Posttraumatic Stress Disorder in Elderly Victims of Crime:

Making the Case for Psychological Injury

By Laurence Miller

Introduction: Elderly Victims of Criminal Assault

The cost of personal crime victimization is estimated at $105 billion annually, including direct costs of medical treatment, lost earnings, and public victim assistance programs. Adding litigated compensation for pain, suffering, and loss of quality of life, bumps the yearly figure up to $450 billion.[14] The elderly may be less likely than other victims to admit to persisting psychological disability after criminal assault, or to seek help, even though they are frequent targets of crime because of their real or perceived vulnerability.[15] This reluctance frequently makes the jobs of both clinicians and attorneys difficult.

There are at least six basic ways that the elderly can be psychologically traumatized by criminal violence: (1) elders may be the direct victims of criminal assault by robbers, muggers, or other "street criminals;" (2) elders may be assaulted by other elders in nursing homes or by frustrated spouses or other family members; (3) elders may be victimized by paid caretakers, such as home health aides or nursing home staff; (4) elders can witness interpersonal violence perpetrated on a loved one, typically a spouse; (5) elders can be the bereaved survivors of violent crime, whether witnessed or not; and (6) the crime can leave the assaulted elder with orthopedic or neurocognitive injuries that impair productive functioning and quality of life, and may contribute to the overall deterioration of physical and mental health, impairment of the ability to care for or consort with a spouse, and reduced life expectancy.[16]

Posttraumatic Stress Disorder: The Clinical Syndrome

Although other kinds of psychological syndromes may follow criminal assault trauma, including phobias, anxiety, panic attacks, and depression,[18] the quintessential psychological syndrome following crime victim traumatization is *posttraumatic stress disorder*, or PTSD.[17] Diagnostically, PTSD is a syndrome of emotional and behavioral disturbance following exposure to a traumatic stressor that is typically outside the range of normal, everyday experience for that person. As a result, there develops a characteristic set of symptoms, which are fairly similar across age groups, but which may have particular manifestations in the elderly.

Anxiety: The patient describes a continual state of freefloating anxiety and maintains an intense hypervigilance, scanning the environment for impending threats of danger. Panic attacks may be occasional or frequent. In elders, this may summate with already existing anxiety about illness, finances, family relationships, or existential death issues.

Physiological Arousal: The patient's nervous system is on constant alert, producing increased bodily tension in the form of muscle tightness, tremors, restlessness, heightened startle response, fatigue, heart palpitations, breathing difficulties, dizziness, headaches, or other symptoms. For many older patients, already concerned about their health, this may lead to compulsive preoccupation with bodily functioning and the development of a *somatization disorder*, especially where the assault has resulted in physical injuries causing pain, cognitive impairment, and/or physical disfigurement.

Irritability: There is a pervasive edginess, impatience, loss of humor, and quick anger over seemingly trivial matters. Friends get annoyed, long-time acquaintances may now shun the patient, and family members may feel abused and alienated.

Avoidance/Denial: Patients try to blot out the event from their mind. They

avoid thinking about or talking about the traumatic event, as well as activities, news stories, subjects, or TV shows that remind them of the incident. Part of this is a deliberate, conscious effort to avoid trauma-reminders, while part involves an involuntary psychic numbing that blunts incoming threatening stimuli.

Intrusion: Despite patients' best efforts to keep the traumatic event out of mind, the disturbing incident pushes its way into their consciousness, typically in the form of intrusive images or flashbacks by day and/or frightening dreams at night.

Repetitive Nightmares: Sometimes the patient's nightmares recapitulate the actual traumatic event; more commonly, the dreams echo the general theme of the trauma, but miss the mark in terms of specific content. The emotional intensity of the original traumatic experience is retained, but the dream may partially disguise the actual event. PTSD-related sleep disturbance may exacerbate the already poor sleep of many elderly, further contributing to daytime fatigue and reduced activity level.

Impaired Concentration and Memory: Social and recreational functioning may be impaired as patients have difficulty remembering names, misplace objects, lose the train of conversations, or can't keep their mind focused on movies, reading material, or card games. Even subtle PTSD-related cognitive deficits may interact with already weak cognitive functioning due to pre-existing dementia and/or depression, effects of head injury sustained in the assault, or other medical complications and medication effects.[19] All these may combine to produce a "threshold effect" of impaired mental status which affects such crucial abilities as driving, keeping track of daily medications, or managing personal finances.

Withdrawal/Isolation: The patient shuns peers and family members, having lost patience for the petty, trivial concerns of everyday family and social life. The hurt feelings this engenders may spur resentment and counteravoidance by those rebuffed, leading to a vicious cycle of mutual rejection and eventual

social ostracism of the elder patient. Another "vicious threshold" may be crossed if this isolation contributes to lack of medical monitoring and/or reduced social stimulation, with deleterious effects on overall health.

Acting-Out: More rarely, traumatized elders may walk off community grounds, wander out of their familiar neighborhood, take unaccustomed risks by driving erratically or getting into dangerous confrontations with other adults, or turning to alcohol or medication abuse.

Re-Evocation of Past Traumas: Patients now in their 70's, 80's, and 90's comprise the generation of the Great Depression and World War II, for whom stoic endurance of adversity was part of their culture and upbringing. Many of these elders survived civilian or military traumas in their youths that may barely have been acknowledged, and certainly not worked-through in that "pretherapeutic" era. Preoccupied and distracted by the daily struggles of adult job and family life, they could afford to put their painful memories on the psychological back burner until the relative quiescence of retirement gives their minds more free time to dwell on the past. Like mental shrapnel that lies dormant until an additional injury triggers a painful spasm, a superimposed trauma such as a criminal assault may summate with a long-buried event to produce a synergistically boosted psychopathological reaction.[20]

Although I could find no studies that relate to crime victimization per se, there have emerged several research reports and case studies of past trauma reawakened in elders under the press of a contemporary stressor. The original experiences mostly center around the WW II era, including battlefield traumas,[21] civilian internment,[22] and the Holocaust.[23] The re-emergence of decades-old intrusive recollections, nightmares, insomnia, and hyper-vigilance in response to a current stressor is a common feature of these reactions. Age-related stressors, such as deterioration of physical health, retirement, and the death of loved ones, have all been identified as precipitants of latent PTSD symptoms.[24] Combat-related PTSD may be more likely to develop, and may produce more severe disability, where there is coexistent head injury.[25]

Several of my own cases have corroborated the association of present victimization and re-evocation of latent PTSD in elderly patients. The original experiences have ranged from WW II battlefield traumas in the European and Pacific theaters, to Holocaust concentration camp survivorship, to childhood sexual molestation by relatives (long before the time that such "abuse" issues became popular), to the experience of prior criminal victimization as children or young adults.

In these cases, the patients were retired and living satisfactory lives when their criminal assaults occurred, usually muggings, purse-snatchings, or carjackings, often with minor or no physical injuries. A typical response is: "I haven't thought about that [the old trauma] in years." These old traumas are not described as repressed, per se, since they could be volitionally recalled during the ensuing decades. Rather, these elders had managed to "put the bad memory behind them," until a current criminal traumatization dragged it to the forefront of consciousness.

Making the Case for Psychological Injury in Elderly PTSD Victims: Clinical, Forensic, and Practical Considerations

Attorneys know that there are four elements of a successful civil tort case: (1) duty, (2) negligence, (3) causation, and (4) damages. In elderly PTSD cases, the duty and negligence issues will not differ fundamentally from other tort cases, except where, for example, a facility failed to provide mandated special accommodations for the elderly and handicapped, such as wheelchair ramps or special security, or in facilities specifically geared toward the elderly, such as senior centers or nursing homes.

With regard to *causation*, the main issue will center around preexisting or coexisting medical and psychological conditions. As noted above, many of the cardinal symptoms of PTSD, such as cognitive impairment, sleep disturbance, and mood disorders, have high base rates in the elderly population. In addition, many elders may have histories of prior psychological trauma that may be contributing to the present post-assault traumatic disability syndrome.[26]

The challenge for the forensic psychologist is thus twofold: (1) to tease out the separate contributing threads of causation regarding the current psychological impairment in a particular patient, and assign, if possible, credible weightings to the various causal factors; and (2) to document how the assault trauma has exacerbated, worsened, or extended the degree or time course of disability initiated by the prior psychological injuries (if any).

The attorney's role will typically involve making the case for a *thin eggshell* effect and a but-for theory of causation: "Mr. Senior struggled during the Depression, was wounded at Iwo Jima, lost his daughter in a car crash during the Bicentennial, is recovering from a triple bypass he had last year, and now cares for his Alzheimer-afflicted wife. He has always bounced back from adversity and gamely gone on; he's a true survivor, a trooper. But his recent assault in the dimly-lit hotel parking lot was too much for even this resilient man to take - it was the proverbial straw that broke the camel's back."

The other issue relates to *damages*, and this takes two forms. First, if traumatic disabilities are cumulative, what "percentage" of the impairment is due

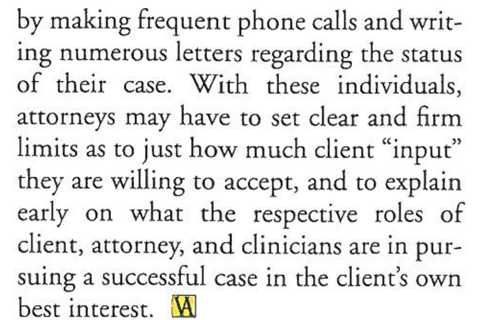
to the current injury? Clinicians and attorneys who operate within the Workers Compensation system are familiar with the challenge of quantitatively apportioning causation among different injurious events. Here again, clarity of diagnosis and skill in presenting the conclusions to the factfinder are the tools used to make an effective case for psychological injury.[27]

The other part of the damages issue relates to amount of compensation. Since most elderly are retired, lost wages and earning capacity are usually minor factors, so future health care costs and impaired quality of life become the major areas of focus. Assuming little or no physical injury, mental health costs may range from negligible (a few counseling sessions) to catastrophic (long-term psychiatric hospitalization or nursing home placement).

Typically, most elder psychological trauma victims resist extensive mental health intervention and may direct their complaints to more seemingly face-saving physical symptoms. In this regard, pain and suffering, loss of consortium, punitive damages, and other "intangible" claims may be more relevant in tort cases involving elders. It is important for attorneys to work closely with clinicians, forensic medical economists, and other experts in preparing a fair and credible demand.

A final issue relates to working with elderly clients themselves. Many of these individuals are from a generation raised to respect professionalism and defer to authority, and thus make very cooperative clients. However, as noted above, some elders may deny or downplay their disabilities, fearing that any disclosure of infirmity may render them "incompetent" or constitute a blow to their fragile ego-stability. They may thus be reluctant to pursue lawsuits that might question their mental status or subject them to unwanted scrutiny. These clients, even if persuaded to take legal action, may be frustratingly uncooperative, failing to answer questionnaires, to keep forensic examination appointments, or to return phone calls. Attorneys may have to enlist the aid of doctors, family members, and other support systems to coax such clients into cooperating with legal procedures. Even if reluctant to take action on their own behalf, these elders may respond to appeals to their sense of responsibility in terms of "providing for loved ones."

Other elders are anxious, insecure, lonely, and/or somatically preoccupied with their injury and its effect on their lives. These elders may be experiencing a sense of thwarted justice, spurred by the current criminal assault and fueled by the memories of unresolved past inequities. Such clients may beg for extra attention by making frequent phone calls and writing numerous letters regarding the status of their case. With these individuals, attorneys may have to set clear and firm limits as to just how much client "input" they are willing to accept, and to explain early on what the respective roles of client, attorney, and clinicians are in pursuing a successful case in the client's own best interest.



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