

## Prolonged Exposure Therapy for a Vietnam Veteran With PTSD and Early-Stage Dementia

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*Although prolonged exposure therapy (PE) is considered an evidence-based treatment for PTSD, there has been little published about the use of this treatment for older adults with comorbid early-stage dementia. As the number of older adults in the United States continues to grow, so will their unique mental health needs. The present article describes the successful coordination of care and application of PE in the assessment and treatment of a Vietnam veteran with comorbid PTSD and early-stage dementia. Measures related to the patient's cognitive and psychological functioning were obtained before, during, and after treatment. PE was associated with significant declines in PTSD and depression symptoms. Moreover, the patient's cognitive functioning was made clearer in the absence of severe psychiatric symptoms. Factors contributing to the patient's positive response are discussed.*

ACCORDING to the 2010 U.S. Census, there are approximately 40 million individuals age 65 years and older living in the United States (Werner, 2011). Between 2000 and 2010, this sector of the population increased by 15.1% and is one of the country's fastest growing age groups (Howden & Meyer, 2011). Given this rapid increase, there is a growing urgency to develop innovative treatments not only to address older adults' medical needs, but also their concomitant mental health needs (Jeste et al., 1999).

Currently, depression and anxiety are the most common mental health conditions reported among older adults (Kastenschmidt & Kennedy, 2011). In a large-scale, 12-month prevalence study of Massachusetts Medicare and Medicaid enrollees ages 65 and older, 13.2% had depressive disorders, followed by 6.3% with anxiety disorders (Lin, Zhang, Leung, & Clark, 2011). In this study, chronic posttraumatic stress disorder (PTSD) was not included in the anxiety disorder category, but was rather subsumed into an "other" category that included patients with adjustment disorders and unspecified psychosis. Twelve-month prevalence rates approached 14.5% when examining the anxiety disorder and "other"

categories together. This study also showed an 11.2% 12-month prevalence rate of dementia. Thus, anxiety, depression, and dementia are common and important clinical issues to identify, manage, and treat when working with older adults.

With regard to anxiety disorders specifically, PTSD among older adult veterans may be more common than typically discussed in the literature on geriatric mental health needs at large. Rauch, Morales, Zubritsky, Knott, and Oslin (2006) found that 18% of older adults in VA primary care and 8% of older adults in non-VA primary care report PTSD symptoms. In another review, Averill and Beck (2000) found that the prevalence of PTSD among World War II and Korean veterans ranged from 3% to 56%, depending upon sample characteristics and diagnostic methods. A number of case studies have also documented the presence of PTSD among older adults (Burgmer & Heuft, 2004; Johnston, 2000; Mittal, Torres, Abashidze, & Jimerson, 2001; van Achterberg, Rohrbach, & Southwick, 2001). Among Vietnam War veterans specifically, possible delayed-onset PTSD has been observed (Watson, Kucala, Manifold, & Vassar, 1988). This later-onset pattern has been attributed to various causes, including age-associated reductions in physical and mental resilience (Ruzich, Looi, & Robertson, 2005), life events such as retirement and bereavement, current sociopolitical events resembling past traumas (e.g., Persian Gulf War, Operation Iraqi Freedom, Operation Enduring Freedom), and developmental tasks specific to later life (e.g., finding meaning; Averill & Beck, 2000). Of

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note, two recent studies showed that veterans with PTSD may be twice as likely to develop dementia later in life compared to those without PTSD (Qureshi et al., 2010; Yaffe et al., 2010). Thus, with regard to the older veteran population in particular, PTSD and dementia may be a common co-occurrence that clinicians will increasingly need to address.

There have been promising advances in the development and adaptation of psychosocial treatments for treating depression and anxiety in older adults. Cognitive behavioral therapy, interpersonal therapy, and problem-solving therapy have been shown to be efficacious in the treatment of older adults with depression (Cuijpers, van Straten, Andersson, & van Oppen, 2008; Das, Greenspan, Muralee, Choe, & Tampi, 2007). Cognitive behavioral therapy has also been shown to be effective in the treatment of anxiety among older adults (Ayers, Sorrell, Thorp, & Wetherell, 2007; Schuurmans et al., 2006; Stanley et al., 2009). Despite this progress, many of these studies have excluded older adults with cognitive impairments. Moreover, there are no clinical guidelines or controlled trials to inform clinicians' work with older adults with PTSD and mild to moderate cognitive impairments, such as early-stage dementia.

In the Institute of Medicine's recent review of the state of PTSD treatment, only exposure therapies were considered sufficiently empirically supported for treatment of PTSD (Institute of Medicine, 2007). Prolonged exposure therapy (PE), a particular variant of exposure therapy, has been shown to be particularly effective in treating PTSD across various trauma samples, including combat veterans (Foa et al., 1999, 2005; Paunovic & Ost, 2001; Rauch et al., 2009; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Rothbaum, Astin, & Marsteller, 2005; Schnurr et al., 2007; Tuerk et al., 2011). Despite the strong evidence base for PE, clinicians may assume that adults with PTSD and dementia would be inappropriate candidates for PE given their cognitive, perceptual, and motor limitations. Notably, however, the neuropsychological profiles of patients with PTSD show some of the same performance deficiencies as patients with dementia, such as deficits in tasks of attention, verbal memory, and executive functioning (Scott Mackin, Lesselyong, & Yaffe, 2011; Vasterling, Brailey, Constans, & Sutker, 1998). Unsurprisingly, there is currently no convincing evidence that PE would be contraindicated for individuals with PTSD and mild to moderate co-occurring cognitive deficits. Moreover, given that PE places more emphasis on behavioral assignments such as in-vivo exposure, this approach may be more appropriate than other evidence-based treatments for PTSD that place more emphasis on cognitive restructuring (e.g., Cognitive Processing Therapy). This is supported by research showing that behavior management therapies to address the neuropsychiatric symptoms associated with dementia are superior to and more durable than other psychosocial

interventions (Livingston, Johnston, Katona, Paton, & Lyketsos, 2005).

The purpose of this case report is to present a clinical example of implementing PE to treat PTSD in a Vietnam veteran with early-stage dementia. Although there are methodological limitations inherent to case reports, we hope this report will (1) offer clinical suggestions for assessing and treating adults with this diagnostic presentation, (2) highlight the important role that the treatment of psychiatric symptoms can play in improving differential diagnosis and the quality of life in adults with dementia, and (3) stimulate scholarly inquiry into this clinical topic.

## Case Presentation

### Demographics and Presenting Problem

The patient, Mr. C,<sup>1</sup> was a 65-year-old Air Force veteran, evaluated and treated across four clinics at a Midwestern VA medical center in the United States: Primary Care, Neuropsychology, Geropsychiatry, and the PTSD clinic. The time line for his evaluation and treatment across these four clinics is depicted in Figure 1.<sup>2</sup> Mr. C served in a noncombat position in the Air Force for 18 months during the Vietnam War. Upon returning from Vietnam, Mr. C was employed for 35 years as a machinist until he was encouraged to retire early due to declining work performance. Mr. C presented to primary care in January of Year 1 with executive functioning and memory deficits, including a loss of well-learned technical skills, loss of computer and mathematical skills, forgetfulness in daily conversation/activities, as well as an increase in PTSD symptoms related to a trauma he witnessed while serving in the Vietnam War (see below). Over the past few years of his retirement, Mr. C's wife of 40 years reported that he also exhibited personality changes such as uncharacteristic irritability and apathy. In addition, his sleep had become increasingly disrupted, and he was reportedly acting out his nightmares, which had resulted in minor physical injuries. Current or past substance abuse and closed head injuries were ruled out. Based on this presentation, Mr. C's primary care physician referred him to a geropsychiatrist and for neuropsychological testing to determine the presence of a primary mood disorder versus cognitive disorder. Mr. C's geropsychiatrist titrated him up to daily doses of 200 mg of sertraline and 10 mg of donepezil, which remained his medication regimen throughout the course of his treatment in the PTSD clinic.

<sup>1</sup>Details of this case have been modified to protect patient's confidentiality. Informed consent procedures were followed in accordance with the privacy and confidentiality guidelines put forth by the medical center and the International Committee of Medical Journal Editors.

<sup>2</sup>Although Figure 1 accurately reports the time elapsed between assessments and treatment, the months were altered to protect Mr. C's confidentiality.

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