Care Staff Helpsheet

Dementia Support Australia

Post-traumatic stress disorder and dementia care

Background

Post-traumatic stress disorder (PTSD) is a set of reactions that can develop in people who have experienced a traumatic event that threatened their life or safety, or that of others around them. Four clusters of difficulties are associated with PTSD: reliving the trauma (including unwanted memories, flashbacks, nightmares); hyperarousal (jumpiness, irritability); avoidance; and emotional numbing. An estimated 5–10% of the general population will develop PTSD at some stage in their lives.

"Most people who experience a traumatic event do not go on to develop PTSD."

Treatment

Where possible, the first line of intervention should be psychological therapy, with either trauma-focussed cognitive behavioural therapy, or eye movement desensitisation and reprocessing (EMDR) being recommended approaches. Drug treatments should not be used preferentially as a routine first line treatment over psychological treatments, but where medication is considered necessary, the selective serotonin reuptake inhibitor (SSRI) antidepressants should be considered first choice.

PTSD and dementia

Some people living with dementia will have had PTSD diagnosed earlier in their lives. There are reported cases of PTSD symptoms emerging at the time that dementia is developing and where clear links to an exposure to trauma decades before can be established. In such cases PTSD with delayed onset might be considered.

"Social support and social connectedness are the strongest predictors of resilience and recovery from exposure to trauma."

Care Staff Helpsheet

Dementia Support Australia

Key tips for caring for people with both dementia and PTSD

- Even when cognitive impairment is mild and a diagnosis of chronic PTSD or PTSD with delayed onset can be made, people with dementia may not have the ability to engage with cognitive therapy and the exposure component that is an intrinsic part of this. Think about using behavioural techniques such as relaxation or activity programming instead to manage symptoms. Reminiscence of positive times might be more helpful than talking about the trauma. Enlist the assistance of family and friends to use and reinforce helpful strategies.
- Adapting the environment to minimise or eliminate triggers for PTSD is probably more effective than attempting cognitive restructuring in people with dementia.
- As with all medications prescribed for people living with dementia, careful consideration of individual cases will determine whether a trial of medication is indicated.
- In moderate-severe dementia, the neuropsychiatric symptoms of BPSD (Behavioural and Psychological Symptoms of Dementia) can overlap significantly with PTSD symptoms. In many cases, even if PTSD is considered as a diagnosis, it will not be possible to make the diagnosis with confidence, because of the limited information that a client can provide about his or her internal world, thoughts and experiences. However, knowledge of past trauma can sometimes provide a hypothetical explanation for behaviour changes and responses to care, and can be extremely helpful to carers in understanding why their patient or client may be reacting to specific triggers. In turn, this knowledge can be used to develop strategies that are more likely to be successful.

References:

1. Beyond Blue (www.beyondblue.org.au)
2. Phoenix Australia – Centre for Post-traumatic Mental Health: Australian Guidelines for the treatment of Acute Stress Disorder and Posttraumatic Stress Disorder