Psychology & Quality of Life:
PCTI Assessment & Treatment in Late life

Jewish Federations of North America
Innovations in Person-Centered, Trauma-Informed (PCTI) Care Training
Washington D.C., USA

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Disclosures

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Objectives

1. Recognize the prevalence, cause and impact of co-occurring psychological issues (i.e. cognitive difficulties, substance use, and severe mental illness) associated with trauma.

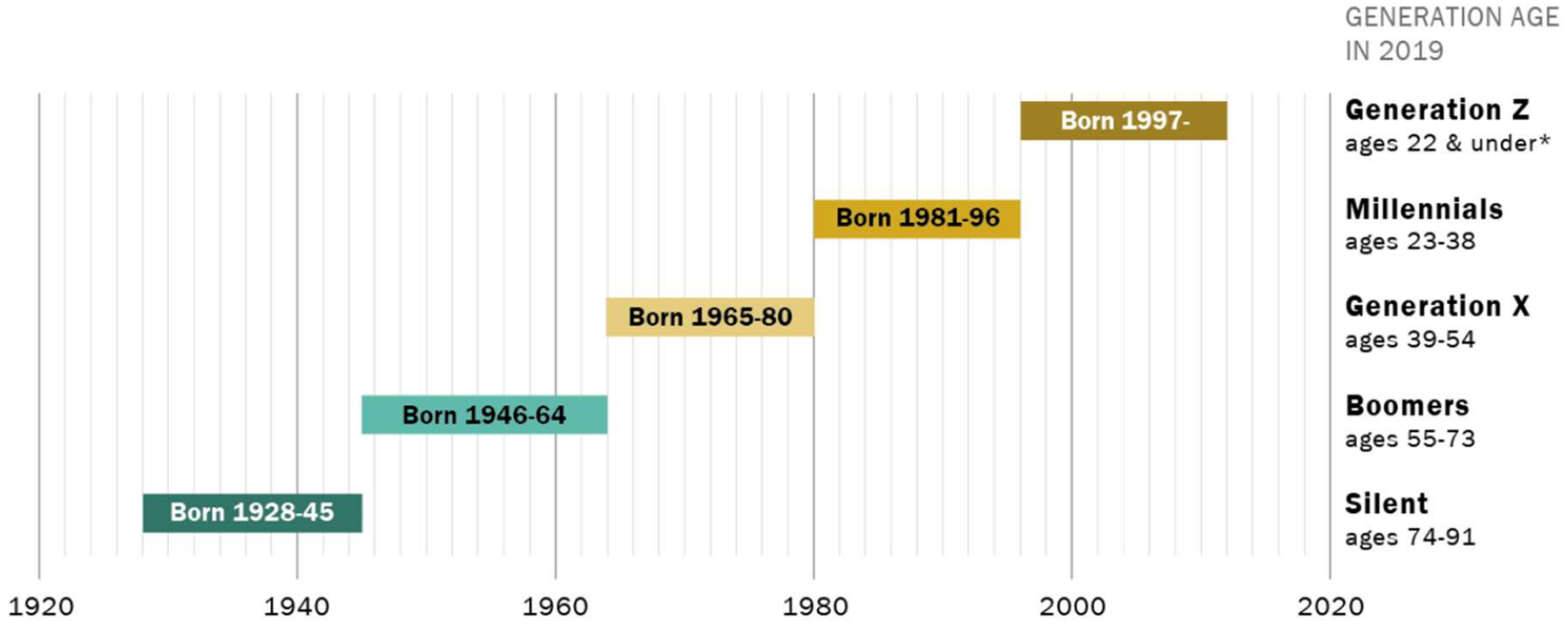
2. Discuss person-centered, trauma-informed screening and treatment strategies for these co-occurring psychological issues.

3. Mobilize participants to take action to improve the delivery of care for clients by providing relevant strategies, screeners and resources.


Frame of Mind:
Reframing Aging from "Them to Us"
0:01 / 2:02

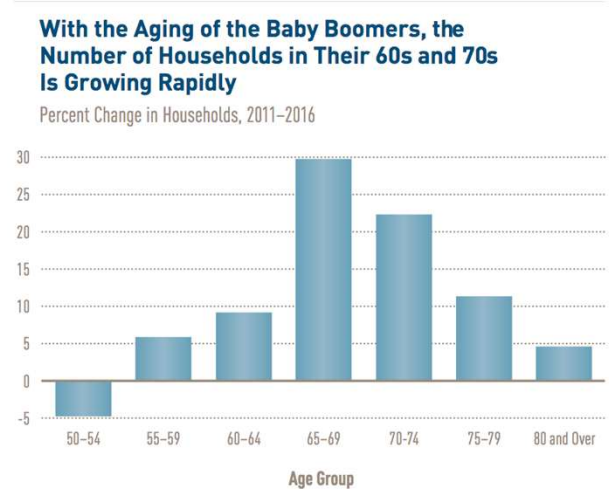
Baby Boomers?

Generations and Age

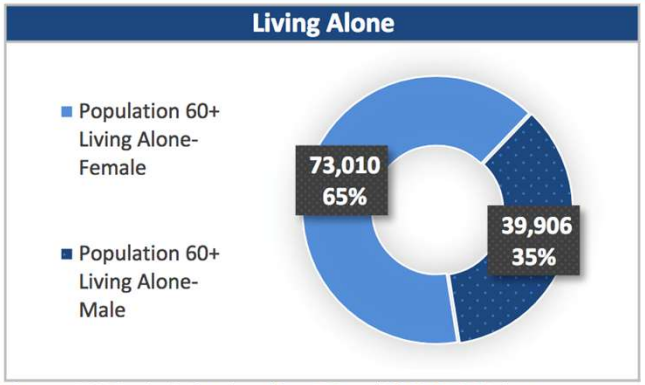


*No chronological endpoint has been set for this group. Generation Z age ranges vary by analysis.

Where are they living?

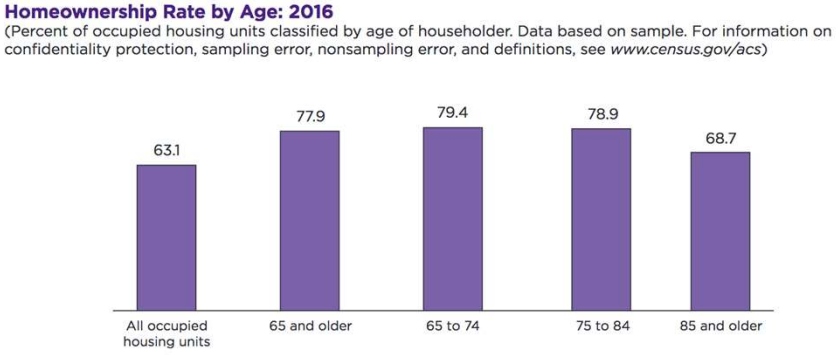


Source: JCHS tabulations of US Census Bureau, American Community Survey 1-Year Estimates.



Source: DOEA calculations based on EDR and 2011-15 ACS data

The vast majority of older adults continue to live in the community and do not transition to nursing homes or older adult living facilities[2]



Source: U.S. Census Bureau, 2016 American Community Survey, 1-year estimates.

So what does this mean for us?

- Roughly 20% of community-dwelling older adults have a diagnosis of serious mental illness[34]
- Roughly 90% of adults[1] and 74-85% of older adults[2,3] in the United States report trauma exposure.

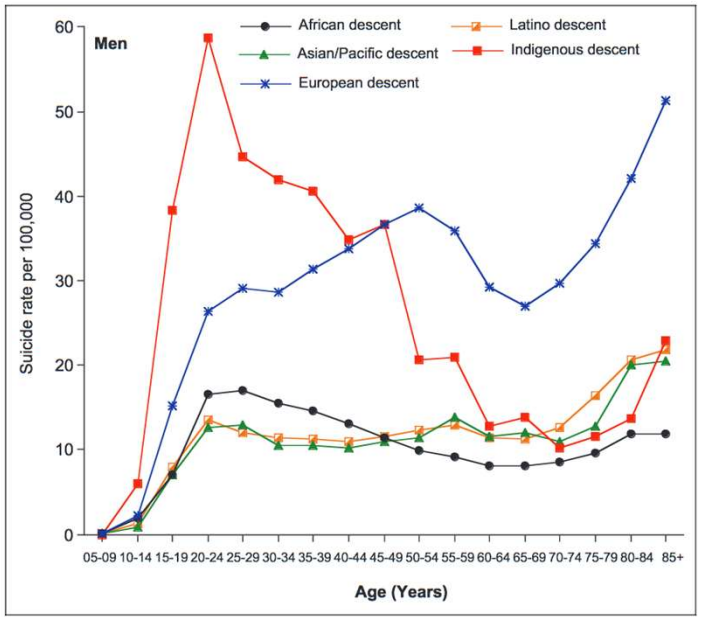
Table 1. Prevalence rates of traumatic events.

Category	Potentially traumatic event	*N* (%) reported	*N* most distressing event
Death and illness	Unexpected death of loved one (O)	1673 (66.52)	779
	Illness or accident of loved one (O)	1001 (39.80)	239
	Personal life-threatening illness (S)	561 (22.31)	345
	Abortion/stillbirth (S/O)	901 (35.83)	110
Adult physical assault	Armed robbery to self or other	237 (9.42)	39
	Physical assault by stranger (S)	168 (6.68)	23
	Witness attack or murder (O)	135 (5.37)	21
	Death threat (S)	393 (15.63)	27
	Intimate partner physical abuse (S)	227 (9.03)	31
	Stalked (S)	160 (6.36)	16
Sexual assault	Touched sexually against will (S)	309 (12.29)	62
Accidents and disaster	Motor vehicle accident (S)	569 (22.62)	162
	Natural disaster (S)	178 (7.08)	81
	Other serious accident to self or other	250 (9.94)	51
Childhood violence	Childhood physical abuse (S)	167 (6.64)	26
	Witnessed family violence (O)	316 (12.56)	87
Warzone exposure	Warzone exposure	266 (10.58)	110
Unclassified	Other distressing event	614 (24.41)	158
	Nondisclosed event	132 (5.25)	50

Notes: S = self-oriented event. O = other-oriented event. Abortion/stillbirth was classified as a self-oriented event for women and as an other-oriented event for men. Participants rated the PTSD symptom severity of their self-nominated most distressing traumatic life event.

Trauma: The impact

- Trauma exposure across the life span is a risk factor for:
  - Late life suicidal ideation[2,]
  - Post traumatic stress disorder symptoms[3]
  - Reduced quality of life[4]
    - Associated with pain[5], depression[6], multimorbidity[7] & disability[8].
  - Cognitive decline[9]
  - Dementia[10,11]



Trauma and Psychological Issues?

Individuals with PTSD may have up to:

- 2 times the risk of developing dementia[10,11]
- XX SA
- XX LTMI

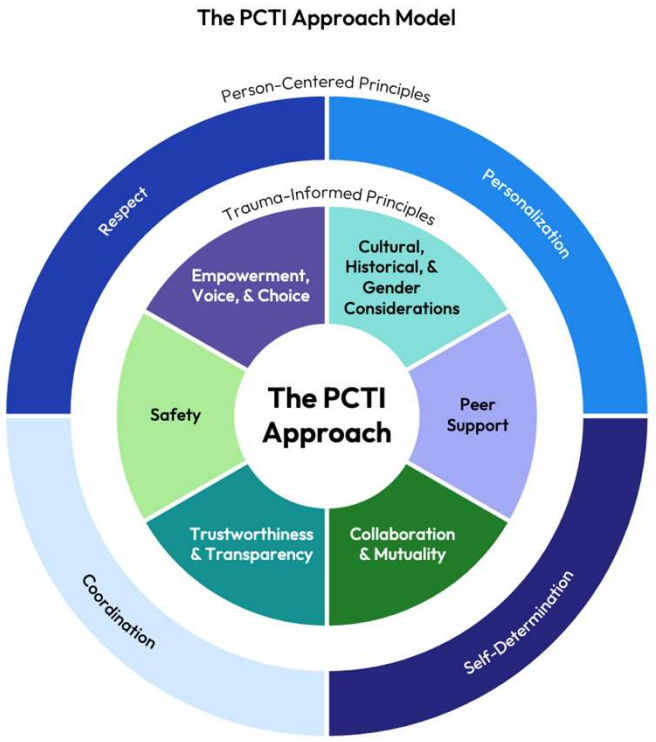
BUT intervention is possible and social support may be protective [12]

So how do we foster growth?

Person-Centered, Trauma-Informed (PCTI) Approach

PCTI approach is

- A holistic model of care that promotes the health and well-being of individuals by accounting for the role of trauma across the life course and by resisting re-traumatization, while also focusing on the strength, agency, and dignity of the person receiving care.
- Universal; it can be used by any person at any level of any organization, in any care setting, and with any population.



6 TIC Principles

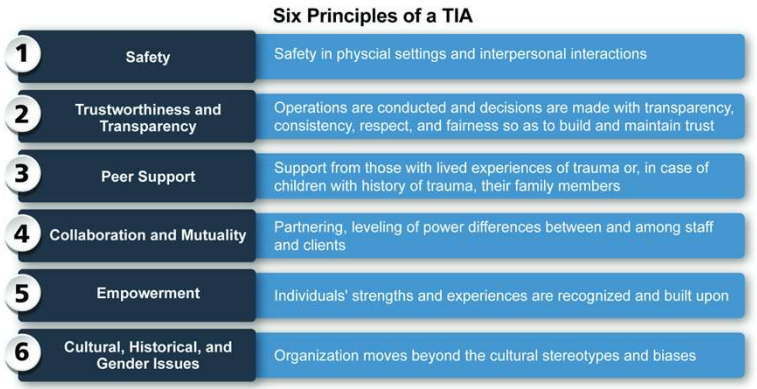
Based on the work of the Substance Abuse and Mental Health Services Administration, the six principles of the trauma-informed approach include:

- **Safety.** Creating an environment where people receiving care, their families, and staff feel physically and psychologically safe.
- **Trustworthiness and transparency.** Ensuring that operations and decisions are clear and transparent to build and maintain trust among people receiving care, family members, and staff.
- **Peer support.** Connecting people receiving care and their family members with others who have shared experiences to offer mutual understanding, support, and self-help.
- **Collaboration and mutuality.** Leveling power differences and recognizing all staff, people receiving care, and families have an important role to play in the care and support provided.
- **Empowerment, voice, and choice.** Recognizing and building off an individual's strengths and experiences, ensuring their own choice, goal setting, and decision-making.
- **Cultural, historical, and gender considerations.** Providing culturally responsive care and support that account for historical trauma, traditional cultural practices, justice, equity, and inclusion.

Trauma-Informed Care

Trauma-informed approach to assessment considers the client's trauma experiences in ALL[13] aspects of

- Intake
- Testing
- Diagnosis
- Feedback



Prioritizing client's sense of choice, safety and control[13].

How do we do this?

Substance Abuse and Mental Health Services Administration: Practical Guide for Implementing a Trauma-Informed Approach. SAMHSA Publication No. PEP23-06-05-005. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Service Administration, 2023.

Where to start?: The more you know! Cognition!

How does trauma impact development, adaptive and coping skills, and physical and mental health, and **cognitive functioning**?

Overall cognitive ability, and specific Cognitive Domains can be impaired by trauma exposure.[14,16,17, 18] Such as:

- **Complex Attention/Working Memory**[14,15,16]
- **Memory**[1,14,16]
- **Executive functions**[1,14] (ability to plan, organize, and regulate goal-directed behavior)

And trauma survivors often present with cognitive complaints.

What does this look like?: Complex Attention Deficits

- Impairment in spontaneous and focused attention, poor performance in attentional tasks; performance may fluctuate during the day and from day to day. [1]
  - *Major Deficits :* Has increased difficulty in environments with multiple stimuli (TV, radio, conversation); is easily distracted by competing events. Is unable to attend unless input is restricted and simplified. Has difficulty holding new information in mind, such as recalling phone numbers just given, or reporting what was just said. Is unable to perform mental calculations. All thinking takes longer than usual, and components to be processed must be simplified to one or a few.
  - *Mild:* Normal tasks take longer than previously. Begins to find errors in routine tasks; finds work needs more double-checking than previously. Thinking is easier when not competing with other things (radio, TV, other conversations, cell phone, driving). [5]

What does this look like?: Executive Function Deficits

Impairment in tasks requiring initiation, planning, concept formation, rule finding, set shifting or set maintenance; impaired mental speed. [1]

- *Major Deficits :* Abandons complex projects. Needs to focus on one task at a time. Needs to rely on others to plan instrumental activities of daily living or make decisions.
- *Mild Deficits:* Increased effort required to complete multistage projects. Has increased difficulty multitasking or difficulty resuming a task interrupted by a visitor or phone call. May complain of increased fatigue from the extra effort required to organize, plan, and make decisions. May report that large social gatherings are more taxing or less enjoyable because of increased effort required to follow shifting conversations. [5]

What does this look like?: Memory Deficits

Impairment in free recall of recent events or in tasks requiring learning new material, memory usually improves with cueing, recognition is usually better than free recall. [1]

- *Major Deficits :* Repeats self in conversation, often within the same conversation. Cannot keep track of short list of items when shopping or of plans for the day. Requires frequent reminders to orient to task at hand.
- *Mild:* Has difficulty recalling recent events, and relies increasingly on list making or calendar. Needs occasional reminders or re-reading to keep track of characters in a movie or novel. Occasionally may repeat self over a few weeks to the same person. Loses track of whether bills have already been paid [5]

But when is it Dementia?

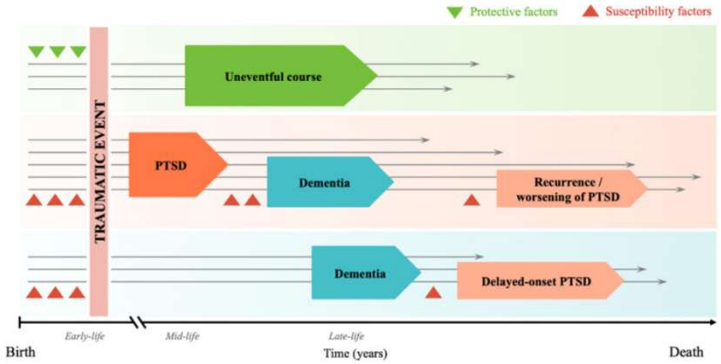
"Dementia" is acquired cognitive decline in one or more areas caused by a variety of underlying neuropathologies[20] (e.g. Alzheimer's, vascular, lewy bodies, Pick, Parkinson, Huntington, etc.) that affects between 4 to 5 million older adults in the United states[21].

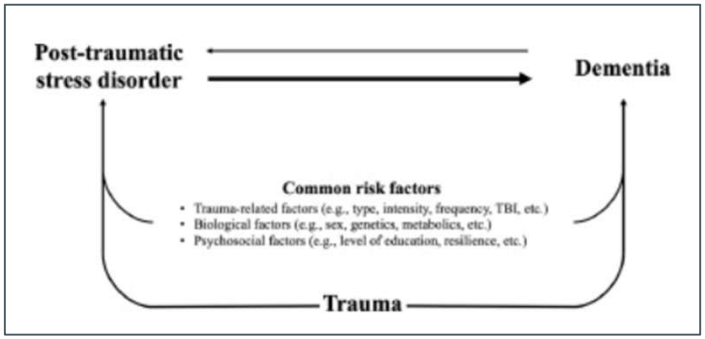
Trauma and Dementia?

Individuals with PTSD may have up to twice the risk of developing dementia compared to the general population.[10,11]

BUT intervention is possible and social support may be protective [12]

So how do we intervene?





Trauma Informed Intakes

Screen everyone for possible trauma and suicide [22]

- **Present focused:** When gathering information, consider the purpose of the request in relation to present functioning and health
- **Transparent**: Talk about why you are asking and how the findings will be used
- **Psychoeducate:** Trauma impacts self-regulation and cognition AND normalization on this in relation to coping (i.e. emotion/executive functioning and attention)
- **Autonomy (Voice and Choice)**: Trauma informed care does not require discussing trauma details and remind clients they have a choice to "skip" or not answer questions
- **Ground (Safety)**: Taking breaks when needed and make sure client is safe and ready to leave

How do I screen cognition in a Trauma informed way?

Always Assess in later life?

- Maybe! Utilizing a good Global Cognitive Screener [23] can give clients more information about how they are functioning AND reduce distress:
  - **Montreal Cognitive Assessment** (MoCA; 10 min.)
  - Mattis Dementia Rating Scale (MDRS; 20-30 min.)
- Or Test by Cognitive Domain but watch for triggering content (i.e. Ana Tompson of South Boston)

So, I should always Screen?

Many individuals with cognitive decline or dementia do not receive a diagnosis. One study showed that physicians were unaware of cognitive impairment in more than 40 percent of their patients with impairment[24] and another that 55 percent of patients with cognitive impairment had not been evaluated by a physician[25]

This failure to evaluate cognitive complaints can delay treatment of underlying disease and may result in safety issues for the patient and others[26,27]as these cognitive issues often worsen over time. [26, 28,29]

Screening can be Therapeutic?[30]

Yes!

Benefits of Early Screening

- ✔ ***If screening is negative:*** Concerns may be alleviated, at least at that point in time.
- ✔ ***If screening is positive and further evaluation is warranted:*** The patient and physician can take the next step of identifying the cause of impairment (for example, medication side effects, metabolic and/or endocrine imbalance, delirium, depression, Alzheimer's disease). This may result in:
  - Treating the underlying disease or health condition
  - Managing comorbid conditions more effectively
  - Averting or addressing potential safety issues
  - Allowing the patient to create or update advance directives and plan long-term care
  - Ensuring the patient has a caregiver or someone to help with medical, legal, and financial concerns
  - Ensuring the caregiver receives appropriate information and referrals
  - Encouraging participation in clinical research

Trauma-Informed Cognitive Feedback[13]

If a cognitive screener is "fine" but the client reports difficulty?

- Provide therapeutic feedback that acknowledges and validates distress regarding impaired functioning and perceived loss[31]

If cognitive screener indicates decline, what do we do?

- Provide feedback about current functioning, strengths and recommend follow up to identify strategies to offset deficit areas and aid future planning. [32]

Overall, feedback should emphasis screener is a "snapshot" and cognitive change is a symptom of trauma related psychopathology which could be addressed in psychotherapy (i.e. emotions can impact your results)[33]

So what can we do?: Takeaways

- Trauma's impact on psychological and cognitive functioning is prevalent and impactful (to patients, caregivers, and treatment providers)!
- Detection is possible with proper and routine assessment.
- With proper detection, we can improve quality of care and modify deficits!

Questions?

Comments?

Concerns?

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Integrating PCTI Approaches in Treatment of Serious Mental Illness

Jennifer Davidtz, PhD

Introduction

- **Overview of Serious Mental Illness (SMI)**
  - Conditions significantly impairing functional capacity (employment, relationships, daily responsibilities)
  - Common diagnoses: Major Depressive Disorder, Bipolar I/II, Schizophrenia/Schizoaffective Disorder, PTSD, personality disorders, severe anxiety disorders
- **The Salience of Trauma in SMI Population**
  - High prevalence of trauma exposure in SMI populations: >90% report at least one traumatic event
  - Current PTSD prevalence in SMI populations (28-43%) significantly higher than general population (3.5-7%)
  - Increased risk of repeated traumatization: CTSD

Why Trauma-informed care is Essential

- The experience of SMI is influenced by trauma – trauma is one of the most salient pathways to SMI – *and* it exacerbates trauma
- Comorbidity of SMI and trauma complicates symptom presentation and treatment
- A trauma-informed approach recognizes that health and well-being are influenced by individual, interpersonal, organizational, community, and policy factors: cf community psychology values:
  - Acknowledgement of social inequalities
  - Social responsibility of providers
  - Ecological approach (person in context)
  - Empowerment
  - Citizen Participation/self help
  - Focus on strengths
  - Public policy

Guiding Principles

PERSON-CENTERED

- Personalization
- Self-determination
- Coordination
- Respect

TRAUMA-INFORMED

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender considerations

Core Tenets of PCTI Care for SMI

- Holistic and Individualized Care: Acknowledges the role of trauma while centering on strengths, agency, and dignity
- Prioritizing Safety and Preventing Re-traumatization: Providing education/information and fostering the development of skills to reduce the risk of further harm
- Fostering Agency, Dignity, and Self-Determination: Empowering individuals to direct their care and reinforce competence
- Collaborative Decision-Making with Patients and Families: Partnership approach, including peer support, which acknowledges the importance of community
- Addressing Social Determinants of Health and Structural Inequities: Advocating for equitable access regardless of background

Benefits of Integrated PCTI for SMI

- Treatment plans addressing SMI symptoms and trauma simultaneously
- Lower risk of relapse and improved long-term outcomes (e.g., reduced substance use, hospitalizations)
- Enhanced patient engagement and trust, leading to better adherence
- Improved staff well-being and reduced burnout

Evidence Based Practice: SMI

- Individual and group psychotherapy:
  - Psychodynamic, cognitive behavioral, humanistic/existential, supportive psychotherapy
- Assertive Community Treatment
- Intensive Case Management (ICM)
- Dual diagnosis treatment programs (SUD and SMI)
- Family focused approaches
- Clubhouses
- Supported employment, vocational rehabilitation

Evidence based practice: trauma

- Three-phase model for CTSD:
  - Safety and stabilization
  - Remembrance and mourning
  - Reconnection and integration
- Skills-based approaches:
  - Dialectical behavior therapy
  - Skills training in affect and interpersonal regulation (STAIR)
- Trauma processing approaches
  - Cognitive processing therapy (CPT)
  - Prolonged exposure (PE)
  - Eye Movement Desensitization and Reprocessing
  - Other: narrative therapy, somatic therapy

Outcomes

- Increased trust, adherence, and collaboration
- Reduced symptoms, improved functioning, improved agency and subjective well-being
- Reduced need for restrictive and coercive treatment approaches
- Improved staff morale and decreased burnout and vicarious/secondary traumatization

Challenges

- Holding in mind that we are treating people, not diagnoses – the role of stigma and the medical model in perpetuating this challenge
- Access to care and resources
- Training for clinicians in trauma-informed care
- Interdisciplinary collaboration
- Support by leadership/administration – the different levels of "the container and the contained" (Bion, 1962)

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PCTI Assessment and Treatment: Substance Use Disorders and Aging

Jessica J. Ruiz, PsyD, ABPP

Are Substance Use Disorders Common in Late-Life?

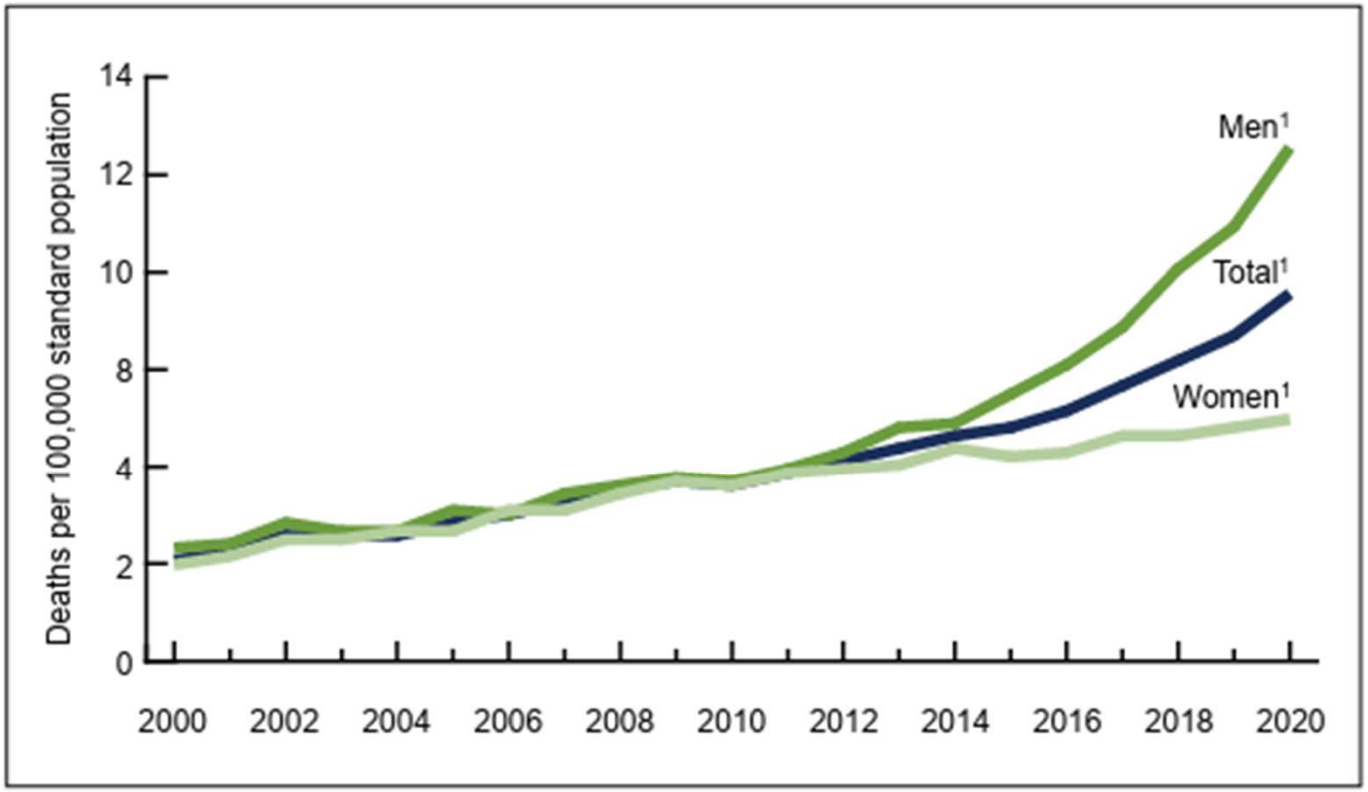
Prevalence of Substance Use Disorders (SUDs) in Older Adults

- Historically, older adults have not had high rates of drug use.
- This is changing…
- Members of the Baby Boomer generation have the highest rates of early life substance use and are more likely to continue substance use into later life.
- Rate of SUDs in older individuals has more than doubled from 2007 to 2020.
- The rate of SUDs in current group of older adults is higher than any previous cohort of older adults.
- The number of older adults needing treatment for SUDs is increasing across genders and all racial/ethnic groups.

Rates of drug overdose deaths for adults aged 65 and over increased from 2000 through 2020.

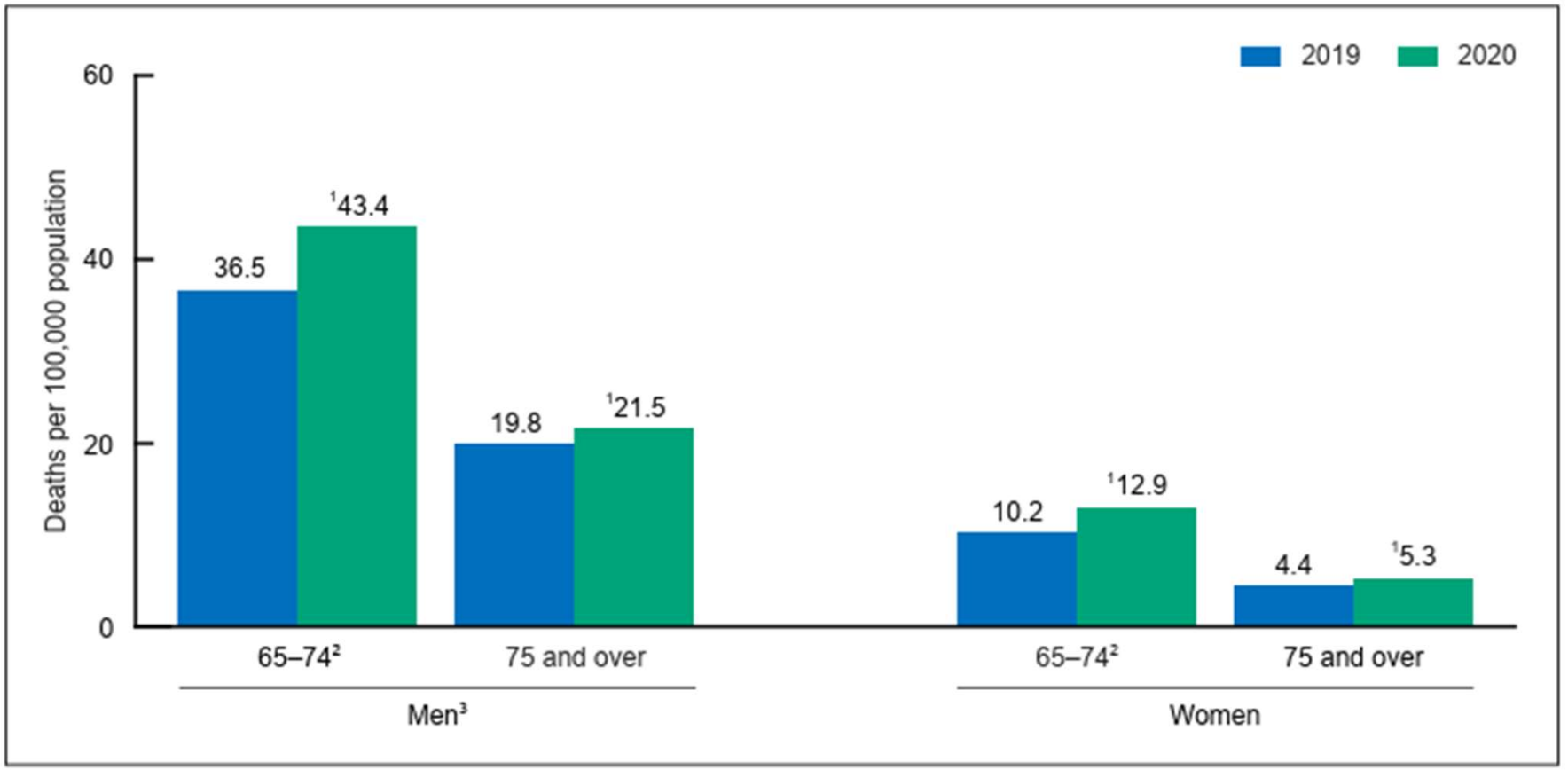
- Between 2000 and 2020, age-adjusted rates of drug overdose deaths for adults aged 65 and over increased from 2.4 deaths per 100,000 standard population to 8.8 (Figure 1).

Figure 1. Age-adjusted drug overdose death rate for adults aged 65 and over, by sex: United States, 2000–2020



[1]Significant increasing trend from 2000 through 2020 with different rates of change over time; $p < 0.05$.
NOTES: Drug overdose deaths are identified using the *International Classification of Diseases, 10th Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db455-tables.pdf#1.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Figure 1. Rate of alcohol-induced death for adults aged 65 and over, by age group, sex, and year: United States, 2019 and 2020



[1]Rate significantly higher than rate in 2019, $p < 0.05$.
[2]Rates significantly higher than those for age 75 and over in each year, $p < 0.05$.
[3]Rates significantly higher than those for women for all age groups and years, $p < 0.05$.
NOTE: Alcohol-induced deaths are identified using *International Classification of Diseases, 10th Revision* codes E24.4, F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K85.2, K86.0, R78.0, X45, X65, and Y15.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Dr. Sanjay Gupta: Cannabis is having a senior moment



By Dr. Sanjay Gupta, CNN

8 minute read · Updated 11:37 AM EDT, Mon August 7, 2023



Risk Factors for SUD in Late Life

Physical Risk Factors:

- Male sex (for alcohol), female sex (for prescription drug)
- Caucasian ethnicity
- Chronic pain
- Physical disabilities or reduced mobility
- Transitions in care/living situations
- Poor health status
- Chronic physical illness/polymorbidity
- Significant drug burden/polypharmacy

Psychiatric risk factors:

- Avoidance coping style
- History of alcohol problems
- Previous and/or concurrent SUD
- Previous and/or concurrent psychiatric illness

Social risk factors:

- Affluence
- Bereavement
- Unexpected or forced retirement
- Social isolation (living alone or with nonspousal others)

Substance Use Disorders (SUDs) in Late Life

- Increased Risk of:
  - Mood & anxiety disorders (in particular, depression, anxiety, and PTSD)
  - Sleep disorders
  - Cognitive impairment
  - Drug interactions (slower metabolism, lower body fat)
  - Greater physical disability (liver disease, cardiomyopathy, falls)
  - More severe withdrawal
  - Interactions with medications

How many adults 65+ use alcohol?

- The 2023 National Survey on Drug Use and Health (NSDUH) reported that **28.9 million people ages 12 and older** met criteria for an Alcohol Use Disorder (AUD) in the past year

- **2.7 million people ages 65+ met** criteria for an AUD in the past year
  - In the past one-month period
    - **7.0 million** people ages 65+ reported binge drinking
    - **1.9 million** people ages 65+ reported heavy alcohol use

- In 2020-2021, **38% of all alcohol-related deaths** were people ages 65+

- (NIAAA, 2024b)

Alcohol Use and Aging



Effects Change as we Age



The body's ability to metabolize alcohol **slows with aging** and makes the body more sensitive to its effects



Age-related physiological changes:

Decreased lean muscle mass
Less water in the body



As a result **older adults reach a higher blood alcohol content** (BAC) than younger adults when **consuming the same amount of alcohol**

Less muscle to absorb alcohol
Higher risk at any level of use
Increased risk of dehydration

(Merrick et al., 2008; Owens, 2023)

Impact of alcohol use on older adults



Cognitive impacts

- Reduced cognitive functioning
- Neurocognitive impairment
- Issues with memory, thinking, attention, and judgement



Biological impacts

- Lower global brain volumes
- Increased CNS dysfunction
- Aging makes organ systems (e.g., liver) more vulnerable to alcohol



Motor impacts

- Impaired reaction time, coordination, and balance



Increased risk of accidents

- Greater risk of falls and related injuries
- Impaired driving precision leading to more car crashes

(Allen et al., 2024; NIAAA, 2024a; Keyes et al., 2023; Matthews & Koob, 2023; Sklar et al., 2014)

Impact of alcohol use on older adults



Mental health conditions

- Alcohol consumption can worsen existing mental health conditions (e.g., depression)



Physical health conditions

- Alcohol can worsen common medical conditions (e.g., diabetes, respiratory infections)
- Contributing cause of cancer, cardiovascular disease, & liver damage



Hospitalization and mortality

- Older adults have highest rate of alcohol-related ER visits
- Greater risk of mortality
- Increased rate of hospitalizations



Polypharmacy

- Older adults at greater risk of polypharmacy (multiple medical conditions)
- Medication interactions

(Allen et al., 2024; Keyes et al., 2023; Owens , 2023)

Trauma and Substance Use

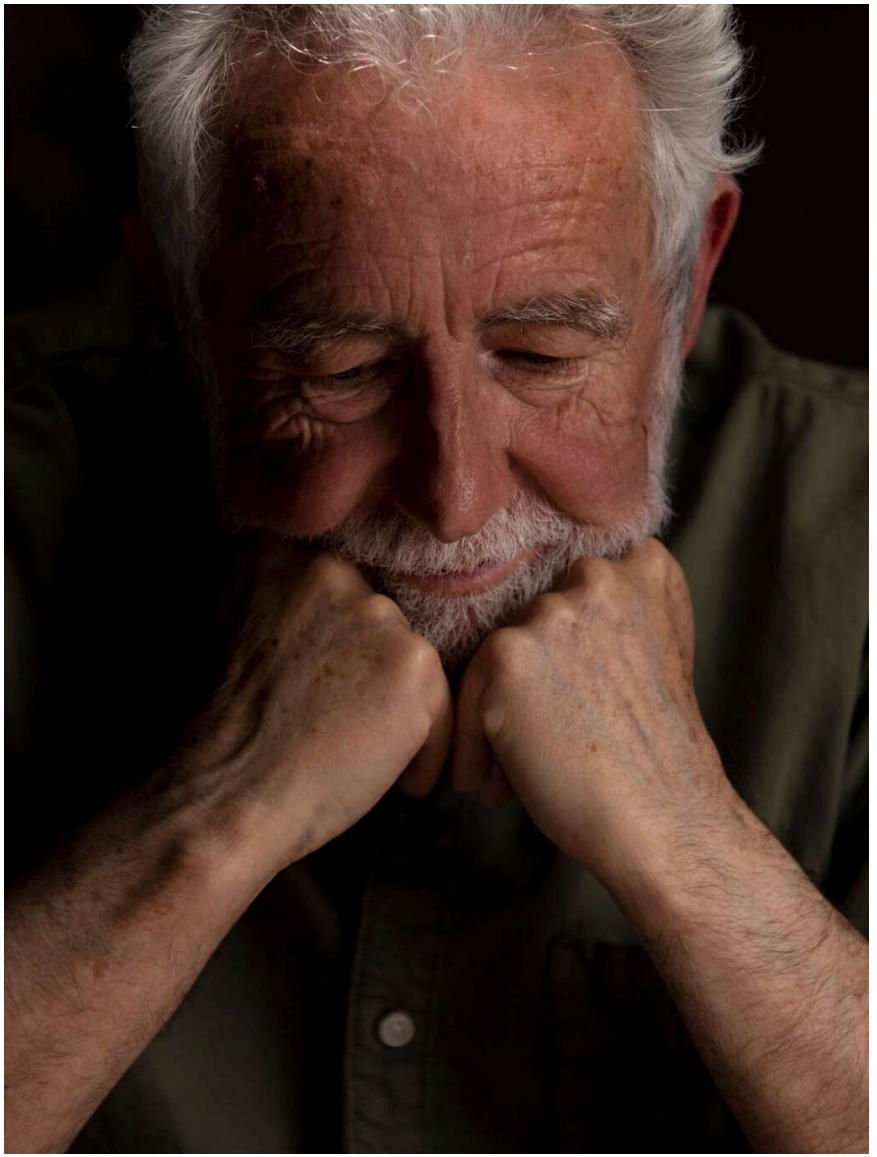




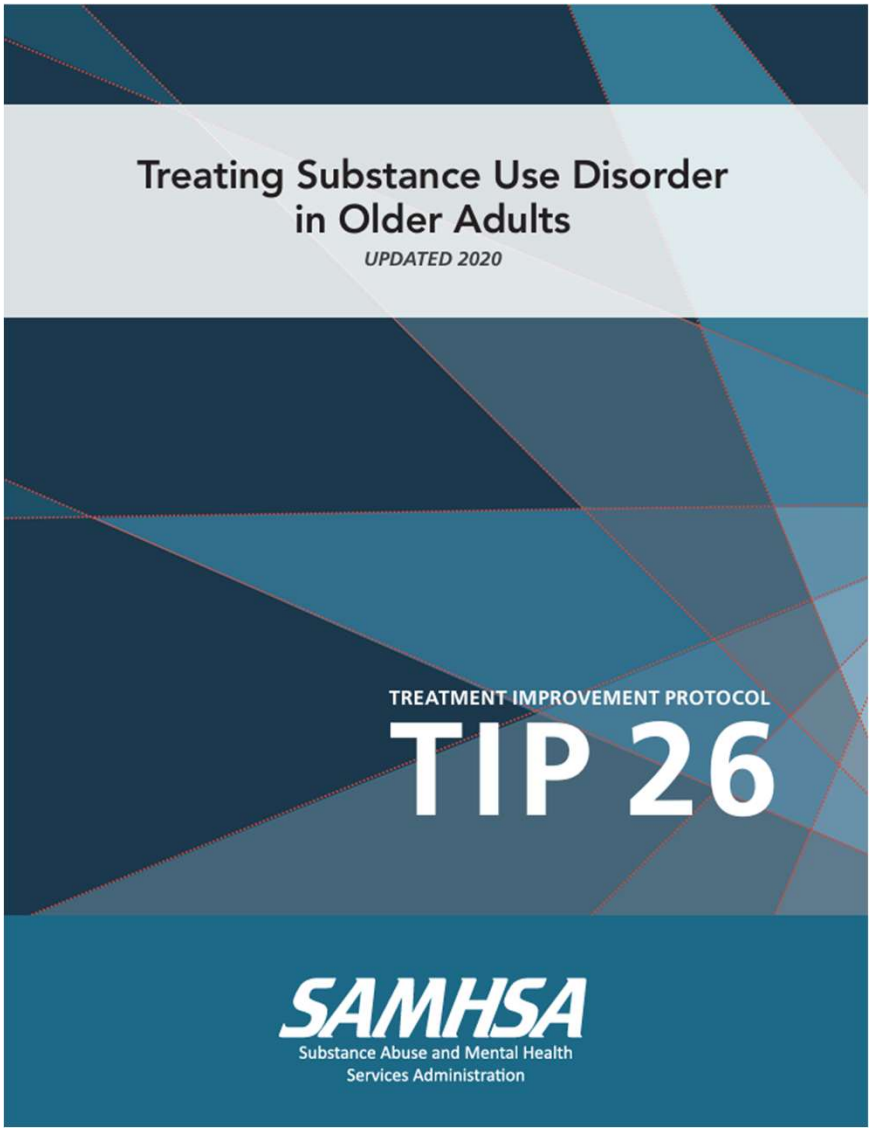
Missing the Mark



Barriers to Treatment



Importance of Screening



PCTI Assessment

- Language is important- mindful of how we ask about use, avoid labels (e.g. “addict” “alcoholic”).
- Age-sensitive and age-specific interventions can help increase older adults’ chances of achieving and sustaining long-term recovery.
- The treatment/service environment itself also should be adapted to this population, for example, through organization-wide training and encouragement of staff attitudes responsive to older clients’ needs.
- Consider each older client’s cultural background, gender, and age of onset of an SUD, all of which can influence treatment needs and recovery outcomes.

Diagnostic Considerations- SUD and Aging

- SUD can be difficult to recognize in older adults and lead to treatment delays due to medical comorbidity, neurocognitive impairment, and functional decline (Seim et al., 2020).
- A key consideration in the treatment of older adults with SUD is that they often have co-occurring general medical illnesses (Wu and Blazer, 2014).
- Substance use can complicate the course and management of existing illnesses and they, in turn, can worsen the consequences of substance use and SUD.

Screening Tools

- **Alcohol Use Disorders Identification Test (AUDIT)**
  - Assesses alcohol consumption, drinking behaviors, and alcohol-related problems
- **Comorbidity Alcohol Risk Evaluation Tool (CARET)**
  - Identifies older adults with specific behaviors that place them at increased risk for harm from alcohol
- **Short Michigan Alcohol Screening Test- Geriatrics (SMAST-G)**
  - Identifies potential alcohol abuse in older adults

(Han & Moore, 2018; Naegle, 2012; Owens, 2023)

Alcohol Screening for Older Adults

Michigan Alcoholism Screening Test—Geriatric Version (MAST-G)

1. After drinking have you ever noticed an increase in your heart rate or beating in your chest?
2. When talking with others, do you ever underestimate how much you actually drink?
3. Does alcohol make you sleepy so that you often fall asleep in your chair?
4. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
5. Does having a few drinks help decrease your shakiness or tremors?
6. Does alcohol sometimes make it hard for you to remember parts of the day or night?
7. Do you have rules for yourself that you won't drink before a certain time of the day?
8. Have you lost interest in hobbies or activities you used to enjoy?
9. When you wake up in the morning, do you ever have trouble remembering part of the night before?
10. Does having a drink help you sleep?

Motivational Interviewing (MI)

- Motivational interviewing (MI) is an approach to counseling that aims to strengthen a person's motivation and commitment to behavior change by helping them resolve their ambivalence about the change. MI fosters a partnership between clinicians and patients, allowing the clinician to demonstrate empathy, build rapport with the patient, learn about the patient's world, and help the patient achieve change

PCTI Care and MI

MI Spirit incorporates four interwoven processes: Partnership, Acceptance, Compassion, and Evocation (PACE) (Miller & Rollnick, 2013):

- **Partnership** is an active collaboration between provider and client. A client is more willing to express concerns when the provider is empathetic and shows genuine curiosity about the client's perspective.

- **Acceptance** is the act of demonstrating **respect for and approval of the client**. It shows the provider's **intent to understand** the client's point of view and concerns. Providers can use MI's four components of acceptance—absolute worth, accurate empathy**, autonomy support**, and affirmation—to help them appreciate the client's situation and decisions.

- **Compassion** refers to the provider actively promoting the client's welfare and prioritizing the client's needs.

- **Evocation** is the process of eliciting and exploring a client's existing motivations, values, strengths, and resources.

Interventions

- Guided Self-Change
- COPE Model
- Seeking Safety
- Creating Change Model


Q&A

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