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**POSTTRAUMATIC-STRESS DURING LATER LIFE: A
CROSS-SECTIONAL AND LONGITUDINAL
INVESTIGATION**

**A thesis presented in partial fulfilment of
the requirements for the degree of
Doctor of Philosophy
in Psychology at
Massey University**

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*To Nana and Pop,
who provided the inspiration for this project,
and who proudly encouraged me during the initial stages,
but passed away before its completion.*

ABSTRACT

Older people may not only fall victim to traumatic events, but will inevitably encounter a host of late-life stressors that threaten psychological and physical well-being. In addition to current distressing occurrences, many older people will have past unresolved traumatic memories that have the capacity to generate trauma-related symptoms and impinge on present-day functioning.

Much of the existing literature and research on late-life traumatisation concerns the impact of prior war- or Holocaust-experiences. Empirical investigations into the traumatizing effects of lifetime trauma exposure and late-life stressors within community-based samples of older people are scarce.

The present study explored the manifestation of trauma-related symptoms in a sample of New Zealand's older (60+ years) citizens. The goal was to discover the extent that lifetime trauma, recent trauma and recent stressors impact on posttraumatic stress disorder (PTSD), trauma-related perceptions and physical health during later life. Additionally, a new theoretical framework of traumatisation, Trauma-Schema Theory, was introduced and given some preliminary testing. Trauma-Schema Theory maintains that trauma-schemata, cognitive-emotional frameworks that guide information processing, are responsible for traumatic-stress by eliciting beliefs and perceptions that confirm an overwhelming sense of threat, vulnerability and powerlessness. This theory provides viable explanations for occurrences specific to later life, including delayed PTSD reactions in older people, and the triggering of PTSD symptoms in response to late-life stressors.

The present study used a cross-sectional/longitudinal design with two data collection points, each one year apart. Questionnaires measuring PTSD, anxiety, depression, dissociation, self-rated physical health, control beliefs, posttraumatic vulnerability perceptions, trauma history and past-year stressors were mailed out to 2000 older adults who had responded to community based advertising. Of these 1489 adults returned questionnaire one (Q1). One year later consenting participants were sent questionnaire two (Q2), which was similar, but contained a measure of past-year trauma exposure in

place of lifetime trauma exposure. Altogether, 1050 respondents returned Q2. Mean ages for Time 1 and Time 2 were 72.1 years and 71.7 years, respectively. Each sample consisted of around one-third males and two-third females and most were of New Zealand European descent.

Lifetime trauma exposure and past-year stressors were reported at high rates among the samples. Nearly half of the longitudinal sample also reported at least one past-year traumatic event. Of the psychological measures, PTSD was most strongly associated with lifetime trauma, lifetime abuse, multiple lifetime trauma, past-year abuse and past-year multiple trauma. Depression was most strongly associated with past-year trauma. Due to the limited scope of the study, PTSD was the only symptom type further assessed in relation to the other variables.

A series of hierarchical multiple regressions were performed and a number of mediational models were tested. Cross-sectional data analyses showed that both lifetime trauma and lifetime abuse predicted PTSD symptoms. Distress from late-life stressors mediated the trauma-PTSD associations. Longitudinal data analyses indicated that late-life stressors establish the pathway from recent trauma to PTSD escalation over one year. Posttraumatic vulnerability perceptions and control beliefs mediated a large proportion of all associations between event variables (i.e., lifetime trauma, lifetime abuse, recent trauma, recent stressors) and PTSD, providing preliminary verification of Trauma-Schema Theory. Additional analyses also indicated that PTSD, not trauma per se, is responsible for late-life physical health decline.

Limitations of the study and practical implications of the findings are reported. An emphasis on the importance of future research is portrayed, and ideas for future empirical work on traumatic-stress in New Zealand's older population are provided. Finally, practical implications of the findings are reported with the hope that older traumatised adults will, one day, receive the appropriate clinical care necessary to enhance the quality of their lives.

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PREFACE

"The older recipient is not simply the passive recipient of events and changes.

The individual is an actor in his or her own life, coping and managing"

(Hyer & Sohnle, 2001, p. 3)

Like many other countries in the western world, New Zealand's population is aging, and older people represent a growing number and percentage in society. By the year 2041 New Zealand's aging population is projected to rise by over 50%, from around half a million currently, to well over one million¹ (Statistics New Zealand, 2007). An increased older population comes with a number of consequences, including an escalating demand for health-care services.

A sizeable proportion of health problems in older adults utilizing health-care services will stem from traumatic stress. However, the majority of these symptoms will not be identified as having a trauma-related etiological basis. This is because physical- and mental-health professionals are limited in their knowledge about the extent and nature of trauma-related problems during later life. Although the psychological literature is brimming with information about the physical and psychological effects of trauma, research regarding the manifestation of trauma-related problems in older people is scarce.

Why older adults have been overlooked as the focus of traumatic-stress research is unknown. An acquaintance once insinuated that I was wasting my time studying older adults, since this group are living the last phase of their lives. Perhaps this perspective is shared by others who have disregarded older adults in research ventures on traumatic-stress. However, all people, regardless of age, have the right to an improved quality of life. Older adults deserve to be provided with help to assist with the alleviation of psychological distress. This includes being offered appropriate assessment and therapeutic care that cater to their unique developmental needs. Because psychosomatic symptoms increase and physiological functions take longer to return to baseline as aging

¹ This projected figure is assuming low fertility, high mortality and long-run annual net migration of 5000 and is, therefore, conservative.

occurs (Hyer & Sohnle, 2001), it seems even more urgent that research efforts focus on understanding late-life traumatic stress, so that physical deterioration and increased health-care utilization by an increasing older population, can be prevented.

With this in mind, the present research was designed to enhance understanding of trauma-related problems during later life, with the ultimate goal of informing those who provide health-services to older adults. A cross-sectional/longitudinal study was designed. In putting together the questionnaire, a large number of inventories were utilized. Although I was aware that all data collected from the questionnaire could not be sufficiently evaluated within the limited scope of the present thesis, the opportunity to gather important longitudinal information on a large scale was embraced with future goals in mind. These included further statistical analyses of any unprocessed data, in addition to the continuation of longitudinal research on the psychological and physical well-being of the same sample for many years into the future. The extensive documentation of trauma-history, recent traumatic events and psychological symptoms also create an opportunity for detailed longitudinal analyses on subgroups of respondents (e.g., abuse victims; respondents currently meeting PTSD criteria; ethnic minorities) who have already given consent to be contacted in the future.

As detailed within the body of the thesis, choosing which variables to exclude from the project was based on the statistical assessment of symptom variables and their relationships with all lifetime and recent trauma variables. In the end PTSD symptomatology was kept to represent traumatic-stress in older people because PTSD had the strongest correlations with all but one of the trauma variables. Depression, dissociation and anxiety were eliminated from all subsequent analyses.

Finally, all test statistics presented in this thesis were rounded to two decimal places. Mean age and mean frequency of traumatic and stressful events were rounded to one decimal place, which was one extra place more than the original data. Percentages were rounded to one decimal place in the Results and to the nearest whole percent within the literature review and the Discussion as deemed appropriate by APA (1994).