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# The Case for Early Psychotherapy in Aging Combat Veterans Experiencing Late Onset Stress Symptomatology

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Delayed onset post-traumatic stress disorder (DPTSD) is defined as onset of PTSD symptoms 6 months or more after a trauma. There is a wide range of variation in prevalence of DPTSD in combat veterans, ranging from 8.3-34% [1-3], but many studies cite a narrower prevalence of 20-25% [4-6]. Symptoms of combat related DPTSD may develop even after a prolonged silent period of 20-40 years [7]. The presence of life stressors such as the deterioration of physical health, death of family members and friends, retirement and lack of social support can precipitate trauma related symptoms in later life. Brain aging may also be a variable as one case report found an association with cognitive deficits with delayed onset of trauma and stress related symptoms [8].

DPTSD may be a part of the waxing and waning nature of PTSD [9]. It may present clinically following a symptom free period [10,11] as an exacerbation of sub threshold PTSD symptoms, or following many of the stressful events accompanying aging such as loss of employment. Loss of partner or loss of independence may also precipitate DPTSD [2,5,10]. Individual coping and resilience play important roles in development of these symptoms [12-14].

While PTSD is recognized as a clinical disorder, stress related symptoms may emerge in a non-pathological form called late onset stress symptomatology (LOSS). It is considered to be part of the spectrum of the normal ageing process. However, if not resolved, LOSS may progress to sub threshold or full blown PTSD with more severe clinical symptoms and life disruption [7,15,16]. Davison et al. [7] characterized the LOSS phenomenon in ageing combat veterans who were: a) exposed to highly stressful combat events in their early adulthood; b) asymptomatic for years after trauma exposure; c) functionally successful over the course of their lives; and d) begin to register increased combat related thoughts, feelings and reminiscences as they encounter the changes and challenges of ageing. LOSS symptoms may be precipitated by significant life stressors, and/or emerging cognitive deficits [8]. Rather than having the core symptoms of PTSD such as flashbacks, avoidance and negative emotions, LOSS symptoms comprise repeated thoughts about combat related trauma, irritability and/or nightmares that do not impair daily functioning [15,16].

There are biological factors associated with trauma and stress related disorders such as hippocampus damage following prolonged exposure to stress with decreased volume [17-19], altered hypothalamic-pituitary-adrenal axis function, increased pro-inflammatory cytokines [20-22] and decreased N- Acetyl Aspartate [23]. In one study of middle aged and elderly veterans, there was no difference in hippocampal volume between veterans with and without PTSD. However, veterans that developed PTSD following their first traumatic event had smaller left hippocampal volumes compared to veterans developed PTSD after exposure to multiple traumatic events. Also, veterans with PTSD had significantly lower urinary cortisol levels and diminished memory performance when compares to veterans without PTSD [24].

As Vietnam era combat veterans are entering, or have entered the years when LOSS is most commonly encountered, it is important to understand the differences among LOSS, subthreshold PTSD and full PTSD, as treatment and psychotherapy are not the same for each presentation [8]. LOSS patients do not need psychiatric medications, but may benefit from psych educational or life review therapeutic approaches [25,26]. The life review approach, which is also called reminiscence therapy, is a form of vocal or silent recall of life events either in individual or group settings. During therapy veterans attempt to accept the negative events, resolve past conflicts, recollect positive memories and reconcile the discrepancy between the ideal and reality. Participants are assisted in finding meaning and worth in life as it was lived, which is critical for successful ageing [26]. Cappeliez et al. [27] suggests placing these functions within a narrative that provides an uplifting life frame work. A number of studies show significant benefit in using 'props' such as photographs, videos, scents, music in older adults with depression and cognitive impairment [28-31]. With these psychotherapeutic approaches, ageing combat veterans are able to recall positive events in their premilitary, military and post military life that were the foundation of their positive quality of life prior to the onset of LOSS. Hence, rekindling their faltering or lost positive self-identity prior to the stressors accompanying aging, in addition to building problem solving skills using CBT, may reduce their negative perceptions and undergird the positive cognitive processes that had enabled them in the past to have a healthy life with normal ageing for decades following their combat tours.

If LOSS can be conceptualized as a normal aging event, which is a reversible phase of combat stress, early therapeutic intervention using established non pharmacologic augmented psychotherapeutic methods, may result in significant clinical benefits. As LOSS is considered a healthy, but transitional, state along the continuum of combat stress sequelae, early intervention is recommended to prevent the progression of LOSS to subthreshold PTSD and full PTSD. Such strategies should improve the veterans' quality of life in their elder years and reduce health care system burden (Figure 1).

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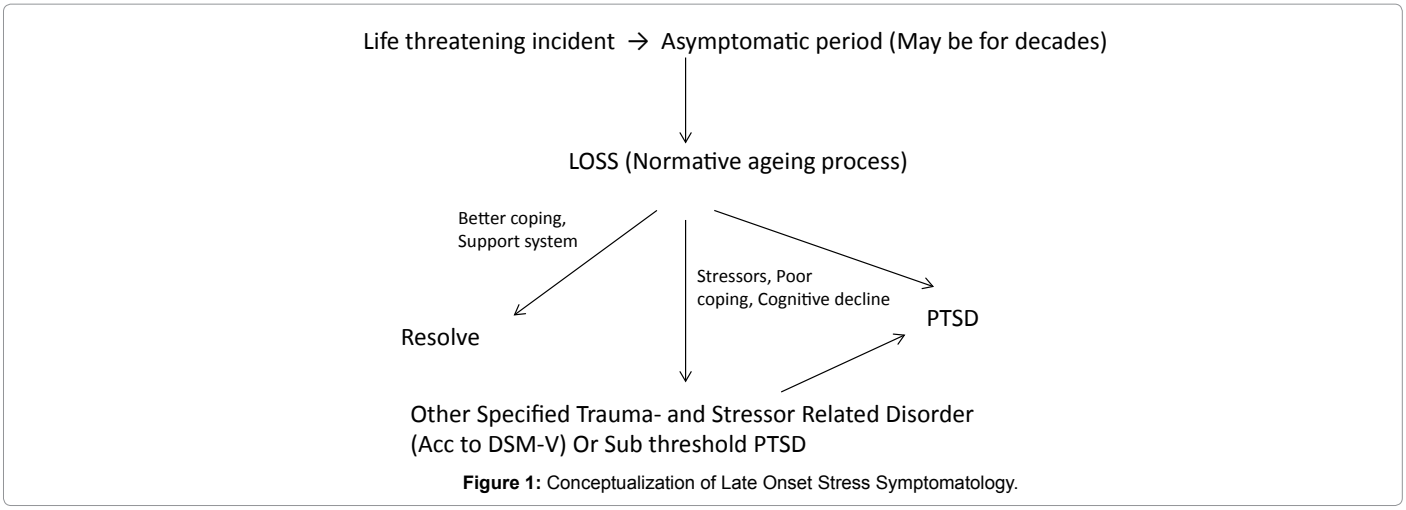


**Figure 1:** Conceptualization of Late Onset Stress Symptomatology.

## Conflict of Interest

The authors report no conflict of interest. The report findings do not represent the views of the Department of Veterans Affairs or the United States Government.

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