Table 2.) Many of these types of actions can be taken by any provider, not only mental health specialists. Given that certain types of traumas can raise questions about faith and spirituality that may be especially salient at EOL, involvement of [pastoral care](#) may be appropriate as well.

Table 2. Environmental Strategies for Management of PTSD Symptoms at EOL

Symptom/presentation	Strategy with selected examples
<p>General</p> <p>PTSD can be associated with a feeling of loss of control, safety and trust</p>	<p>Take care to build trust with patient:</p> <ul style="list-style-type: none"> • Give extra time for rapport building • Always obtain consent for interventions and give clear explanations about need <p>Take actions designed to give the patient control over treatment plan and concerns, when possible:</p> <ul style="list-style-type: none"> • Ask patient's preferences, from "do you want your arms or legs washed first?" to "what aspects of your life are most important to you at this time?" • When making physical contact, verbally cue in advance where and why you must touch <p>Identify cues that make a patient feel safe or unsafe that could be changed:</p> <ul style="list-style-type: none"> • If feeling "trapped," position the room differently or hang mirrors so that patients can see their surroundings fully • Avoid physical restraints or bed alarms when possible • Approach patient slowly and calmly, remaining in line of vision
<p>Intrusive symptoms</p>	<p>Identify any triggers for unwanted recollections or what they find disturbing, and mitigate when possible, e.g.:</p> <ul style="list-style-type: none"> • Give earplugs to block the sound of aircraft that is a trigger, or avoid showing war movies • Be aware that physical characteristics of providers may be reminiscent of war or trauma experiences <p>Identify skills or actions that can help to distract or soothe the patient when triggered e.g., grounding, sensory stimulation, mindfulness exercises, deep breathing, going for a walk</p> <p>If a patient is having a flashback, do not touch them. Rather, call the patient's name in a calm voice and explain where you are and what you're doing e.g., "I am Dr. X, we are in your room at Y Hospital". Repeat this until the patient becomes oriented.</p>

Symptom/presentation	Strategy with selected examples
Hypervigilance or increased arousal	<p>Decrease environmental triggers identified above</p> <p>Aim for a calm, soothing environment as much as possible, with a visible entrance into the room</p> <p>Avoid loud or startling noises</p>
Irritability or anger	<p>Summarize the patient's concerns and empathize</p> <p>Identify immediate triggers along with any unsolved needs these represent (especially around safety, control and trust). Remediate any needs and take any steps that will enhance safety and sense of control.</p> <p>Remain calm and centered, speaking in a conversational tone. If your presence is making emotional arousal worse, tell the patient you are leaving the room, when you will return, and the importance of continuing to provide quality care. Upon return, ask if the patient is ready to allow you into their space.</p>

Note: The above recommendations reflect contributions from Dr. Douglas Lane (VA Puget Sound Healthcare System), Dr. Heather Smith (Milwaukee VAMC), and recommendations from published articles (16, 17).

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Step-wise Psychosocial Palliative Care (SPCC) Model

Given the lack of research on treatment at EOL (see 3 for a review), Feldman (2017) has proposed a heuristic model for providing palliative PTSD care according to the needs of the patient and lifespan prognosis (16). Three stages are outlined that focus on providing rapid improvements in suffering and quality of life, consistent with a palliative model. The 3 stages are outlined in Table 3 below. Moving on to later stages only occurs if the earlier stages did not sufficiently resolve symptoms and there is adequate time and energy to implement the later interventions. Any member of the care team may implement steps in Stage I, with potential referral as needed to mental health specialists in Phases II or III.

Table 3. Stages of the SPCC Model

Stage I: Palliate Immediate Discomfort and Provide Social Support	Stage II: Provide PTSD Psychoeducation and Enhance Coping Skills	Stage III: Treat Specific Trauma Issues
<ul style="list-style-type: none"> • This stage is especially appropriate for those who may live only days or weeks • Active listening—empathy, validation • Learning from patients and family what practical concerns are distressing and directly assisting or advocating • Make changes to the physical environment • Work with healthcare providers and family about how to avoid triggering PTSD symptoms • Educate treatment team: <ul style="list-style-type: none"> ◦ Inform treatment team of patient's diagnosis ◦ Provide team information about PTSD and the impact of PTSD on care • These interventions can be continued through stages II-III 	<ul style="list-style-type: none"> • This stage may be appropriate for a patient with weeks to months to live • Patient and family psychoeducation regarding PTSD symptoms and the dying process (e.g., educate about PTSD, reassure the patient they are not "going crazy," provide information to loved ones with permission) • Teaching skills the patient can use to palliate PTSD symptoms, such as: <ul style="list-style-type: none"> ◦ Relaxation training and breathing re-training ◦ Thought-stopping skills ◦ Mindfulness-based / acceptance skills ◦ Problem-solving interventions ◦ Communication / social-skills training • Train family members in above skills 	<ul style="list-style-type: none"> • This stage may be appropriate for a patient with months to years to live and willingness to discuss trauma • Apply standard PTSD psychotherapy approaches if appropriate given prognosis, energy level, privacy to undertake them, and cognitive functioning • Standard approaches may be modified to tailor to energy level (e.g., meeting for shorter periods of time but more often)

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Medications

The decision about which medications to use for PTSD management at EOL should involve the patient and family members, and keep in mind their highest priorities for treatment. Since the timeline and goals of care may be different at EOL for patients and their families, medications not typically used for PTSD *might* be considered *if* they help ease suffering for the patient *and their family*. In general, for medication changes at EOL, the adage "start low and go slow" is appropriate. However, when prognoses are short, consider titrating medications up relatively quickly so long as no side effects are noted.

Considerations are outlined below:

- Certain SSRI's and SNRI's are considered first-line PTSD medications (18) and may be appropriate for patients with PTSD at EOL, if they have been already taking them, or have a prognosis that will allow time for the medications to take effect. A medication that does not need to be swallowed (and can be rapidly discontinued without significant withdrawal symptoms) may be helpful in case difficulties in swallowing develop (e.g., sertraline vs. venlafaxine).
- Benzodiazepines are generally contraindicated for use in PTSD but may be considered in a palliative setting after weighing pros and cons with patients and their families and considering their goals for care. Benzodiazepines may be appropriate if easing of anxiety and discomfort is paramount; on the other hand, they can cause or worsen delirium leading to patients missing opportunities for remaining quality interactions. So, the decision of whether to use one depends on what is most important at that point to the patient and their family. Concerns about future addiction or dependence are likely to be less relevant for those with a short life prognosis. Benzodiazepines should be used with caution in patients taking opioids. Start at a low dose and monitor for over-sedation.
- Likewise, antipsychotics are generally contraindicated for PTSD, but are frequently used to treat terminal delirium. One VA study found that during EOL care, Veterans with PTSD were more likely than those without PTSD to be prescribed an antipsychotic (6). The largest RCT to date found that antipsychotics may not help delirium and may in fact lead to worse outcomes than placebo (see 19). Start at a low dose and monitor for over-sedation.



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Summary

At EOL, PTSD can make some of the tasks of health care—and of facing mortality—especially challenging. Providers can consider screening for trauma or PTSD and when that is not feasible, utilizing the principles of trauma-informed care to ease any suffering or distress that may be related to past trauma. The [PTSD Consultation Program](#) can be helpful in navigating challenging clinical questions about Veterans at EOL where PTSD has been infrequently studied.

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Available Resources

- [We Honor Veterans](#)  is a collaboration between the Department of Veterans Affairs and the [National Hospice and Palliative Care Organization \(NHPCO\)](#)  where you can search for end-of-life care resources to support Veterans and their families.
- [American Psychological Association's \(APAs\) End of Life Issues and Care](#) site includes links to EOL organizations and featured resources to support psychologists working with diverse patients and families at EOL.

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