Aging with a History of Trauma:

Strategies to Provide Person-Centered, Trauma-Informed Care to Older Adults and Family Caregivers
Acknowledgments

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Acronyms and Abbreviations

ACE
Adverse childhood experience

ACL
Administration for Community Living

CDC
Centers for Disease Control and Prevention

Center
Center on Holocaust Survivor Care and Institute on Aging and Trauma

HHS
United States Department of Health and Human Services

JFNA
The Jewish Federations of North America

LGBTQ+
Lesbian, gay, bisexual, transgender, queer/questioning, and others

MI
Moral injury

PCTI
Person-centered, trauma-informed

PTS
Post-traumatic stress

PTSD
Post-traumatic stress disorder

SAMHSA
Substance Abuse and Mental Health Services Administration

TBI
Traumatic brain injury

VA
United States Department of Veterans Affairs
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In 1998, Felitti and colleagues shocked the world by documenting how common adverse childhood experiences (ACEs) were among Americans. In their study, more than half of adults experienced at least one ACE such as emotional, physical, or sexual abuse, and household dysfunction (Felitti et al., 1998). Today, we can no longer afford to be shocked by these adverse experiences. Not just ACEs, but trauma itself has become one of the preeminent public health challenges facing America today. It is estimated that as many as 90% of Americans will experience a traumatic event in their lifetime, such as violence, war, disaster, and discrimination (Kilpatrick et al., 2013).

Exposure to a traumatic event can leave indelible scars that last a lifetime. When traumatic response is left untreated, its effects can impact an individual’s mental and physical, and overall well-being. To list a few, trauma exposure is associated with an increased risk for health conditions such as heart disease, immunologic disorders, anxiety, depression, hypertension, dental problems, and dementia (McFarlane, 2010; D’Andrea et al., 2011; Jankowski, 2016; de Oliveira Solis et al., 2017; Rouxel et al., 2016; Mohlenhoff et al., 2017; Yaffee et al., 2010). Conversely, the treatment and resolution of traumatic response can build resilience as individuals adapt and recover.

While there is growing recognition of the prevalence and impact of trauma, awareness of the impact of trauma on older adults is lacking. There is limited research on the impact of trauma on the aging process, diverse older adult populations, and family caregivers. Much of the literature on trauma focuses on its effects on youth rather than treating trauma as a life course issue. Simultaneously, there are limited services for older adults with a history of trauma and their family caregivers. Medical and social service providers may not screen for, recognize the signs of, or know how to treat, trauma in older adults. Policy makers and funders may not dedicate sufficient resources to programming for older adults with a history of trauma and their family caregivers.

**Executive Summary**

Trauma itself has become one of the preeminent public health challenges facing America today.
Given these trends, a new approach to service provision called person-centered, trauma-informed (PCTI) care has been developed to support those who have experienced trauma.

PCTI care is a holistic approach to service provision that promotes the dignity, strength, and empowerment of individuals with a history of trauma by incorporating knowledge about the role of trauma into agency programs, policies, and procedures (Eisinger & Bedney, 2018).

PCTI care combines the principles of person-centered care (self-determination, choice, empowerment, and individual preference) with the principles of trauma-informed care (safety, trust and transparency, peer support, collaboration and mutuality, empowerment and choice, and cultural competency) (United States Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). By infusing these principles throughout all functions of an organization, aging service providers can support the health and well-being of older adults with a history of trauma. Whether or not a provider knows that a person has a history of trauma, the PCTI approach can help.

In 2015, the United States Administration for Community Living (ACL) awarded The Jewish Federations of North America (JFNA) a five-year grant to build the capacity of the Aging Network to care for Holocaust survivors and their family caregivers, and expanding the capacity of the Aging Network to provide PCTI care for older adults with a history of trauma and their family caregivers. The Aging Network is a national network of State and Area Agencies on Aging, and Native American aging programs that plan and provide services for older adults to age independently and remain in their homes and communities (ACL, 2023a). Beyond the Aging Network, the work of these grants builds the PCTI care capacity of all who work in aging services. This includes direct service providers, policy makers, funders, volunteers, and researchers.

This work is implemented by the JFNA Center on Holocaust Survivor Care and Institute on Aging and Trauma (Center). Capacity building efforts of both grants have included subgrants to agencies implementing innovative PCTI care projects, and raising national awareness and understanding of PCTI care through publications and presentations. Since 2015, the JFNA Center has awarded subgrants to 87 organizations that have developed over 500 innovative PCTI projects in areas of mental health, socialization, family caregiver support, physical wellness, and PCTI training. These projects have served approximately 45,000 Holocaust survivors, 10,000 older adults with a history of trauma, and 7,000 family caregivers; and trained approximately 20,000 professional service providers and volunteers. Results of these projects show the effectiveness of the PCTI approach in improving social connection, health, and well-being of older adults with a history of trauma and their family caregivers.
In 2021, ACL awarded the JFNA Center a supplemental grant to produce a guidance memorandum with up-to-date guidance for the Aging Network on how to deliver PCTI care to Holocaust survivors, older adults with a history of trauma, and their family caregivers. This publication is an updated and expanded version of the guidance memorandum published by the ACL in 2017 (ACL, 2017). That memo provided recommendations on conducting outreach and service provision to Holocaust survivors. In addition to updates about the needs of Holocaust survivors, this publication includes background information about PCTI care, diverse older adult populations with a history of trauma, and family caregivers.

This guidance memorandum is divided into four sections. The first section introduces the topics of trauma and PTSD, how trauma influences the aging process, and how the PCTI approach can help. The second section provides recommendations as to how aging service professionals and volunteers can better care for older adults with a history of trauma, and their family caregivers, through the PCTI approach. Recommendations provided in this section are based on the JFNA Center’s work with Holocaust survivors, scholarly research, and input provided by contributors to this publication. The third section reviews trauma history and service considerations for several older adult populations with higher rates of trauma than the general United States population. This includes Holocaust survivors; racial and ethnic minoritized groups; LGBTQ+ individuals; immigrants, refugees, and asylees; survivors of crime; survivors of disasters; individuals in high-risk professions; veterans; and individuals with disabilities. The fourth section turns to the impact of trauma on family caregivers of older adults with a history of trauma. Throughout these sections, a few themes will emerge:

- **The impacts of trauma are omnipresent, complex, and profound.**

By the time individuals reach older adulthood, most have experienced one or more traumatic events which can result in physical, mental, and cognitive health conditions. The aging process itself can be traumatic, as it is often accompanied by declines in health, changes in roles and status, and the loss of family members and friends. Symptoms associated with trauma can be challenging to understand and treat in older adults, as trauma presents differently across the lifespan, and trauma symptoms are often hidden by health conditions.

- **Trauma impacts everyone differently.**

People may be exposed to various traumatic events through their profession, geography, or social group. These events may not be perceived as traumatic for all, as everyone may have different coping mechanisms for and reactions to similar traumatic events. For every person, trauma exposure can lead to negative health outcomes, resilience, both, or neither. It is important to understand the overall trends in trauma exposure and its impact while viewing individuals as a combination of their unique circumstances.

- **Trauma impacts family caregivers.**

The experience of caring for a loved one can be traumatic. Bathing and dressing a parent, providing connection for a spouse with
dementia, or planning for end-of-life care can be challenging. Caring for an individual with a history of trauma may be even more complex, as loved ones have to manage trauma symptoms and behaviors. This experience can compound previous traumas with which family members and friends enter their caregiving responsibilities.

- Trauma can be individual, secondary, communal, and intergenerational.

An individual’s exposure to traumatic experiences is multilayered. People are exposed to trauma through events that threaten their personal safety, stories of traumatic experiences of others, oppressive systems of institutional discrimination, and the collective memories of trauma of their community and ancestors. Trauma does not have to be experienced directly to have an impact on one’s health and well-being. Members of racial, ethnic, sexual, and gender minoritized groups often carry the traumatizing experiences of their ancestors and communities, compounding the traumatic experiences they may encounter on their own.

- PCTI care can help.

The PCTI approach has emerged as a best practice in aging services, as it has improved the social connection, health, and well-being of Holocaust survivors and their family caregivers. Based on these results and the prevalence of trauma among the United States population, PCTI care has the potential to improve services for all older adults and their family caregivers. The principles of PCTI care can be integrated into all aspects of policy making, funding, service design and delivery, and organizational operations. By infusing principles of PCTI into medical and social services, all older adults with a history of trauma and their family caregivers can get the care they need and deserve.

Based upon these themes, the publication concludes with a set of recommendations for those working in aging services, in both professional and volunteer capacities. These include:

1. Research issues of trauma, aging, service needs, and PCTI care.

2. Raise awareness and understanding about aging with a history of trauma, and how PCTI care can help.

3. Raise awareness and understanding about the experiences, trauma triggers, trauma prevalence, and service needs of diverse communities.

4. Deepen organizational capacity to provide PCTI care.

5. Build and strengthen PCTI care partnerships.

6. Remove barriers for PCTI service access and utilization.

7. Reduce stigma about trauma and service utilization.

With these recommendations, professionals and volunteers across the United States can infuse PCTI considerations into their work to best serve Holocaust survivors, older adults with a history of trauma, and family caregivers in their communities.
1. Aging and Trauma

1.1 Understanding Trauma

The demographics of the American population are changing. In the United States, more than one in every seven Americans is 65 and older (ACL, 2021). In 20 years, there will be almost 81 million older adults in the United States, more than twice as many as there were in 2000 (ACL, 2021). At the same time, the older adult population is growing increasingly diverse. Racial- and ethnic-minoritized populations have increased from 19% of the American older adult population in 2008, to 23% of older adults in 2018, and are projected to increase to 34% of older adults by 2040 (ACL, 2021). To prepare for these demographic changes, aging services professionals need to expand the nation’s capacity to provide culturally competent services to a growing population of older adults. Essential to providing this care is to view aging holistically by understanding the role of trauma in the aging process.

There is no one singular definition of trauma. However, according to preeminent experts in trauma-informed care, individual trauma is a person’s response to an event, series of events, or set of circumstances which present physical or emotional harm or is life threatening (SAMHSA, 2014; Herman, 1997; Van der Kolk, 2014; American Psychological Association, 2022). These traumatic events can occur once or on a repeated basis and can occur quickly or over a long period of time. For example, individual trauma can result from surviving war, genocide, crime, natural disasters, sexual violence, or child abuse. Trauma can also be a result of experiencing systemic racial, economic, religious, and gender discrimination. Regardless of the type of trauma experienced, these events or circumstances can rupture one’s sense of safety, leaving trauma survivors feeling vulnerable and isolated.

Exposure to traumatic events is omnipresent. Research suggests that almost 90% of American adults have been exposed to at least one traumatic event during their lifetime (Kilpatrick et al., 2013). More than one in four children in the United States experiences or witnesses interpersonal violence in their lifetime (Finkelhor et al., 2009). More than one in three women and more than one in four men in the United States will experience sexual assault, physical violence, and/or stalking by an intimate partner in their lifetime (Black et al., 2011). More than two in five Americans lived in counties hit by climate disasters in 2021 including fires, floods, hurricanes, landslides, and/or severe storms (Kaplan & Ba Tran, 2022).
Such traumatic events can occur not only on an individual level, but they can also affect entire groups. Communal or collective trauma refers to events or circumstances which threaten the safety and security of an entire group, such as institutionalized racism, gun violence, or war (Hirschberger, 2018). As explained by Hirschberger (2018), “collective [or communal] trauma, transforms into a collective memory, and culminates in a system of meaning . . . For victims, the memory of trauma may be adaptive for group survival” (p. 1). This can be seen among older adults who lived through the Great Depression of the 1930s. Those who lived through the deep economic troubles of the Great Depression experienced high rates of unemployment, poverty, food insecurity, and financial instability which led to high rates of suicide and declines in health overall (Danzer, 2003). Today, those older adults who experienced the Great Depression share a collective response that upholds the importance of stability and resourcefulness in the face of another economic upheaval (Cooks-Campbell, 2022).

Whether experienced individually or collectively, trauma can affect multiple generations. There is a growing body of literature on how trauma responses can be transmitted from survivors to their children through story sharing, socialization, and child rearing. Parents can share stories of surviving traumatic events and model trauma-related behaviors (Quinn & Fletcher, 2020). Trauma can also can leave an indelible mark on an individual’s genetics, resulting in the inheritance of both trauma symptoms and resilience (Jiang et al., 2019). Several researchers have found that trauma-related changes in the gene expression of Holocaust survivors can lead children of Holocaust survivors to experience their parent’s trauma symptoms, such as depression, anxiety, and sleep disturbances. (Kellermann, 2013; Zimmerman, 2023; Bierer et al., 2020).

Trauma can also affect those that care for individuals with a history of trauma through secondary trauma. Secondary or vicarious trauma is an individual’s response to hearing about another person’s firsthand traumatic experience or witnessing an individual’s suffering associated with the traumatic experience (ACF, n.d.; McDonough, 2022). A social worker may develop secondary trauma after hearing a client’s stories of domestic and sexual abuse. A psychologist may develop secondary trauma after hearing about a patient’s experience with famine and forced migration. A family caregiver
may develop secondary trauma after hearing a loved one’s experience in active combat or managing trauma-related behaviors. Secondary trauma can lead providers and family caregivers to experience burnout or compassion fatigue, making it harder to care for themselves and the older adults with a history of trauma that rely on their support (ACF, n.d.).

Some individuals who experience or witness a traumatic event, whether firsthand or vicariously, will go on to develop post-traumatic stress (PTS) or post-traumatic stress disorder (PTSD).

PTS is a common physical and psychological response whereby an individual experiences stress in the days and weeks following exposure to a traumatic event.

An individual may avoid situations, sounds, or smells that remind them of the event, have bad dreams, or experience moments of nervousness, racing heart, or sweaty palms. As explained by Ertel (2022), “PTS symptoms can be very intense, but they are typically short-lived and do not significantly detract from quality of life over a long period of time” (para. 12). PTS is a normal response to stressful situations as it is the body’s protective mechanism of avoiding danger.

While PTS resolves for most, some go on to develop PTSD which is a mental health condition involving a heightened and prolonged stress response.

Anyone who witnesses or experiences a traumatic event may feel on edge, recall upsetting memories, or have trouble sleeping. When these sensations persist for several months, recur long past the traumatic event, or interfere with daily functioning, then an individual may receive a clinical diagnosis of PTSD. Approximately six percent of the American population will experience PTSD in their lifetime (United States Department of Veterans Affairs [VA], National Center for PTSD, n.d.-c). For some, symptoms can start shortly following the traumatic event and for others, symptoms may take months or years to appear (VA, National Center for PTSD, n.d.-a, para. 7). PTSD symptoms may come and go over time or can lay dormant for years, emerging for the first time at the end of life. Many who witness or experience a traumatic event may struggle with the trauma for years and, if the trauma has not been healed, its impact can intensify toward the end of life (Janssen, n.d.).

PTSD symptoms may come and go over time or can lay dormant for years, emerging for the first time at the end of life.

While PTSD can develop in anyone who experiences a traumatic event, certain demographics have higher rates of PTSD prevalence. Compared to four percent of American men, eight percent of American women will develop PTSD during their
lifetimes (VA, National Center for PTSD, n.d.-c). Women are thought to experience higher rates of PTSD as women experience higher rates of sexual violence (Vernor, 2019). This type of violence, which includes rape, sexual assault, and child sexual abuse, has a higher likelihood for progressing into PTSD than the traumatic events more commonly experienced by males, which include physical assault, accident, or combat. Women are also more likely to experience and report higher levels of PTSD-related symptoms. These symptoms can include emotional numbing, difficulty sleeping, increased irritability, difficulty concentrating, and being overly alert or easily startled (Birkeland et al., 2017).

Moreover, studies show that gender, racial, and ethnic minoritized groups have higher rates of PTSD than the national average. For example, Pérez Benítez et al. (2014) note that Black or African Americans experience higher rates of trauma exposure and PTSD, and that PTSD is more persistent over time among Black or African Americans than non-Hispanic or Latin Whites. Similarly, Bassett et al. (2014) explain that American Indian and Alaska Native people experience a higher burden of PTSD prevalence than Whites, and that PTSD is “one of the most serious mental health problems” (p. 418) faced by American Indian/Alaska Native populations. Additionally, Ellis (2016) details that LGBTQ+ individuals have higher rates of trauma exposure and PTSD.

And all of this was before the COVID-19 pandemic that has killed over one million Americans. Individuals, families, and communities are currently grappling with the trauma caused by the loss of jobs, connections, and loved ones. While research on the impact of the pandemic on PTSD rates is still emerging, we know that the pandemic affected the collective health and well-being of our society. In particular, the pandemic took a toll on mental health as 30% of adults continue to report symptoms of anxiety and/or depressive disorders compared to 11% reporting these symptoms prior to the pandemic (Panchal et al., 2023; Twenge & Joiner, 2020). The impacts of COVID-19 exacerbated preexisting health disparities as racial and ethnic minoritized groups experienced higher rates of infection, hospitalization, and death (Lopez et al., 2021; Hill et al., 2023). The COVID-19 pandemic also exacerbated preexisting trauma histories. For Holocaust survivors, pandemic lockdowns were reminiscent of the restrictive conditions of ghettos and concentration camps, and resurfaced feelings of vulnerability, uncertainty, and isolation (Cohn-Schwartz et al., 2020).

Those who have experienced traumatic events may experience trauma triggers which are stimuli such as a sound, smell, touch, sight, taste, feeling, or circumstance that remind of past trauma, thus prompting a trauma response.

Once experienced, these triggers can elicit a fight, flight, and/or freeze response in the body (UPMC Western Behavioral Health, 2021). A fight-or-flight response can be characterized by a rapid heart rate, fast breathing, trembling, dilated pupils, or feeling panicked. A freeze response can include decreased heart rate, feeling numb, physical stiffness, fainting, difficulty speaking, or restricted
breathing. Although an individual may be aware of and consciously avoid the stimuli that remind them of previous trauma, once experienced, trauma triggers cause involuntary recall of previous traumatic events.

Everyone experiences trauma triggers differently. For example, a Holocaust survivor may feel an overwhelming sense of dread, fear, and hopelessness when watching news coverage of genocide and war. A survivor of sexual assault may have a racing heart, sweaty palms, and flushed cheeks when being hugged. A military veteran may feel a sense of life-threatening danger and heightened anxiety from the sounds, smells, and shock waves of fireworks. Even individuals who experienced the same traumatic event may have different triggers and respond in different ways. This is due to the unique way an individual's brain and body processes traumatic memories (Bremner, 2006).

Experiencing a trauma trigger can lead to retraumatization, in which “traumatic stress reactions to a new event can feel as intense as they were when the original event occurred” (SAMHSA, 2017, p. 1). This can occur by recalling the details of previous trauma in vivid detail or experiencing a situation which mimics the original traumatic event, series of events, or set of circumstances. An individual may have intense flashbacks that recall the sounds, smells, tastes, and sights and/or experience traumatic stress responses that occurred with the previous traumatic experience. While a trauma trigger may bring these experiences to the fore, retraumatization may cause an individual to perceive the new event as traumatic and can lead to a reemergence of PTS or PTSD symptoms.

An individual’s understanding of their traumatic experiences can evolve over time as life course changes can change perception of previous experiences. Traditionally, trauma has been thought of as static, meaning that an individual’s memories of a traumatic experience remain fixed and unchanged. However, more recent discussions on the topic suggest that, just like memories of ordinary events, memories of trauma are dynamic (Dekel & Bonanno, 2013). For some, symptoms of the trauma can intensify as memories resurface. It is not uncommon for memories of traumatic experiences to be suppressed as a coping mechanism, and only recalled for the first
An individual’s understanding of their traumatic experiences can evolve over time as life course changes can change perception of previous experiences.

time months or years after the original event. For others, memories and response to the original trauma can diminish as therapeutic healing occurs. Without intensifying or diminishing, memories of trauma can also simply change. As an individual goes through life, the meaning of the original trauma shifts in relation to their current life experiences, beliefs, and circumstances.

1.2 Trauma and Healthy Aging

Experiencing a traumatic event carries long-term consequences for an individual’s health. Felitti et al. (1998) conducted a study on adverse childhood experiences (ACEs) and established a ‘strong and cumulative’ link between trauma experienced in childhood and poor health in adulthood. Children from birth to 17 years of age who witnessed traumatic events or grew up in a household subject to instability were more likely to have negative health, well-being, and opportunity outcomes in adulthood.

Since 1998, the understanding of the relationship between ACEs and health outcomes has grown with ACEs now linked to various health conditions including arthritis, chronic obstructive pulmonary disease, obesity, and heart disease (Okwori et al., 2022; Merrick et al., 2019). At least five of the ten leading causes of death have been associated with exposure to adverse childhood experiences (Merrick et al., 2019). Alarmingly, ACEs are strongly connected with the development of depression as over 50% of the cases of depression were attributed to ACEs (Okwori et al., 2022). According to the CDC, preventing ACEs could reduce up to 21 million cases of depression, 1.9 million cases of heart disease, and 2.5 million cases of obesity (Merrick et al., 2019). ACEs are also connected to reduced educational attainment, unemployment, victimization through elder abuse, and mental health problems in old age.

These findings have led to the development of a lifespan perspective on trauma and aging. The life course perspective stresses that aging is a developmental process that spans a person’s entire life, and that experiences, events, and risk exposure in early life can have a profound impact that lingers for decades (Hu, 2021). Some of these impacts may be the direct result of physical changes to the brain and body that occur because of trauma exposure. Hu (2021) argues that repeated exposure to adverse events or experiences in childhood prompts excessive stress-management systems in the body which can impair the brain’s development, growth, and function. Other impacts are likely the result of
what researchers call ‘cumulative disadvantage’ over time, whereby childhood adversity leads to low educational attainment, poverty, limited social support, and poor access to health care. These factors compound over time to negatively impact adults as they age (Thomas et al., 2022).

For example, Draper and colleagues (2008) found that those who experienced physical and sexual abuse earlier in life were at a higher risk for poor physical and mental health in older adulthood. Draper et al. (2008) concluded that “the effects of childhood abuse appear to last a lifetime” (p. 270).

Since the ACE study, lifetime trauma exposure has been linked to the propensity for developing a wide range of physical, mental, and cognitive health conditions. Although trauma may not be the singular cause of health conditions, trauma has been shown to be an associated factor in the emergence of lung disease, dental problems, fibromyalgia, chronic fatigue, cardiovascular disease, gastrointestinal disorders, endocrine disorders, and headache disorders (Spitzer et al., 2011; de Oliveira Solis et al., 2017; Rouxel et al., 2016; Häuser et al., 2013; Dansie et al., 2012; McFarlane, 2010; Salleh, 2008). Similarly, an association has been shown between trauma exposure and anxiety, depression, suicidal ideation, eating disorders, and substance abuse (Williamson et al., 2021; Jankowski, 2016; Panagioti et al., 2012; Brewerton, 2007; Brady et al., 2016). Finally, trauma exposure has been associated with the onset of Alzheimer’s disease and other dementias, sleep disorders, and other cognitive impairments (Mohlenhoff et al., 2017; Yaffee et al., 2010).

Although research on the relationship between trauma and neurological function is emerging, it is increasingly recognized that traumatic events can affect various areas of the brain and can lead to lasting changes in neurological response (Guy-Evans, 2023). Trauma can impact the prefrontal cortex responsible for decision-making, the anterior cingulate cortex responsible for emotional regulation, and the amygdala responsible for fear response. In a brain impacted by trauma, the areas responsible for decision-making and emotional regulation are under activated, and the area responsible for fear response is overactivated (Guy-Evans, 2023; Hayes et al., 2012). This results in persistent traumatic stress symptoms that can include constant fear and hypervigilance, as well as difficulties sleeping, concentrating, thinking clearly, and regulating emotions.

**Lifetime trauma exposure has been linked to the propensity for developing a wide range of physical, mental, and cognitive health conditions.**
Over time, these changes coupled with the emergence of PTSD symptomology can lead to cognitive decline (Burri et al., 2013; Mohlenhoff et al., 2017). For example, it is increasingly understood that trauma exposure is linked to the development of Alzheimer’s or other dementias. United States veterans that have PTSD are nearly two times as likely of developing dementia compared to those veterans without PTSD (Yaffe et al., 2010; Qureshi et al., 2010). While trauma exposure is linked to dementia, the progression of dementia can worsen trauma symptoms or lead to delayed-onset PTSD (Mittal et al., 2001; van Achterberg et al., 2001).

Trauma exposure is also associated with resilience in aging. Older adults are considered psychologically resilient when they do not give in to adversity, but instead successfully adapt to and overcome it (Fontes & Neri, 2015). For some, experiencing a traumatic event can lead to personal growth through reflection or therapeutic interventions. As a result, older adults with a history of trauma can demonstrate resilience when confronted with future traumatic events as well as possible trauma from the aging process. By learning how to cope with prior trauma, individuals can gain tools such as “coping resources, emotional regulation, motivation, sense of purpose and self-efficacy” (Fontes & Neri, 2015, p. 1477), that can serve them throughout their lifetime (Maercker et al., 2016). A factor commonly conflated with resilience is vulnerability, or the susceptibility to harm. While some individuals can have an increased vulnerability to traumatic events, it does not mean that they will lack resilience. In many cases, groups or individuals with high vulnerability to traumatic events show increased resilience to these events. For example, during the COVID-19 pandemic, Holocaust survivors showed higher emotional vulnerability to the negative effects than other older adults, however they also showed high resilience in their will to adapt and live (Carmel et al., 2022).

While trauma impacts healthy aging, the normal changes associated with aging can exacerbate traumatic stress. Retirement, changes in familial roles, the loss of family and friends, social isolation, declining health, and the loss of independence can lead to the reactivation of traumatic stress, even in older adults who had previously been coping well (Davison et al., 2016; Kaiser et al., 2017; Ladson & Bienenfeld, 2007; Paratz & Katz, 2011; VA, National Center for PTSD, 2019). The death of a spouse, partner, or friend can mean losing an important source of support and social connection. The loss of physical strength, illnesses, medical procedures, hospital stays, and end of life issues can make older adults feel like they can no longer protect themselves. The increase of free time can lead to increased reflection of unpleasant and traumatic life events. Simultaneously, coping strategies like exercising or socializing can be more difficult to maintain as individuals with a history of trauma age. These circumstances may make individuals feel alone and unsafe, and vulnerable to the
The reemergence of PTSD (VA, National Center for PTSD, 2019). Chopra (2018) describes case studies of older adults who experience post-traumatic stress disorder (PTSD) for the first time decades after their initial trauma. Even after 20 years without symptoms, PTSD can reemerge (Barman et al., 2016).

Traumatic events such as the COVID-19 pandemic can further strain the adaptive capacity of aging adults with trauma histories. The pandemic generated stress about getting sick, death of loved ones, financial instability, food access, isolation, and limitations in essential services. These stressors disproportionately affected older adults as they are more susceptible to getting the virus and have increased likelihood for complications and death. While some were resilient to the traumatic stressors of the pandemic, other older adults struggled to cope (Rutherford et al., 2020; Choi et al., 2023). In a study by Cohn-Schwartz et al. (2022), older adults who struggled with PTSD symptomology prior to the COVID-19 pandemic were more likely to experience depression, anxiety, and loneliness than those without pre-pandemic symptoms. Similarly, Békés et al (2022) found that older adults that previously experienced ACEs were more likely to experience posttraumatic stress symptoms, more Covid-related fears, and higher levels of anxiety and depression during the COVID-19 pandemic.

Medical and social service professionals often do not diagnose, treat, or account for the role of trauma in the lives of older adults and their family caregivers. Even service providers acutely aware of the role of trauma in society may have difficulty screening and treating trauma among older adults, as symptoms of trauma can present differently in older adults than in younger populations, and can be masked by other conditions (Ladson & Bienenfeld, 2007). At the same time, older adults often do not disclose a history of trauma and many do not make the connection between their current symptoms and a traumatic event that may be years or decades old (McCarthy & Cook, 2018). Disclosing trauma history and/or seeking services can be stigmatized and retraumatizing, and thus older adults with a history of trauma may minimize their symptoms, blame themselves for what happened, or be reluctant to acknowledge trauma-related issues (Chopra, 2018; McCarthy & Cook, 2018).

Without accounting for the role of trauma in aging, older adults who have a history of trauma may be labeled as difficult to care for or treat, especially if they experience trauma-related behaviors or emotions that are misunderstood by staff. Inappropriate responses to trauma-related behaviors and emotions can, in turn, re-traumatize older adults and exacerbate their fear and anxiety (Key, 2018). Providers may not recognize or know how to provide treatment for trauma in aging populations, thus older adults with a history of trauma may be misdiagnosed and receive inappropriate treatments and medications (Key, 2018; McCarthy & Cook, 2018). This further reduces the likelihood of an older adult to seek services and receive appropriate care in the future.

Although there is an increasing understanding of the relationship between trauma and aging, trauma exposure in older adults is often referred to as a ‘silent problem’ or ‘hidden variable’ (Cook et al., n.d.).
2. Person-Centered, Trauma-Informed Care

2.1 The PCTI Care Model

In response to trends in trauma and aging, a new approach to service provision called person-centered, trauma-informed (PCTI) care has been developed to support those who have experienced trauma.

PCTI care is a holistic approach to service provision that promotes the dignity, strength, and empowerment of individuals with a history of trauma by incorporating knowledge about the role of trauma into agency programs, policies, and procedures (Eisinger & Bedney, 2018).

Whether or not a provider knows that a person has a history of trauma, the PCTI approach can help.

The PCTI approach combines the principles of person-centered (PC) care with the principles of trauma-informed (TI) care. PC care is rooted in the principles of self-determination, choice, empowerment, individual preference, and community inclusion (Human Services Research Institute, 2019). For ease of reference, the PCTI care model is used to summarize both person- and family-centered approaches. The PC approach is based on the understanding that the person receiving services is a unique individual whose interests, values, and context should form the basis of care planning and service delivery (SAMHSA, 2023a). The family-centered approach prioritizes involvement of a person’s family in care planning and service delivery, as they may be an integral part of an individual’s context (National Academies of Sciences, Engineering, and Medicine, 2021). While both approaches are similar, they have varying levels of use among diverse communities.

These principles of PC care are complemented by the United States Substance Abuse and Mental Health Services Administration’s (SAMHSA, 2014) principles of TI care. These include:

- safety
- trustworthiness and transparency
- peer support
- collaboration and mutuality
- empowerment, voice, and choice
- integration of cultural, historical, and gender issues
As explained by SAMHSA, these principles can be infused into all areas of an organization’s work including governance and leadership; training and workforce development; cross-sector collaboration; financing; physical environment; engagement and involvement; screening, assessment, treatment services; progress monitoring and quality assurance (QA), policy; and evaluation (SAMHSA, 2023b). By infusing TI principles through all aspects of an organization’s work, a TI organization can be created. According to SAMHSA, a TI organization is one that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization” (SAMHSA, 2014, p. 9).

By infusing these principles throughout all functions of an organization, aging service providers can support the health and well-being of older adults with a history of trauma. The PCTI approach can be applied to all aspects of an organization from the relationship between staff and individuals seeking care to the organization’s space, policies, and procedures. In a PCTI organization all personnel (from the administrative staff to the executive leadership team), all policies and procedures (from asking questions to providing transportation), and all programmatic spaces (from the waiting room to the parking lot) work together to create an environment that is inclusive and always empowering for all people (Eisinger & Bedney, 2018). Creating PCTI environments requires applying PCTI principles not only to those receiving care, but also to the workplace. Just as care recipients are exposed to trauma, so are care providers. PCTI workplaces can increase the capacity for employees to provide PCTI care as the work environment is sensitive to the needs and trauma histories of employees.

The PCTI approach was first introduced in services for Holocaust survivors in 2016 through the work of the JFNA Center. The PCTI approach was infused into Holocaust survivor services due to the population’s high rates of trauma exposure, PTSD, trauma-associated health conditions, social isolation, and poverty. This is compounded by the limited availability of Holocaust survivor services that are sensitive and healing, and resist re-traumatization. Since its introduction, PCTI care has emerged as a best practice in Holocaust survivor care. Evaluations of PCTI programming through the JFNA Center demonstrate the effectiveness of the PCTI approach in improving social connection, health, and well-being of older adults with a history of trauma, as well as their family caregivers. Thus, the PCTI approach has emerged as the ‘universal precaution’ for aging services, or a set of safeguards designed to create a safe and inclusive environment for everyone based on the assumption that all people may have had a past traumatic experience. These precautions are increasingly associated with improved client outcomes and reduced health and social service costs (Hodas, 2006).
2.2 The State of PCTI Care in the United States

In 2021, the JFNA Center conducted a national survey on the state of PCTI care among aging service providers in the United States (Rabin & Bedney, 2022). Almost 200 organizations across the country ranging in size, sector, geography, religious affiliation, service type, and client demographics, responded to the survey. The findings of the study provide a preliminary understanding of the degree to which aging services organizations are aware and capable of providing PCTI care for Holocaust survivors, older adults with a history of trauma, and their family caregivers. Findings revealed that while PCTI care is growing among aging service providers, there remain significant gaps in PCTI care across organizations and client demographics.

Organizations are increasingly recognizing the PCTI approach and gaining deeper understanding of how trauma impacts aging. Seventy-two percent of respondents noted that their organization was aware of PCTI care before participating in the survey (Rabin & Bedney, 2022). Since the PCTI care approach was introduced six years prior to the study, the findings indicate the exciting growth of this field. While many were familiar with the PCTI approach, fewer reported a deep understanding of aging and trauma, or capacity to provide PCTI care. Fifty-eight percent of respondents noted that their organization has a deep understanding of the topic of aging and trauma (Rabin & Bedney, 2022). And only 30% of organizations demonstrated capacity to provide PCTI care to clients (Rabin & Bedney, 2022).

The study also revealed that there may be disparities in PCTI care based on care recipient demographics. Client populations reviewed in this study include those who experience disproportionately high rates of trauma exposure, PTS, and PTSD. These populations include family caregivers and older adults who are African American or Black; American Indian, Native Hawaiian, or Native Alaskan; Asian American; Hispanic or Latin American; LGBTQ+; crime survivors; Holocaust survivors; sexual and domestic violence survivors; survivors of disasters; first responders; veterans; immigrants or refugees; and individuals with disabilities. Lowest organizational PCTI care capacity was reported for American Indian, Native Hawaiian, or Alaska Native older adults; Asian American older adults; and Hispanic or Latin American older adults (Rabin & Bedney, 2022). Highest PCTI care capacity was reported for Holocaust survivors, immigrant or refugee older adults, and older adult survivors of domestic and sexual violence.
violence (Rabin & Bedney, 2022). While organizations reported higher capacity to serve these three populations, more than half of organizations in the study reported limited or no PCTI care capacity to serve Holocaust survivors, immigrant or refugee older adults, and older adult survivors of domestic and sexual violence (Rabin & Bedney, 2022).

Despite the high prevalence of trauma exposure and PTSD among care recipients, organizations serving older adults have limited capacity to provide PCTI care. Many organizations are not aware of PCTI care, and many do not have the capacity to provide it to older adults and family caregivers. Thus, older adults with a history of trauma and their family caregivers go without the PCTI services that would support their health and well-being. To better serve older adults with a history of trauma and their family caregivers, service providers must integrate the PCTI approach across all services, and build the capacity of the organization and its staff to provide PCTI care to all people.

### Percent of Organizations with PCTI Care Capacity for Client Demographics

- **African American or Black Older Adults**: 34%
- **American Indian, Alaska Native, or Native Hawaiian Older Adults**: 18%
- **Asian American Older Adults**: 25%
- **Crime Survivor Older Adults**: 42%
- **Disaster Survivor Older Adults**: 43%
- **Domestic or Sexual Violence Survivor Older Adults**: 45%
- **First Responder Older Adults**: 47%
- **Holocaust Survivor Older Adults**: 54%
- **Immigrant or Refugee Older Adults**: 45%
- **Latin American Older Adults**: 33%
- **LGBTQ Older Adults**: 37%
- **Older Adults with Disabilities**: 42%
- **Veteran Older Adults**: 37%
2.3 Integrating PCTI Care into Service Provision

Infusing the PCTI approach into care delivery cannot be done by aging services providers alone. Everyone working in the field of aging has an important role to play in improving the availability, access, and quality of PCTI care through aging services organizations. Direct care providers can integrate PCTI principles into their intake procedures and therapeutic approaches. Organization leadership can demonstrate commitment and invest in building the capacity of their organization to provide PCTI care. Policy makers can design local, state, or federal plans for integrating PCTI approaches throughout aging services. Funders can support a wide array of community organizations that need resources to implement PCTI principles, as well as implementing PCTI principles into the work of foundations and corporate social responsibility departments. Researchers can explore, identify, and share best practices in PCTI care. Together, service professional and volunteers alike working in aging service can create an environment where direct care providers have PCTI care capacity, and older adults with a history of trauma and family caregivers have access to PCTI care. Below are some considerations for infusing the principles of PCTI care into service delivery. Note, this is not an exhaustive list, and some of these considerations may support more than one PCTI principle.
1. Safety

Aging service professionals and volunteers must create a sense of safety throughout the organization so that older adults with a history of trauma and family caregivers feel physically and psychologically safe in their roles as staff, volunteers, guests, or care recipients. Establishing a sense of safety throughout an organization is fundamental to integrating all other PCTI principles.

- Ensure spaces are welcoming, quiet, well-lit, and accessible.
- Decorate spaces with art representing diverse communities.
- Post inclusive, accessible, and multilingual signage.
- Post resources and materials that acknowledge and welcome family caregivers.
- Allow family caregivers to accompany care recipients for services.
- Employ nondiscriminatory policies.
- Employ affirming communication and behavior that is calm and reassuring.
- Ensure that the history, background, and relationships of care recipients and family caregivers are understood and respected.
- Avoid rigid and inflexible schedules or procedures for care recipients.
- Reduce the amount of time care recipients and family caregivers wait for services.
- Avoid having care recipients wait in line or take a number for service delivery.
- Ensure care recipients and family caregivers have a full understanding of the service or procedure performed.
- Ask for consent before physically touching anyone, whether that touch be a supportive hug or a medical procedure.
- Demonstrate patience and understanding when care recipients and family caregivers hesitate to use services.
- Demonstrate patience and understanding when anyone displays emotional or behavioral trauma symptoms.
- Introduce care recipients and family caregivers to anyone with which they will be interacting, and clarify their role in service delivery.
- Reduce exposure of care recipients and family caregivers to stressful incidents shown on the news, magazines, or other media.
- Provide opportunities for care recipients and family caregivers to inform the design of physical and virtual spaces.
- Create a supportive work environment and provide staff with space and time to decompress and unwind.
- Provide employees with access to assistance programs and other supportive services.

Balancing Safety with Autonomy. When infusing the PCTI approach into an organization’s work, it is essential to find a balance between a care recipient’s autonomy and the safety of the care recipient, other care recipients, staff, and volunteers. At times, it may be necessary to enforce safety guidelines that impinge on personal choice to reduce harm. When doing so, provide care recipients with as much autonomy as possible, uphold policies that protect everyone’s safety, and explain to care recipients and their family caregivers why and how these decisions are made.
2. Trust and Transparency

Aging service professionals and volunteers must promote trust and transparency with older adults with a history of trauma and family caregivers by ensuring organization operations and decisions are conducted openly and honestly. Establishing trust and transparency is essential to creating safe environments where care recipients and family caregivers can heal and thrive.

- Explain the services or procedures an organization performs, who they involve, and how they are done.
- Explain what personal information is collected, how it is used, and how it is stored.
- Take time to answer all questions as clearly and completely as possible, ensuring care recipients and family caregivers do not feel rushed.
- Explain how a care recipient and family caregiver can obtain a copy of their information.
- Provide care recipients and family caregivers with a reliable point-of-contact who they can reach out to for information and assistance.
- Establish rapport and build relationships between staff, volunteers, family caregivers and care recipients to ensure everyone feels comfortable asking questions and providing feedback.
- Follow through on plans, clarify next steps, and be prompt.
- Demonstrate acceptance for care recipients and family caregivers by affirming diverse identities, respecting boundaries, and providing opportunities to share personal experiences.
- Provide care recipients and family caregivers with time to gain comfort with providers prior to asking personal questions or performing invasive procedures.
- Recruit staff and volunteers from the local community and that are representative of the care recipients and family caregivers the organization serves.

3. Peer Support

People working and volunteering in aging services must promote peer support by encouraging older adults with a history of trauma and family caregivers to provide one another with mutual self-help. People with similar experiences can greatly help one another establish safety, trust, and hope, as well as encourage service utilization and collaboration.

- Provide time and space for care recipients and family caregivers to get to know one another.
- Introduce care recipients and family caregivers to one another and help them build relationships.
- Advertise information about peer support groups.
- Host social events such as holiday parties, communal meals, or virtual programs.
- Support care recipients and family caregivers in using technology such as e-mail, video chatting, or texting to facilitate connection with one another, family members, and friends.
- Create a buddy system for care recipients and family caregivers receiving similar services.
- Encourage care recipients and family caregivers to share their challenges and solutions with one another.
- Convene staff celebrations and gatherings to build camaraderie and morale.
- Remind care recipients and family caregivers that they are not alone, referring them to peer support programs whenever possible.
4. **Collaboration and Mutuality**

Those engaged in aging services must promote collaboration and mutuality by partnering and leveling power differences between staff, volunteers, older adults with a history of trauma, and family caregivers. All who engage with an organization must be treated equally and equitably, including executive leadership, direct service providers, administrative staff, volunteers, family caregivers, and care recipients.

- Create environments built on trust, collaboration, and shared power.
- Explain how providers will work with care recipients and family caregivers to meet their respective goals.
- Create joint care plans that align provider recommendations to the care recipient’s priorities, wishes, strengths, and support systems.
- Incorporate family caregivers into care plans according to their and their loved one’s preferences, whether they be family members or friends.
- Encourage care recipients and family caregivers to take an active role in care plans.
- Encourage everyone to provide honest feedback on all aspects of care.
- Create feedback processes that maintain anonymity and/or confidentiality.
- Incorporate everyone’s feedback into service delivery wherever possible.
- Communicate to all how feedback was integrated into programming.
- Express gratitude and provide compensation to care recipients and family caregivers for their participation and collaboration.
- Provide opportunities for care recipients and family caregivers to design and modify services by creating a role for them in organizational planning and operations.
- Provide opportunities to staff and volunteers of all levels of seniority and tenure to design and modify services.
- Leverage communal and individual strategies of resilience into program planning and service delivery.

5. **Empowerment, Voice, and Choice**

Aging service professionals and volunteers must promote empowerment, voice, and choice by leveraging the strengths and experiences of older adults with a history of trauma and family caregivers. Enabling everyone to exercise agency, autonomy, and shared decision-making is essential to creating a PCTI environment.

- Create environments that are inclusive of everyone.
- Ensure that all care recipients and family caregivers are informed of the services for which they are eligible.
- Provide care recipients and family caregivers with as much choice as possible in selecting which services are used and how they are received.
- Ensure participation in services is optional and not linked to future services eligibility.
- Ensure care recipients and family caregivers know that they can opt out of services at any time.
- If a service or procedure is required, explain why it is required.
- Allow care recipients and family caregivers to ask questions to ensure comfort with services.
• Obtain consent before initiating any services, procedures, or data collection.
• Use appreciative inquiry in all assessments, interviews, programs, services, and diagnostic procedures.
• Ensure care recipients and family caregiver preferences are followed by including them as advisors to design services, procedures, forms, and spaces.
• Demonstrate that feedback is important by listening empathetically to everyone’s experiences and stories.
• Respond to feedback quickly and thoroughly and be transparent when feedback may not be integrated into a process or system.
• Ensure care recipients and family caregivers always have a way to express their thoughts, interests, and concerns, including anonymously.
• Provide services in a variety of service settings, times, and providers, and allow care recipients and family caregivers to choose the best options for their care.
• Offer support for care recipients and family caregivers to develop self-advocacy skills to advocate for care and for their needs to be heard and met.
• Ask care recipients about how and when they would like to include family caregivers in service and care planning.
• Ask family caregivers how they would like to be involved in their loved one’s care, and include family caregivers as partners in care teams whenever possible.

Appreciative Inquiry. Appreciative inquiry is a strengths-based or asset-based approach to social change. Rather than focusing solely on deficits and challenges, this approach identifies what is already working. This approach can empower individuals and communities to build upon strengths to guide aging services.

6. Cultural, Historical, and Gender Issues

Those working and volunteering in aging services must integrate an understanding of cultural, historical, and gender issues across all services and procedures to create healing, safe, and empowering environments where the previous principles of PCTI care are upheld.

• Disaggregate and analyze program data to identify disparities in care access, utilization, experiences, and outcomes.
• Address disparities in care by engaging underserved communities in the design of programming and diversity, equity, and inclusion initiatives.
• Ensure that organization staffing of leadership, direct care providers, and volunteers is diverse and reflective of the communities supported.
• Ensure services and resources are in the preferred language of care recipients and family caregivers, and provide translation services wherever possible.
• Ensure all forms and signs reflect culturally appropriate language and terminology.
• Provide culturally appropriate food for services, procedures, and events.
• Celebrate holidays and traditions whenever possible.
• Provide space for everyone to share and celebrate their culture.
• Enable care recipients and family caregivers to integrate spiritual beliefs and cultural customs into service delivery.
• Leverage local, communal, and historical practices in care recipients and family caregiver support.
• Provide opportunities for everyone to share and reaffirm their identity.
• Enable everyone to have privacy to observe religious practices.
• Ensure decorations in the organization are representative of diverse cultures.
• Acknowledge, understand, and engage in dialogue about the impact of -isms (i.e., ageism, classism, anti-Semitism) and -phobias (i.e., xenophobia, transphobia, Islamophobia) on the experiences of care recipients, family caregivers, staff, and volunteers.

• Acknowledge and understand that -isms and -phobias are critically important in all conversations about justice and equity.
• Provide opportunities for organizational leadership, staff, and volunteers to improve their cultural humility and cultural competence.
• Recognize and accommodate the role of historical and communal trauma.
• Provide opportunities for staff and volunteers to reflect on their own cultural background and its influence on values, beliefs, assumptions, and biases.
• Understand that cultural, ethnic, religious, and other minoritized communities are not homogenous, and that each client may have different needs and wishes.
• Understand the diversity of relationships between care recipients and family caregivers, including alternative family structures.
• Ensure skilled and empathetic supervision of staff.

**Cultural Competence, Humility, and Responsiveness.** Cultural competence is “the ability of individuals and systems to respond respectfully and effectively to people of all cultures” (National Technical Assistance and Evaluation Center for Systems of Care, 2009, p. 2). This can be done through learning about one’s personal beliefs, values, and customs, and how they relate to those of others. This learning is furthered by cultural humility, which is the commitment to continuous learning as well as the understanding that one cannot know everything about the culture of others. Cultural competence and humility can help those involved in aging services learn about the cultural views of older adults with a history of trauma and family caregivers (Kirmayer & Jarvis, 2019). Through this, aging service professionals can design and implement culturally responsive PCTI care, which uses an understanding of cultures to provide support, overcome barriers (Think Cultural Health, n.d.), and create an inclusive and equitable space for all.
### 2.4 Enhancing Organizational PCTI Care Capacity

Building the PCTI approach into aging services relies on the capacity of aging services organizations to provide PCTI care. Organizational PCTI care capacity is the ability and readiness of organizations to use the PCTI approach in all aspects of their work. Outlined by the JFNA Center in its 2021 study, organizational PCTI care is a summary of an organization’s performance across five key areas: resource capacity, infrastructure capacity, PCTI knowledge and skill capacity, organizational climate capacity, and partnership capacity (Rabin & Bedney, 2022). These areas are used to conduct organizational PCTI care capacity assessments and serve as a useful tool for an organization to determine its baseline and needs as well as “evaluate its readiness and capacity for making systemic change” (SAMHSA, 2023b, p. 12).

1. **Resource Capacity**

   To have PCTI care capacity, an organization must ensure it can finance, staff, and materially support PCTI care. Implementing PCTI care programming, creating safe and welcoming environments, and training staff in the PCTI care approach requires staff, material, and financial resource commitments. To achieve this, an organization must invest in the essential components of resources capacity:
   - staff resources (e.g., number of staff, skill level),
   - material resources (e.g., facilities, equipment), and
   - financial resources (e.g., financial assets, in-kind contributions).

2. **Infrastructure Capacity**

   To have PCTI care capacity, an organization must ensure alignment between PCTI care principles and the policy and physical environment of the organization. Alignment with the physical environment ensures that PCTI principles guide the design of physical spaces to protect both physical and psychological safety of clients and staff. This alignment creates an organizational infrastructure strong enough to support PCTI care delivery. To do so, an organization must invest in the essential components of infrastructure capacity:
   - mission alignment (e.g., written goals establishing PCTI care as an essential part of the organizational mission),
   - systems, procedures, and protocols (e.g., operational policies or guidelines for providing PCTI care), and
   - physical environment (e.g., spaces are welcoming and promote a sense of safety, community, and connection).

3. **PCTI Knowledge and Skill Capacity**

   To have PCTI care capacity, an organization’s staff must have technical knowledge, skill, and expertise in both the fields of change...
management and PCTI care. To do so, an organization must invest in the essential components of PCTI knowledge and skill capacity:

• change management skills (e.g., leadership and communication skills required to usher organizational changes),

• PCTI program implementation skills (e.g., ability to provide PCTI case management, socialization activities), and

• availability of PCTI care training (e.g., onboarding on PCTI care; continuing education on PCTI care; coaching, mentorship, and quality supervision).

PCTI Training. Staff in all positions are key drivers for organizational change. Thus, organizations can build their PCTI care knowledge and skill capacity by training leadership, staff, and volunteers about aging, trauma, and PCTI approaches. Some training topics include:

• The prevalence of trauma among older adults in the US and in their community.

• The role of trauma in the aging process and how trauma affects physical, mental, and cognitive health and well-being.

• The emotional and behavioral signs and symptoms of trauma, trauma triggers, and retraumatization.

• The role of trauma in family caregiving.

• The trauma histories of the clients and communities served including individual experiences, common trauma triggers, and service needs.

• Best practices in PCTI care for their clients and community and what other organizations serving similar populations are doing to provide PCTI care.

• The cultural, historical, and gender issues affecting their clients and community, and how this intersects with trauma and trauma treatment.

• PCTI care principles and how they can be implemented into an organization.

• How to sensitively screen and assess for trauma.

• How to assess caregiver needs and how to accommodate those needs throughout different points in each caregiver’s caregiver trajectory.

• The referral network of services available for individuals and family caregivers available through the organization and community.

• How to educate individuals and family caregivers on topics of health and well-being, self-advocacy, and self-care.

• The role of vicarious trauma, compassion fatigue, and staff burnout in work with older adults with a history of trauma, and how to employ self-care strategies.
4. Organizational Climate Capacity

To have PCTI care capacity, an organization staff and leadership must prioritize and galvanize around a shared commitment to PCTI care through active engagement in PCTI programming, training, and activities. To do so, an organization must invest in the essential components of organizational climate capacity:

- staff commitment (e.g., participation in trainings, embody PCTI care through action),
- leadership commitment (e.g., prioritization of PCTI care throughout the organization, support of PCTI care initiatives), and
- PCTI care championship (e.g., organization has an assigned staff member or working group to champion PCTI care).

5. Partnership Capacity

To have PCTI care capacity, an organization must have internal, cross-departmental partnerships, as well as partnerships with other organizations and the community. Creating a culture of PCTI care is based on the understanding that all human beings are interdependent and that their actions impact each other. Tailoring care based on an individual’s preferences and history of trauma often requires internal teamwork, external referrals, and community engagement. To do so, an organization must invest in the essential components of partnership capacity:

- internal partnerships (e.g., cross-departmental collaborations in support of PCTI care),
- external partnerships (e.g., partnership with other organizations serving older adults), and
- community partnerships (e.g., partnerships with older adults in the community).

Increasing PCTI care capacity of aging service organizations means making deep and meaningful changes to ensure that the PCTI approach is infused throughout an entire organization and not nominally addressed through one organizational initiative or time-bound activity. This means dedicating material, fiscal, and staffing resources to building and supporting PCTI care. It also means establishing, revising, or instituting policies, procedures, and priorities that center PCTI care within the organization’s work. PCTI care capacity requires practical experience in PCTI care programming, as well as the knowledge of how to manage organizational change. Integral to this organizational change and sustained PCTI care capacity is the demonstrated commitment of organizational leadership and staff to integrate PCTI principles into their work. And finally, PCTI care capacity requires an organization to establish and maintain partnerships across departments, organizations, and communities to better provide a holistic network of care.
3. Older Adults with a History of Trauma

Implementing PCTI care throughout the field of aging services requires a deep understanding of the PCTI care model, how trauma affects aging, and how trauma affects diverse communities of older adults. As noted earlier, as many as 90% of Americans will experience a traumatic event in their lifetime (Kilpatrick et al., 2013) and approximately six percent of Americans will go on to experience PTSD (VA, National Center for PTSD, n.d.-c). While trauma exposure is pervasive, certain groups of older adults are more vulnerable to experiencing it. Studies have shown that Holocaust survivors, racial and ethnic minoritized groups, LGBTQ+ individuals, immigrants and refugees, survivors of crime, survivors of disasters, individuals in ‘high-risk professions’, veterans, and individuals with disabilities have higher rates of trauma exposure than the general American population. While direct service providers do not need to know everyone’s individual stories of trauma to provide PCTI care, it is helpful to understand the trends of trauma prevalence across diverse communities.

While trauma exposure is pervasive, certain groups of older adults are more vulnerable to experiencing it.

The following section introduces the role of trauma in the lives of diverse older adults, illustrating the need for PCTI care model across all communities. Content for this section is based on the limited research available about how trauma affects diverse older adult populations, the JFNA Center’s experience supporting Holocaust survivors, and insights from expert contributors listed in the acknowledgments section of this publication. This content serves as a starting point for those working in aging services. Further research and practical examples are needed to build the field of PCTI care. It is incumbent on aging service professionals to explore these trends to provide PCTI care equally and equitably.
3.1 Holocaust Survivors

The Holocaust was the systematic, state-sponsored persecution and murder of six million European Jews by the Nazi German regime and its collaborators between 1933 and 1945. In addition to Jewish victims, the Nazi regime persecuted and murdered millions of Jehovah’s Witnesses, men accused of homosexuality, people with disabilities, and members of groups considered to be racial or ideological enemies including Roma, Poles, and Soviet officials and prisoners of war. This section specifically refers to Jewish Holocaust survivors.

The persecution of Jews during the Holocaust took many forms, including legal discrimination, boycotts of Jewish businesses, obligatory markings such as the yellow Star of David badge, organized violence and riots, physical displacement and deportation, and internment. In 1941, the Nazis began to murder Jews on a more systematic scale, with mass shootings and deportation to concentration camps or death camps. Jews were transported from their homes across Europe in overcrowded rail cars by the thousands, where they often had to stand for days without food, water, bathrooms, heat, or medical care (The Holocaust Explained, n.d.). Many were killed immediately upon arrival in sealed gas chambers at death camps, while others who were seen as healthy and strong were assigned to forced labor at concentration camps. This labor included sorting through the personal possessions of murdered Jews and removing bodies from the gas chambers. In addition to mass killings and forced labor, the Nazi regime conducted medical experiments on prisoners. These experiments included testing human responses to freezing temperatures, infectious disease, torture, high altitude, dismemberment, lobotomies, sterilization, and military combat. Most who were subject to these experiments died during experimentation, were killed shortly after, or survived with traumatic injuries, disabilities, and PTSD.

By the end of WWII, two-thirds of Europe’s Jewish population was killed, and thousands of Jewish communities were destroyed. Of those who survived, many fled to Western European countries, the British mandate of Palestine, Canada, the United States, Australia, and Latin America. From 1933 to 1945, it is estimated that between 180,000 and 220,000 European refugees arrived in the United States (United States Holocaust Memorial Museum [USHMM], n.d.). Since 1945, there have been several waves of Holocaust survivor migration to the United States, including a large migration of Holocaust survivors from the Former Soviet Union after 1991. In 2010, the Conference on Jewish Material Claims Against Germany estimated that there were 127,300 Holocaust survivors living in the United States, and the population was projected to reduce to 67,100 by 2020 (Miller et al., 2009). The number of Holocaust survivors in the United States likely further reduced during the COVID-19 pandemic. Today, Holocaust survivors living in the United States are in their late 70s, 80s, and 90s.

Many Holocaust survivors struggle with a variety of mental health challenges, a stark and powerful reminder of the long-term impacts of trauma on survivors. As a result of their experience, Holocaust survivors experience PTSD at much higher rates than the general American...
According to a small study by Kuch and Cox (1992), 46% of participating Holocaust survivors exhibited PTSD symptomology. In addition, Holocaust survivors experience higher rates of depression, anxiety, sleep disturbances such as night terrors, lower life-satisfaction, and increased stress and loneliness compared to their non-survivor peers (Sharon et al., 2009; Van Pelt, 2013; O'Rourke et al., 2018; Kover, 2014; Barak, 2013; Barak & Szor, 2000; Brodsky et al., 2010). For some Holocaust survivors, these mental health conditions are present throughout life, while for others these conditions can evolve or present for the first time in older adulthood.

Additionally, Holocaust survivors have increased rates of physical health conditions resulting from prolonged starvation, confinement, abuse, and PTSD. Research has shown that Holocaust survivors have an increased risk for a variety of physical ailments such as cardiovascular conditions, stroke, diabetes, osteoporosis, gastrointestinal issues, dental problems, impaired vision, and cancer (Stermer et al., 1991; Van Pelt, 2013; Zamstein et al., 2018, Paratz & Katz, 2011; Keinan-Boker et al., 2015; Marcus & Menczel, 2007). As a result, many Holocaust survivors struggle to perform activities of daily living and require assistance for tasks such as bathing and eating (Kover, 2014; Samuels, 2014; Van Pelt, 2013). As Holocaust survivors age, it is expected that their physical health will continue to decline and their need for services and supports will grow (Miller et al., 2009).

Finally, Holocaust survivors experience increased rates of cognitive challenges such as dementia (Kodesh et al. 2019). Holocaust survivors are one point two times more likely to develop Alzheimer’s disease or other dementias than their non-survivor peers (Kodesh et al. 2019). The emergence of dementia among Holocaust survivors is attributed to impact of trauma and PTSD on the brain. PTSD may cause the development of dementia, and the emergence of dementia may exacerbate PTSD. As Paratz and Katz (2011) note, cognitive decline is thought to diminish a Holocaust survivor’s capacity to inhibit intrusive traumatic memories, resulting in the reemergence of PTSD symptoms accompanied by intense feelings of anxiety and depression. Survivors with dementia may experience frequent nightmares and flashbacks to the horrors they suffered during the Holocaust (Samuels, 2014).

Exacerbating health challenges, many Holocaust survivors live in poverty with limited access to essential services and supports. It is estimated that as many as 35% of survivors in the United States live below the poverty line (Hoffman & Weiner, 2019). Poverty rates are far higher for...
Holocaust survivors living in major metropolitan areas as well as survivors from the Former Soviet Union (ACL, 2017). Holocaust survivors living in poverty struggle to meet their basic needs of food, housing, and healthcare. For Holocaust survivors, poverty in later life can trigger memories of deprivation during the Holocaust (ACL, 2017). Some Holocaust survivors receive financial compensation from the German government or support from United States government programs. However, it is widely recognized that these supports are not enough to meet the persistent and growing needs of Holocaust survivors as they age (Hoffman & Weiner, 2019).

With limited resources, many Holocaust survivors are vulnerable to social isolation, health deterioration, and retraumatization. Aging can be difficult for anyone. Physical health and stamina start to decline, retirement changes familial roles, and aging loved ones may pass away. For Holocaust survivors, however, these changes and losses can also trigger memories, fears, and emotions associated with the Holocaust. The loss of physical strength and the growing need for health and social services can evoke feelings of vulnerability previously felt during the Holocaust.

For example, physical strength was critical for survival during the Holocaust. Jews who were labeled as too old, weak, sick, frail, or disabled were murdered. For those who survived in the Nazi ghettos or escaped, physical strength was needed to withstand unbearable conditions—starvation, freezing weather, and hiding. After the Holocaust, physical strength and ability provided a coping mechanism to manage stress and maintain independence. While increased frailty and disability is common throughout the aging process, it can be frightening and retraumatizing for Holocaust survivors, as they lose the very things which their survival depended upon in the past.

The loss of physical strength and the growing need for health and social services can evoke feelings of vulnerability previously felt during the Holocaust.

Physical abilities are not the only thing lost during aging. Loved ones, family members, friends, neighbors, fellow Holocaust survivors, and community members will all be aging too. As a result, the social circle of Holocaust survivors may shrink as individuals’ abilities change, and some individuals pass away. Additionally, retirement can bring its own challenges. Retirement can change one’s view of their role in their family or community, sense of productivity, level of social interaction, and coping mechanisms. While work can provide great meaning and distraction, retirees may struggle to find new social roles and ways to occupy their time in meaningful ways. Thus, retirement may be linked to feelings of vulnerability and decreased independence. With additional free time and fewer coping mechanisms, Holocaust survivors may spend
more time thinking about previous traumatic experiences and searching for ways to make meaning. Some Holocaust survivors may even wrestle with the label of ‘survivor’, which can be a source of identity and pride for some, while being dissonant and anxiety-provoking for others.

Not all Holocaust survivors are prepared to discuss these losses and feelings of retraumatization. As Brenner (2020) explains, some Holocaust survivors have never talked about their childhood experiences during the Holocaust. This leaves many Holocaust survivors unprepared for processing these experiences during older adulthood, at which point repressed trauma can resurface and cause great emotional distress. This reemergence of trauma magnifies the challenges of aging, “creating a group that ages differently and has more acute needs than do other older Americans” (Samuels, 2014, p. 2). Aging service providers need to be aware of these dynamics to avoid mislabeling, misdiagnosing, or providing inappropriate treatments for Holocaust survivors.

Although Holocaust survivors have higher rates of physical, cognitive, and mental health challenges, they are reluctant to receive services due to feelings of distrust, fear, and shame. Holocaust survivors may be distrustful of medical professionals, fear medical systems and institutionalization, or fear the stigma associated with health conditions. Reluctance to seek care is heightened among survivors from the Former Soviet Union (ACL, 2017). And many services are provided in a way that can be triggering for Holocaust survivors and cause retraumatization. As a result, many Holocaust survivors go without the services and support necessary for healthy aging.

For Holocaust survivors, medical settings are full of potential trauma triggers, including foreign noises and smells, medical or dental instruments, forms, staff in uniforms, sick individuals, and absence of loved ones. Routine medical or dental visits and procedures or emergency medical transportation can trigger memories of the Holocaust. For example, medical forms that ask for a family history may be triggering for individuals who lost their family in the Holocaust and do not know their family’s medical history. Having to undress, put away personal items, say goodbye to loved ones, and being escorted to undergo an invasive procedure may trigger flashbacks about living in concentration camps or undergoing medical experiments. All too often, medical procedures are performed quickly, without allowing time for a Holocaust survivor to understand the procedure, ask questions, and gain comfort with their provider.
The potential for retraumatization increases in institutional settings like nursing homes, assisted living, hospices, and long-term care facilities. As summarized by ACL:

“removal from one’s home can have added meaning as the loss of autonomy, control, and independence can be reminiscent of similar losses experienced during the Holocaust. For example, admissions procedures, uniformed staff, medical personnel and procedures, showers, regimented schedules and routines, loud sounds and voices, restrictions to movement, the lack of privacy, and even waiting in line for food can all trigger memories associated with the Holocaust” (2017, p. 4).

When a Holocaust survivor enters an institutional care facility, they are leaving their homes, belongings, privacy, autonomy, and loved ones behind. In this new environment, individuals must familiarize themselves with new people, sounds, and routines. Holocaust survivors may have difficulty overcoming these challenges as some of the new stimuli, relationships with service providers, and dependence on care may be trauma triggers and cause retraumatization.

Consequently, some survivors experience heightened anxiety when learning of health conditions, seeking medical care, or using medical aids such as canes, dentures, glasses, and hearing aids (Paratz & Katz, 2011). In cases where Holocaust survivors are retraumatized in medical settings, they may exhibit physical and emotional trauma symptoms such as flashbacks, hypervigilance, increased pulse, avoidance, and agitation. Without proper training, medical professionals may misunderstand, misdiagnose, and incorrectly treat Holocaust survivors.

With higher rates of health ailments and poverty, Holocaust survivors can benefit from a variety of social services including programs that provide nutritious meals, socialization, case management, transportation, and legal aid. These social services may have different meaning or style of implementation for Holocaust survivors. For example, whereas food security is important for all older adults, the availability of adequate, nutritious, and culturally appropriate food holds significant meaning for survivors who experienced hunger and starvation during the Holocaust. Similarly, while all older adults would benefit from transportation services increasing access to appointments, errands, and socialization, these services have special significance for Holocaust survivors. Survivors may avoid public transportation options as they may trigger memories of lining up, boarding crowded vehicles, and being unsure of the transportation route. Survivors can also greatly benefit from PCTI legal services to ensure access to benefits, housing, advanced planning, and reparations.

Each social service program must be conducted in a way that is conscientious of Holocaust survivors’ history and trauma triggers, as even the best intentioned of social service programs can be retraumatizing. For example, given the history of starvation and depravation, it is important that congregate meal programs make clear that there
will be abundant food, that survivors will be able to choose the food they would like to eat, and that attendees will be able to take food home. Similarly, given the historical meaning of physical health, it is important that home modification program staff explain the use of grab bars, walk-in tubs, or ramps; form a trusting relationship with Holocaust survivors; and keep program participation confidential.

Even where services are available, Holocaust survivors may face increased barriers to accessing and utilizing programs. Some may experience shame and fear in seeking social services as they think it may express their vulnerability or need for institutionalization. Others may be hesitant to seek support, as they are reluctant to complete forms or participate in programs that would identify them as Holocaust survivors. Eligibility for some services may require identifying as a Holocaust survivor, an identity not all survivors are comfortable with. Thus, many may forgo financial support to avoid the triggering reflection on their identity and registration in government records.

Just as Holocaust survivors have challenges in accessing support, organizations seeking to provide social services may struggle to conduct outreach. As noted by ACL (2017), “regardless of the proactive steps taken by providers to be mindful of the unique support needs and preferences of Holocaust survivors, many survivors may still avoid seeking out assistance, thus making the task of reaching them even more challenging” (p.12). Thus, Holocaust survivors remain underserved despite growing needs.
3.2 Racial and Ethnic Minoritized Groups

The demographics of the American population are changing. In the United States, the older adult population is increasingly diverse, multiethnic, and multiracial. Racial and ethnic minoritized populations have increased from 19% of American older adults in 2008, to 23% of older adults in 2018, and are projected to increase to 34% of older adults by 2040 (ACL, 2021). This shift signals a moment to study the role of trauma in the lives of the increasingly diverse older adult population.

When compared to White Americans, older adults from racial and ethnic minoritized communities experience higher rates of exposure to trauma as well as higher frequency of PTSD. While there are limited studies comparing trauma exposure across all racial and ethnic groups, especially among older adults, studies into specific demographic groups bear illuminating results. For example, research shows that Black or African Americans, American Indian and Alaska Native, and Hispanic or Latin Americans each have higher rates of trauma exposure and PTSD prevalence compared to White Americans (Roberts et al., 2011; Bassett et al., 2014, Pole et al., 2005). Roberts et al. (2011) found that Black or African Americans have one point two times greater likelihood of developing PTSD than White Americans. In another study, American Indian and Alaska Native youth experience PTSD at a rate of 22%; the same rate as veterans returning from Iraq and Afghanistan and triple the rate of the general population (Lechner et al., 2016).

The trends in PTSD prevalence among civilians are mirrored in the United States military, as shown through the National Vietnam Veterans Readjustment Study, American Indian Vietnam Veterans Project, and the Hawaii Vietnam Veterans Project. Through these studies, researchers found that Black or African American, Hispanic or Latin American, American Indian, and Hawaii Native veterans displayed greater rates of PTSD than White veterans (Kulka et al., 1990; Dohrenwend et al., 2008; Beals et al., 2005; Friedman et al., 2004). In subsequent longitudinal studies on the same veteran population, the greater frequency of PTSD was found to be persistent throughout the life course of these veterans (Steenkamp et al., 2017; Beals et al., 2005; Friedman et al., 2004). Although studies have not been conducted into trauma exposure and PTSD prevalence among all racial and ethnic groups, there is cause to suspect that similar disparities exist between many racial and ethnic minoritized groups and White Americans.
Researchers have found that disparities in PTSD prevalence may be related to the type and severity of prior trauma as well as the services available to cope with this trauma. When compared to White Americans, racial- and ethnic minoritized groups are often exposed to greater prevalence of traumatic events and circumstances within their lifetime. Starting in youth, children of different races and ethnicities experience ACEs such as abuse, neglect, and household dysfunction unequally. Approximately 60% of Black or African American children and 50% of Hispanic or Latin American children experience an ACE compared to 40% of White children (Sacks & Murphey, 2018). This may continue throughout their lifetime and into older adulthood as individuals from racial and ethnic minoritized communities may be more likely to experience race-based discrimination and violence.

Racial- and ethnic minoritized groups are often exposed to greater prevalence of traumatic events and circumstances.

According to the Pew Research Center’s survey on racial attitudes in America, approximately 70% of Black Americans and 50% of Hispanic Americans have experienced discrimination based on their race or ethnicity (Pew Research Centers [Pew], 2016). Holliday et al. (2020) revealed that this racial discrimination is likely to be one of the factors driving up rates of trauma exposure and PTSD among Black or African Americans, as racial discrimination presents significant association with PTSD symptomology. For example, discrimination can present in the disproportionate police profiling of Black or African Americans through frequent occurrences of being stopped, searched, and mistreated. This racial profiling can result in mistreatment, violence, and death. As a result, many Black or African American males who are profiled, mistreated, stopped, and searched, go on to develop symptoms of anxiety and PTSD (Alves-Bradford et al., n.d.).

Racial profiling of Black and African American people has led to mass incarceration. Since the 1970s, policy makers and law enforcement have pursued a public safety approach that is tough on crime, filling United States prisons at alarming rates. Mass incarceration has particularly affected racial and ethnic minoritized people, making the punishment tougher for lesser crimes. As a result, Black or African American people make up over 40% of the incarcerated population, while making up only 13% of the American population as a whole (Larrabee Sonderlund et al., 2022). Black or African American people with a history of trauma may be at a greater risk for arrest or incarceration, and incarceration can be a traumatic experience (Jäggi et al., 2016). Many individuals experience or witness violence while incarcerated. In a 2009 study, 35% of men and nearly 25% of women experienced physical victimization while incarcerated (Wolff et al.). This violence can trigger symptoms associated with an individual’s preexisting PTSD and result in new PTS symptoms for others (Widra, 2020). The compounded effects of structural racism, discrimination, and trauma
can adversely affect how individuals reenter their communities after incarceration, affecting their relationship with their family and community, furthering the cycle of trauma.

Racial discrimination is also likely to be a factor in PTSD prevalence among American Indian and Alaska Native populations, as discrimination is a driver for violent crimes on Indian reservations (Tighe, 2014). According to the National Congress of American Indians, on average, violent crimes on Indian reservations are more than two-and-a-half times greater than the national rate, with the rates in some reservations 20 times greater than the national rate. Among these violent crimes, many target women and girls. According to the Indian Law Resource Center (n.d.), “more than 4 in 5 American Indian and Alaska Native women have experienced violence, and more than 1 in 2 have experienced sexual violence.” (para. 1). Much of this crime is linked to discriminatory judicial systems that prevent tribal governments from prosecuting non-Indian offenders who commit 88% of violent crimes against Indian women (National Congress of American Indians, n.d.). Under the current judicial system, not only are tribal governments not allowed to prosecute non-Indian offenders, but also the United States legal system fails to prosecute these crimes. This creates an environment that encourages law breaking and increasing crime rates, subsequently leading to increased trauma exposure (Williams, 2012).

Some of these crimes are based on hate. According to the FBI’s Uniform Crime Reporting Program, in 2020 there were 8,263 hate crimes in the United States, in 75% of which the victim was targeted based on religion, race, ethnicity, or ancestry (Federal Bureau of Investigation [FBI], 2022). Of these hate crimes, the majority were committed against Black or African Americans and Jewish Americans. Unfortunately, since 2020, the number of hate crimes against all racial and ethnic groups continue to rise, with particularly stark increases of hate crimes against Asian Americans (Takamura et al., 2022). The proportion of older adults that are crime victims is significant as older adults are often perceived by offenders as more vulnerable and less likely to report the incident (Takamura et al., 2022). Compared to younger individuals, older adults are also less likely to recover from crime (Office for Victims of Crime [OVC], 2018).

Regardless of whether an individual experiences race-based discrimination or violence in youth or in older adulthood, individual and systemic experiences of racism increase the frequency and severity of trauma prevalence among racial and ethnic minoritized populations and thus increase the prevalence of PTSD. As explained by Ford et al. (2015), while ethnic and cultural differences can be a source of resilience, they may also “lead to chronic stressors such as social stigma, discrimination, and oppression, which can increase psychological trauma and PTSD” (p. 505). For example, Sibrava et al. (2019) conducted a longitudinal study which found that frequency of discrimination experiences prior to traumatic events is associated with lower rates of recovery from PTSD among Hispanic or Latin American and Black or African American adults five years later. Discrimination is a traumatic event in and of itself and does not need to be frequent to have an impact.
Additionally, members of ethnic and racial minoritized communities often experience trauma in simultaneous, multilayered, and compounding ways. Traumatic events occurring on the individual level, such as ACEs or discrimination, can be compounded by communal and intergenerational trauma. For example, while experiencing ongoing patterns of discrimination and violence, Black or African American communities also contend with past traumatic events such as enslavement, the Jim Crow era, the Tuskegee experiments, and police violence (Grayson, 2020). American Indian and Alaska Native communities contend with a history that includes forced removal from their lands, forced acculturation, massacres, and mass sterilization (Chavez Cameron & Phan, 2018). Japanese Americans share a history of incarceration in internment camps by the United States government after the bombing of Pearl Harbor, and subsequent loss of Japanese culture and language (Nagata et al., 2019). These legacies of trauma leave a lasting impression on a group’s collective memory, and impact the way in which these populations are viewed, resulting in systemic and institutional biases, which can be further traumatizing.

Whether individual, communal, or historical, coping with traumatic events may be challenging due to limited services and supports. Roberts et al. (2011) note that racial and ethnic minoritized groups are less likely to seek treatment for PTSD than White Americans, and fewer than half of racial and ethnic minoritized people with PTSD tend to seek treatment. For example, in a study by Pérez Benítez et al. (2014), although PTSD among Black or African American individuals was determined as likely chronic and associated with anxiety, mood disorders, and low psychosocial functioning, less than 30% of their study sample received psychosocial treatment. Even when seeking services, racial and ethnic minoritized groups are more likely than White Americans to delay seeking help (McGuire & Miranda, 2008). This delay may be due to trauma from medical racism, and structural, linguistic, and cultural barriers in the health care system.

Language barriers can limit awareness of services and increase difficulty of utilizing public transportation, completing paperwork, and communicating with mental health personnel. Often, translation services are inaccessible, and language-appropriate educational materials and services are unavailable. This is compounded by a lack of culturally appropriate mental health supports. For example, “many Indigenous people feel stereotyped, ignored, and disrespected by non-Indigenous providers. Many programs serving Indigenous people are often not culturally relevant or sensitive to the significant trauma within Indigenous communities” (Roessel, n.d., p. 3). As noted by Spoont and McClendon (2020), “mental health care at its best may help to mitigate some of the adverse effects of discrimination; at its worst, it can exacerbate disparities in PTSD prevalence rates and illness severity” (p. 2).
As discussed by Adomako (2019), simultaneously, inequitable and limited access to community resources such as grocery stores, pharmacies, health care providers, and transportation significantly contributes to the exposure to race-related stressors and creates barriers to achieving healthy aging. The cumulative exposure to racism results in disenfranchisement, making political participation difficult and limiting access to community resources such as healthy and nutritious foods, education, employment, health care, and housing. In turn, disenfranchisement leads to widening mental, physical, cognitive, and social health disparities between Black or African American communities and other segments of the United States population.

**Equity Versus Equality.** To decrease trauma and health disparities among racial and ethnic minoritized groups, it is important to consider the difference between equity and equality. Equity “recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome” (GW Online Public Health, 2020, para. 1) instead of providing everyone with equal resources no matter what they individually need. Only through equity can there be equality and justice, breaking down the systemic causes for trauma exposure and systemic barriers to care for older adults with a history of trauma.
3.3 LGBTQ+ Individuals

Just as the aging population is growing in the United States, so is the population of older adults who identify as lesbian, gay, bisexual, transgender, queer/questioning, and other sexual and gender minoritized people (LGBTQ+). It is estimated that of the 40 million Americans aged 65 and older, four million identify as LBGTQ+ (National LGBT Health Education Center, 2019). The number of older adults that identify as LGBTQ+ is likely to continue increasing as the population of older Americans doubles during this time. These population estimates are likely low, as individuals aged 65 and older are less likely to openly identify as LGBTQ+ when compared to younger cohorts. Many older Americans may not self-identify, as they grew up in a time where LGBTQ+ individuals faced greater discrimination, criminalization, and social isolation than younger cohorts.

LGBTQ+ older adults were born and raised before today’s LGBTQ+ rights movement began, and some LGBTQ+ older adults were actively involved in building the modern LGBTQ+ movement. During the lifetime of LGBTQ+ older adults, relationships with individuals of the same sex were not only not accepted in mainstream society, but also criminalized and pathologized. Since the colonial period, same-sex relationships in the United States were criminalized and remained so until the 1960s. In 1952, the American Psychiatric Association included homosexuality in its diagnostic manual as a psychiatric disorder, which remained until 1973. Transgender identity was similarly defined as a disorder until 2013. Only in 1962 did Illinois become the first state to decriminalize same-sex sexual acts, and it wasn’t until 2003 that the Supreme Court determined that laws criminalizing these acts were unconstitutional. Although same-sex marriage was legalized in 2015 throughout the United States, continuous legal challenges and contentious political discourse on the topic remain. For LGBTQ+ people entering later life, being open and ‘out’ in public is difficult because of the perceived and actual discrimination.

Today, PTSD disproportionately affects LGBTQ+ individuals because of individual, historical, and communal trauma. According to the National Center for PTSD, LGBTQ+ individuals are at a higher risk of developing PTSD due to increased trauma exposure (Valentine et al., 2019). While the estimated prevalence of PTSD among the general population is six percent, the National Center for PTSD notes that PTSD prevalence may be upward of 40% for the LGBTQ+ community (VA, National Center for PTSD, n.d.-c; Valentine et al., 2019). As explained by SAGE (n.d.), these rates of PTSD remain high among the older adult LGBTQ+ population and tend to increase with each increased age cohort. These high rates of PTSD are related to the reality that sexual minoritized adults in the United States report greater incidence of childhood mistreatment and trauma exposure than the general population (Roberts et al. 2010). Thus, LGBTQ+ older adults are more likely than their non-LGBTQ+ peers to experience depression, anxiety, and other PTSD symptomology. Among LGBTQ+ older adults, depression is twice as likely as in the general population (File & Marlay, 2022).
In addition to the historical trauma of discrimination and oppression, PTSD disproportionately affects LGBTQ+ individuals due to increased rates of physical violence, harassment, bullying, and intimate partner violence. From 2020 to 2021, LGBTQ+ individuals experienced a 70% increase in hate crimes, the second highest increase in hate crimes among minority groups. (Li & Lartey, 2023). LGBTQ+ individuals are 9 times more likely to experience hate crimes than non-LGBTQ+ individuals (Flores et al., 2022). These crimes include verbal harassment, violence, discrimination, and intimidation. According to the 2015 United States Transgender Survey, almost 10% of respondents were physically attacked in the previous year for being transgender (National Resource Center on Domestic Violence, n.d.). Additionally, research shows that LGBQTQ+ individuals have higher lifetime rates of intimate partner violence than the general population. For example, compared to 35% of heterosexual women, over 40% of lesbian women and 60% of bisexual women have experienced sexual assault, violence, or stalking by an intimate partner (National Center for Injury Prevention and Control [NCIPC], 2010).

While LGBTQ+ individuals already experience overwhelmingly high rates of discrimination and violence, intersecting identities can increase these occurrences and further compound the trauma exposure among LGBTQ+ individuals. For instance, Black or African American transgender and non-gender conforming individuals experience higher levels of discrimination than other transgender and non-gender conforming individuals (National LGBTQ Task Force, n.d.). As a result, Black or African American transgender and non-gender conforming individuals are at a higher risk for issues such as HIV, poverty, suicide, and homelessness (National LGBTQ Task Force, n.d.).

Compounding this trauma, societal institutions have perpetuated systematic discrimination against the LGBTQ+ community. Religious, education, employment, policing, law, military, and medical institutions have imposed discriminatory practices and stripped rights of LGBTQ+ individuals. This includes dishonorable military discharge and removals of VA benefits, medical professionals refusing to provide services, and firing employees based on sexual orientation. Institutional discrimination leaves many disadvantaged, arriving at older adulthood with fewer social and financial resources to seek service and supports to age well. This is exacerbated by social rejection, as some individuals may be ostracized from their families of origin, friends, and communities due to their sexual identity. As a result, some older adults are distanced from their biological families and close to their chosen
families, partners, and friends. While chosen families provide support, they are often not recognized by social institutions, perpetuating discrimination and retraumatizing older adults.

As a result of individual, historical, and communal trauma, many LGBTQ+ individuals conceal their identity. According to Candrian and Cloyes (2021), 40% of LGBTQ+ people aged 60-75 said their physician does not know their sexual orientation. Older adults may conceal their sexual orientation for fear of traumatization, hostility, abuse, and discrimination in medical care, home care, assisted living, or long-term care. In fact, 46% of transgender older adults reported being denied or provided inferior health care because of their gender identity (Candrian & Cloyes, 2021). Additionally, 75% of older LGBTQ+ adults felt forced to go back into the closet when entering long-term care to avoid discrimination or mistreatment (Candrian & Cloyes, 2021). LGBTQ+ adults may believe that they may need to hide their identity to not risk losing access to long-term care or senior housing. Not having traditional family systems comprised of biological or legally recognized relationships can increase LGBTQ+ older adults’ vulnerabilities to social isolation and its consequences (Yang et al., 2018). According to SAGE,

"trauma related to their sexual orientation and/or gender identity has left many of these elders distrusting the institutions they may need at end of life" (Thiel, 2018, p. 1).
3.4 Immigrants, Refugees, and Asylees

The United States is home to more immigrants than any other country in the world. By latest estimates, immigrants make up about 14% of the American population, or approximately 44 million people (Wu, 2022). This immigrant population, which has more than tripled since the 1970s, is very diverse. Immigrants that call the United States home arrive from almost every country in the world. The leading country of origin for immigration is Mexico, which comprises 24% of the American immigrant population (Budiman, 2020). This is followed by immigrants from China, India, the Philippines, and El Salvador. Of all global regions, immigrants from Asia account for the largest and largest growing immigrant group in the United States. In 2021, Asian people represented 31% of the immigrant population and, by 2055, Asian communities are projected to grow to 38% (Hanna & Batalova, 2021; Budiman, 2020). Today, nearly half of all immigrants live in California, Texas, and Florida, with the largest populations living in the metropolitan areas of New York, Los Angeles, and Miami (Budiman, 2020). Almost one quarter of immigrants living in the United States are undocumented.

Included in statistics about the immigrant population are refugees and asylees, people forced to flee their home country because of persecution based on race, religion, nationality, social group affiliation, and/or political opinion. Since the start of the Refugee Program in the 1980s, the United States has accepted over three million refugees and asylees. Just in the last ten years, the United States granted refugee and asylee status to nearly half a million individuals from around the world. In the last decade, these refugees and asylees have primarily been from Burma, Iraq, Democratic Republic of the Congo, Bhutan, and Somalia. The number and origin of refugees and asylees has changed over time according to United States policies and conflicts around the world. The leading states for refugee resettlement are California, Texas, and New York, and for asylee resettlement are California, Illinois, and New York (Baugh, 2022).

The immigrant population in the United States is aging. The number of immigrants age 60 and older is anticipated to rise sixfold from three million in 1990 to 20 million in 2050 (Wu, 2022). This increase of older adult immigrants outpaces growth of any other immigrant age group, resulting in older adults representing an increased share of the immigrant population (Camarota & Zeigler, 2021). Additionally, older adult immigrants are becoming a larger portion of the older American population. In 2000, older immigrants represented around 10% of the American older adult population, with this number rising to almost 14% in 2019 (Camarota & Zeigler, 2021). As noted by Wu (2022), “by the year 2060, foreign-born immigrants will represent almost a quarter of the United States older population” (para. 1). The increasing older adult immigrant population can be attributed to the increasing age at which immigrants arrive in the United States, as well as the rapid aging of the existing immigrant population (Camarota & Zeigler, 2021).

Immigrants aged 65 and older tend to have poorer mental health outcomes than American-born older adults (Rutgers Institute for Health, Health Care
While migration can be associated with resilience, it can also be coupled with traumatic events and circumstances that are risk factors for PTSD. Immigrants face PTSD at a higher rate than the American population. A study by Bustamante et al. (2017) showed that 47% of global migrants experience PTSD, much higher than the global average of four percent (Koenen et al., 2017). While there are no studies on the prevalence of PTSD among the entire American immigrant population, there is ample evidence to suggest global trends in PTSD relate to the American immigrant population. For example, studies about the Hispanic or Latino immigrant population show high rates of PTSD. In a study of foreign-born Hispanic or Latino parents migrating to the US, 34% experienced trauma during their migration process and 21% were at risk for PTSD (Perreira & Ornelas, 2013). Another study revealed that undocumented Hispanic or Latina immigrants experience PTSD at a rate of 34%, which is nearly four times the rate of women in America (Hawkins, 2019).

The reasons for high PTSD prevalence among immigrants, refugees, and asylees are complex. Individuals migrating to the United States face trauma exposure prior to migrating, while migrating, and during the acculturation process. As explained by Bustamante (2017), immigrants are disproportionately at risk for trauma exposure prior to migration. In their home country, immigrants can experience hunger, lack of shelter, illness, violence, abuse, war, and persecution. When arriving to the United States, immigrants can face discrimination, family separation, detention, or threat of deportation. Once in the United States, immigrants may have acculturation difficulties, language barriers, limited access to services and supports, unemployment or underemployment, loss of social networks and cultural ties, and poverty. Many immigrants experience traumatic grief responses as they suffer many losses, including loss of loved ones, community, cultural group, homeland, housing, and employment (Killikelly et al., 2018).

The stress of the violence and trauma associated with migration can result in a variety of physiological reactions. Some refugees experience physical symptoms such as headaches, stomachaches, muscle tension, pain, restlessness, insomnia, fatigue, and gastrointestinal issues (McLean Hospital, 2022). While many immigrants, refugees, and asylees arrive with limited to no financial resources, few social supports, and trauma-related health conditions, they often do not receive the care and resources that they need (Wu, 2022; Song & Teichholtz, n.d; Tonui et al. 2022; Teverovsky, 2007; Bustamante et al., 2017; Jang & Tang, 2021). Often, the physical symptoms that refugees experience due to their

The number of immigrants age 60 and older is anticipated to rise 6x.

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trauma can differ from those experienced by American-born individuals, making it difficult for doctors to determine the root cause (World Health Organization, 2022a; Rohlof et al., 2014). Service providers learn more about trauma and aging, as well as educate refugees, immigrants, and asylees about healthcare resources and work to reduce barriers to care (Wu, 2022; Song & Teichholtz, n.d.; Racine, n.d.; Bustamante et al., 2017; Tonui et al. 2022; Teverovsky, 2007).

While immigrants have great need for health services and supports to cope with trauma and its physical and mental health implications, immigrants often face significant barriers in accessing care. Immigrants may not be able to access care due to language proficiency, confusion arising due to the complexity of navigating how the healthcare system works, limited health insurance, service affordability, transportation issues, and limited healthcare referrals (Song, & Teichholtz, n.d.). Many services provided to immigrants are not linguistically accessible or culturally validated. Care is often provided without oral or written translation, and without integrating culturally validated language, tools, and services (Hacker et al., 2015). As a result, many immigrants may find seeking and utilizing care insurmountably difficult and not inclusive.

For undocumented immigrants, the difficulty of accessing care is compounded by legal and systemic barriers (Bustamante & Portillo, 2022). Immigrants who have not achieved legal status may fear deportation, and those who have may fear the deportation of a family member or close friend (Chavez-Duenas et al., 2019). Similarly, immigrants with temporary or refugee status may worry that they will be denied immigration or turned down for jobs and housing if they seek mental health support (Song, & Teichholtz, n.d.). These challenges are compounded by the discrimination and institutional racism faced by racial and ethnic minoritized groups in the United States. Black or African American individuals experience some of the highest rates of racial profiling by police in the United States (Lofstrom et al., 2022). However, studies show that racial profiling affecting Black or African American communities also affects Hispanic or Latin American communities as Hispanic or Latin American individuals are disproportionately stopped and searched by law enforcement (Lofstrom et al., 2022). This is associated with government policies and societal sentiments on immigration and minority rights.

Individuals migrating to the United States face trauma exposure prior to migrating, while migrating, and during the acculturation process.
have been historically associated with trauma. For example, immigrants and refugees from the Former Soviet Union may fear authority and interaction with healthcare systems, as public institutions were a former source of abuse and repression (Teverovsky, 2007). Older adult immigrants, refugees, and asylees may have more difficulty than others in adjusting to a new culture and its approach to mental health, as it may be difficult to accept concepts such as counseling or medication support for mental health if that is not the approach used in their culture. However, as immigrants, refugees, and asylees age, their need for services will increase. Culturally responsive mental health services are needed to support America’s growing immigrant, refugee, and asylee population.

Many immigrants may find seeking and utilizing care insurmountably difficult and not inclusive.
3.5 Survivors of Crime

It is unknown how many Americans will become victims or survivors of crime during their lifetime. Currently, the Federal Bureau of Investigation (FBI) and the Bureau of Justice Statistics (BJS) conduct annual studies about crime statistics, but the results of these studies paint an incomplete picture. Each study reviews a limited set of crimes, only those crimes reported to the police, and includes statistics from participating policing agencies (Gramlich, 2020). According to some estimates, less than half of all crimes are reported to police (Statista Research Department, 2022; Gramlich, 2020). And in the latest study by the FBI, only eight in ten police departments participated (Gramlich, 2020). While incomplete, looking through FBI and BJS data provides a preliminary understanding of crime in the United States. According to data from 2019, the most common form of crime reported is property crime including theft, burglary, and motor vehicle theft. Less commonly reported but still prevalent is violent crime including aggravated assault, robbery, rape, and murder. Although reported crime rates have decreased over time, the United States has experienced an increase in all types of reported crime during the COVID-19 pandemic (Meyer et al., 2022).

While statistics from the FBI and BJS on all reported property and violent crime are challenging to extrapolate to the US population, there is an abundance of data on childhood sexual abuse, sexual assault, and intimate partner violence. In the US, one in nine girls and one in 53 boys under the age of 18 is sexually assaulted or abused by an adult stranger, acquaintance, or family member (RAINN, n.d.-a). Above the age of 18, one in six women and one in 33 men experience attempted or completed rape in their lifetime (RAINN, n.d.-b). Throughout their lifetime, one in four women and one in 10 men experience intimate partner violence such as sexual or physical violence, stalking, or psychological intimidation (VA, National Center for PTSD, n.d.-d). Sexual and intimate partner violence affect Americans of all ages, socio-economic classes, races, religions, and sexual identities. The impact of these crimes can last a lifetime.

A subset of crime affecting older adults in particular is elder abuse. Abuse can happen to anyone throughout their lifetime; however, older adults may be more vulnerable and less likely to recover from victimization. Elder abuse includes physical, emotional, sexual, and financial abuse as well as neglect and abandonment. It is estimated that up to 5 million older adults are abused each year, representing approximately 10% of older adults in the United States (National Council on Aging [NCOA], 2021; OVC, 2018). Financial abuse is becoming increasingly common and includes financial neglect, exploitation, and health care fraud. The losses associated with financial abuse amount to $36.5 billion annually (NCOA, 2021).

Elder abuse can happen in all types of settings including the home, and residential care facilities or medical institutions. These crimes are often committed by family members, paid caregivers, and strangers. Perpetrators of almost 60% of elder abuse cases are family members including adult children or spouses (NCOA, 2021). For
some offenders, elder abuse is a result of the normalization of violence and manipulation as a means of resolving problems and regaining power and control. For others, such as paid caregiving staff, elder abuse may result from understaffing, improper training, and burnout.

Surviving a crime, especially a violent crime, can result in physical injury and health conditions. According to the United States Department of Health and Human Services, exposure to violence can result in the development of a variety of health conditions including asthma, hypertension, cancer, stroke, and mental health issues (Healthy People 2030, 2020). For example, approximately three quarters of female survivors and half of male survivors of intimate partner violence experience physical injury leading to “conditions affecting the heart, muscles and bones, and digestive, reproductive, and nervous systems” (NCIPC, 2022, para. 6). With regard to elder abuse, the World Health Organization (2022b), explains that victims may experience “physical injuries, premature mortality, depression, cognitive decline, financial devastation and placement in nursing home” (para. 8). The lifetime costs associated with these injuries is estimated to be $3.6 trillion dollars in medical services, lost work productivity, and criminal justice costs (NCIPC, 2022).

Compounding the physical health implications, the mental health consequences of crime can be profound. Compared to those who have not experienced crime, survivors of crime have much higher rates of PTSD. Research by Kilpatrick and Acierno (2003) revealed that crime survivors experience PTSD at a rate of 25% which is much higher than the national average of 6%. Some crimes are associated with higher rates of PTSD, including sexual assault and intimate partner violence. In a study by Kessler et al. (1995), about 45% female of sexual assault survivors reported having PTSD, a rate higher than PTSD among

It is estimated that up to 5 million older adults are abused each year, representing approximately 10% of older adults in the United States.

Offenders often target older adults as they could be more vulnerable and less likely to report crimes. Many victims of elder abuse have limited family nearby, are physically frail, and have disabilities, memory problems, or dementia. Victims often depend on others for help with daily activities such as bathing, dressing, and getting around. While abuse is rampant, according to the National Council on Aging, only one in 24 cases of abuse are reported to authorities (NCOA, 2021). Many older adults are fearful of reporting and seeking support services as they are ashamed of the mistreatment, may blame themselves for the abuse, are fearful of getting their caretaker in trouble or losing caretaker support, or may not be able to seek help and explain their situation due to disability.
male active combat military members (Sharkansky, n.d.). In terms of intimate partner violence, studies suggest female survivors may experience PTSD rates between 31% to 85% (Mignone et al., 2017). Some crime survivors develop PTSD immediately after experiencing the crime. However, for many, PTSD can develop years after the traumatic incident. For example, a study by Easton et al. (2019), found that male survivors of childhood sexual abuse experienced higher levels of depressive symptoms in their fifties, sixties, and seventies compared to men without that history. Similarly, a study by Cook et al. (2011) found that female survivors of physical or sexual assault earlier in life report continued and significant levels of PTSD well into older adulthood.

This may also become true for individuals who have experienced mass shootings. Almost 60% of American adults have experienced or know someone who has experienced gun violence (Newman & Brown, 2020). With the recent rise in mass shootings and the growing older adult population, it is likely than many older adults will have experienced gun violence in the years to come. While the studies are limited, studies show that mass shootings can have mental health consequences for affected individuals (Lowe & Galea, 2017). According to The National Center for PTSD, about 28% of individuals who have experienced a mass shooting will develop PTSD (Novotney, 2018). Those same individuals are also at a greater risk for developing other mental health conditions such as depression, anxiety, and substance abuse.

Victims of crime may require legal, medical, and social services. However, seeking and utilizing those services may be challenging. First, many crime survivors may not know what services are available to them, how to access those services, and the benefits of seeking help. Not all victim services are labeled as such, and not all service providers work within well-connected referral networks. Second, even when victims are informed about services, they may be hesitant to use them. Many crime victims harbor feelings of shame or guilt, fear that they will not be believed by providers, or fear that they will be blamed for the traumatic event. Victims of crime may not identify their experience as a crime, explaining that their experience is a result of “how things were back then”. In turn, they may not identify themselves as a victim of crime or crime survivor, and, in turn, not seek services. Additionally, many crime survivors fear the consequences of seeking help, such as the retaliation of the offender, losing custody of children, being rejected by family members, and losing housing, finances, or public benefits. This is compounded with a mistrust of the victim services and criminal justice system, and a lack of services that are culturally competent, person-centered, and trauma-informed (Smith & Hope, 2020).
3.6 Survivors of Disasters

Every year, many communities across the United States are affected by natural or man-made disasters. In 2021, one in 10 homes across the United States were impacted by natural disasters such as hurricanes, wildfires, winter storms, or severe weather events (Wachner, 2022). By other estimates, as much as 40% of the American population lives in counties affected by climate disasters (Kaplan & Ba Tran, 2022). With climate change, the rate of natural disasters is expected to increase as Americans face increased coastal flooding, longer hurricane seasons, droughts, and irregular weather patterns. The burden of natural disasters is compounded by man-made disasters such as oil spills, terrorist acts, mass violence, and cyberattacks. While older adults may be more resilient to this trauma, they may also be more vulnerable to disasters. Older adults may be less able to prepare for and recover from disaster, and those working in disaster recovery may not know how to support older adults (VA, National Center for PTSD, n.d.-f).

Racial and ethnic minoritized communities tend to experience these climate disasters at higher rates, are less protected from climate disasters, and are less supported after a disaster. For example, over 80% of the homes lost in Hurricane Katrina belonged to Black Americans due to the disparities in neighborhood levee reconstruction after Hurricane Betsy prior (Rysavy & Floyd, n.d.). As a result of environmental racism, racial and ethnic minoritized communities also often lack access to a clean environment and are more susceptible to environmental hazards such as air pollution (Patnaik et al., 2020).

Whether large or small, these disasters have a great effect on the financial, physical, and mental health of the American population (Solomon & Green, 1992). For example, natural disasters in 2021 led to nearly $57 billion in property damages (Jacobson, 2022). While some have disaster insurance to cover these costs, many government and private insurance programs are increasingly unable to cover the costs of rebuilding communities due to the increase in disaster frequency and severity (Cho, 2022). Compounding financial loss, disasters can also lead to physical injury such as cuts and wounds, animal bites, hypothermia, burns, and brain and spinal cord injuries (Bartholdson & van Shreeb, 2018; Oshiro et al., 2022). Disasters can also result in large amounts of toxic particles being released into the air, putting individuals at risk for respiratory illness or lung injury (Bandyopadhyay & Paul, 2012). Some of these physical injuries lead to chronic health conditions and disability, requiring further financial support to cover medical costs.
Whether experiencing property loss or physical injury, disasters are inherently traumatic events. During natural or man-made disasters individuals can lose loved ones, witness terrifying circumstances, fight for survival, and lose a sense of community. While some individuals recover, many go on to experience PTSD symptoms in the short- and/or long-term. According to the Substance Abuse and Mental Health Service Administration, some level of trauma symptoms is common for anyone who has been affected by disasters (SAMHSA, 2022). Various studies found that anywhere from 30% to 60% of survivors experience PTSD after a disaster (Galea et al., 2005). PTSD does not only affect those directly affected by the disaster, but also those involved in rescue efforts. It is estimated that anywhere between five percent and 40% of rescue workers go on to experience PTSD (Galea et al., 2005). PTSD among rescue workers and other high-risk professions is discussed in the next section.

A fraction of disaster survivors with trauma symptoms seek and utilize mental health services (Lowe et al., 2015). During and immediately following a natural disaster, mental health resources may be limited. Connection to in-person and virtual counseling may be reduced, medical professionals may be focused on triaging life-threatening medical events, and survivors may be focused on accessing basic food, shelter, and water. Once mental health services are accessible, survivors may face financial barriers in accessing care. Mental health coverage may not be included in every health plan, eligible providers may be overbooked due to increased demand, and out-of-pocket costs may be prohibitive. Even when mental health services are reached, utilization rates may be low due to social stigma and limited culturally competent services.

Older Adults with a History of Trauma

While older adults may be more resilient to this trauma, they may also be more vulnerable to disasters.

In the immediate aftermath of a disaster, people require food, water, and shelter; safety; and the support of family and friends. Once these needs are met, needs shift to the management of stress reactions; grief and loss; and assimilation back into their community (Jordan, 2015). The initial needs of disaster survivors may be met by the Federal Emergency Management Agency, local government, and non-profit organizations. The secondary and psychological needs of disaster survivors may be met by a large network of government, private, and non-profit organizations.
3.7 Individuals in High-Risk Professions

Workers of certain professions are at higher risk than others of exposure to traumatic events and subsequent development of PTSD. This includes police officers, firefighters (career and volunteer), emergency medical services workers, health care workers, and social workers. Individuals in these and other high-risk professions may witness or personally experience traumatic events frequently, if not daily. For example, it is estimated that 15% of social workers, 19% of medical emergency services workers, 24% of police dispatchers, 35% of police officers, 37% of public health care workers, and 37% of firefighters develop PTSD throughout their career (Weaver, 2021; Tull, 2022; Obuobi-Donkor et al., 2022; Blumenfield & Byrne, 1997; Bryant-Genevier et al., 2021; Bride, 2007). These rates of PTSD are significantly higher than the national average of 6% (VA, National Center for PTSD, n.d.–c).

The health implications of trauma exposure among high-risk professions are profound. For some professionals such as firefighters and police officers, the traumatic event may have left psychological as well as physical scars. This can be a result of car crashes, burns, shootings, and exposure to toxic chemicals (Moad, 2011; Guidotti & Clough, 1992). For example, firefighters experience traumatic physical injuries at an alarmingly high rate. There are approximately 1.1 million firefighters in the United State, out of which approximately 317,000 are career firefighters, and the remainder are volunteers (Fahy et al., 2022). Of those career firefighters, approximately 88,000 are injured every year with 2,000 injuries being life threatening (Houser, 2004).

The combination of physical injuries such as traumatic brain injuries, along with traumatic stress and PTSD is associated with higher rates of Alzheimer’s and other dementias among some in high-risk professions. Studies of 9/11 World Trade Center first responders found
that the combination of traumatic exposure and PTSD resulted in higher rates of cognitive dysfunction than the general population (Hruby, 2021). Overall, 14.8% of responders in the study exhibited cognitive dysfunction comparable with early onset Alzheimer’s or other dementias, while the rate for similar cognitive dysfunction in the general population is less than one percent (Clouston et al., 2017; Mayo Clinic Staff, 2022). Evidence from this and follow-up studies shows that the cognitive symptoms experienced by these first responders are associated with physical exposure at the World Trade Center such as toxic dust and chronic PTSD (Clouston et al., 2022; Kuan et al., 2020). More than 20 years after 9/11, World Trade Center first responders are entering older adulthood with trauma exacerbated by cognitive impairment.

In addition to physical injuries, many high-risk professions can experience moral injuries. Moral injury (MI) occurs in response to acting or witnessing behaviors in traumatic or unusually stressful circumstances that go against an individual’s values and moral beliefs (Norman & Maguen, n.d.). During these events or circumstances, “people may perpetrate, fail to prevent, or witness events that contradict deeply held moral beliefs and expectations.” (Norman & Maguen, n.d., para. 1). Some examples where moral injury may occur include when a firefighter must follow orders to evacuate although they have not been able to confirm whether there are people in need of rescue (Dill et al., 2023), a medical professional may fail to prevent a patient from suffering or dying, and a police officer may witness a miscarriage of justice.

MI is very common in high-risk professions and its impact is significant. A 2020 study by Rosen et al. revealed that frontline health care workers experienced MI at a rate of 41% (Rosen et al., 2022). A 2021 study by Dill et al. reported that firefighters experienced MI at a rate of 58% (Dill et al., 2023). As a response to moral injury, people may feel guilt, shame, disgust, and anger. When morally injurious events occur frequently and/or response to moral injury are left untreated, other mental health disorders can develop including anxiety, depression, suicidal ideation, traumatic stress responses, and PTSD (Dill et al., 2023; Norman & Maguen, n.d.; Rosen et al., 2022). Experiencing MI can lead to the development of mental health conditions as well as intensification of the severity of the mental health conditions (Norman & Maguen, n.d.).

Trauma exposure, PTSD, and MI are contributing factors to reduced work quality, burnout, job loss, and early retirement. However, for many, trauma symptoms do not get left behind in active service. Trauma, PTSD, and MI may affect individuals throughout retirement. For example, a study regarding Irish emergency medical service (EMS) workers found that trauma symptoms persist into
retirement as the sample’s EMS retirees had PTSD symptoms at double the rate of non-EMS retirees (Bracken-Scally et al., 2014). A study concerning retired American firefighters showed similar results. Of the 315 retired firefighters aged 51 to 80, about 22% showed symptoms of PTSD and 11% met the full criteria for PTSD diagnosis (Pepper, 2021). This was compounded by other psychological conditions experienced by retired firefighters, as approximately 22% suffered from depressive symptoms, 16% suffered from anxiety symptoms, 27% experienced substance abuse, and 11% experienced suicidal ideation (Pepper, 2021). These rates were significantly higher than the national average for each mental health condition.

For those high-risk professionals, retirement may feel like a finish line, a break, and an end to traumatic stress. However, for many, retirement represents the start or evolution of their PTSD symptoms. The transition from working to retirement can bring on many changes including the loss of social supports and routine, reduced business, emergence of medical conditions, and time for reflection. It is during this difficult transition that PTSD and MI symptoms can change, intensify, resolve, or emerge for the first time, known as delayed-onset PTSD (Andrews et al., 2007; Dill et al., 2023).

Retirees of high-risk professions have great need for medical and social services. However, seeking care may be difficult due to inadequate resources, limited knowledge, fractured social networks, and professional and social stigma. In terms of access, there may be few resources developed specifically for older adults who have retired from high-risk professions, and physical access to those services may be limited due to distance, transportation issues, or low supply (Health Research & Educational Trust, 2017). Even when services are available, many may not be aware of those resources and may not see the connection between their current health and PTSD and/or MI. Many retirees of high-risk professions think that their physical and psychological challenges are related to the natural aging process rather than to previous trauma exposure. Co-occurring physical, cognitive, and mental health conditions complicate an individual’s diagnosis and referral to appropriate service providers.

Simultaneously, not all older adults from high-risk professions want to discuss PTSD, as they may fear the shame and stigma that accompany such a diagnosis. The culture of high-risk professions such as law enforcement and emergency responders places emphasis on individual resilience, strength, and bravery which make it challenging to show vulnerability and accept support (Heyman et al., 2018). This is compounded for workers who fear that disclosing a mental health condition may jeopardize their job, and for retirees the fear that others will find out and that their diagnosis would jeopardize benefit eligibility. To access resources, learn and understand the role of trauma on healthy aging, and overcome stigma, older adult retirees and workers of high-risk professions need to have strong and transparent peer and social networks. Unfortunately, many individuals of high-risk professions struggle to maintain social supports as a result of PTSD, MI, and/or the demands of the job (VA, National Center for PTSD, n.d.-i; Syracuse University, n.d.; Help for Our Heroes, 2022).
3.8 Military Veterans

According to the United States Department of Veterans Affairs (VA), there are an estimated 18 million veterans living in America (VA, 2022a). This equates to nearly 6% of the American population. Most veterans are men; however, the share of female veterans is projected to increase in the coming years (Schaeffer, 2021). As with the American population, the veteran population is also expected to become increasingly diverse (Schaeffer, 2021). By 2050, the portion of veterans that identify as non-White will grow from 21% to 28% (VA, 2022a). Approximately half of veterans are aged 65 and older (VA, 2022a). Veterans who are older adults were active during World War II, the Korean War, the Vietnam War, and during peacetime.

As a result of wartime and/or peacetime service, many veterans develop PTSD. The estimated lifetime prevalence of PTSD among military veterans is 7%, slightly higher than the national average of 6% (Shnurr, n.d.). For some cohorts, PTSD rates as a result of military service are higher. According to the National Vietnam Veterans Readjustment Study, it is estimated that approximately 30% of Vietnam Veterans had PTSD throughout their lifetime (VA, National Center for PTSD, n.d.-e). A follow-up study conducted in 2013 showed that approximately 1 in 10 of those veterans had PTSD almost 40 years after the Vietnam War (O’Day, 2018). Similar to national trends, female veterans have higher rates of PTSD than males. It is estimated that 13% of female veterans develop PTSD during their lifetime compared to 6% of male veterans (Shnurr, n.d). As noted in earlier sections, PTSD rates among veterans also vary by race, sexual orientation, and sexual identity. Just as civilian racial and gender minoritized people experience PTSD at higher rates, so do racial and gender minoritized people in the military (Kulka et al., 1990; Dohrenwend et al., 2008; Beals et al., 2005; Friedman et al., 2004; Volkers, 2021).

There is a common misconception that these rates of PTSD among veterans are caused solely from trauma exposure of active combat. However, combat and non-combat service members such as medical, administrative, logistics, and IT personnel may be exposed to trauma during training, non-combat operations, disaster recovery, and humanitarian assistance (Swords to Plowshares, 2022). Significant sources of trauma exposure in the military include sexual assault, race- and gender-based violence, deployment, and combat.

The United States military has persistently high rates of sexual assault. A study by Breslin et al. found that, of the nearly 1.3 million service members surveyed, “6.2 percent of women and 0.7 percent of men reported experiences...”
consistent . . . with sexual assault” (RAND, n.d.-a, para. 2; Breslin et al., 2019). Another study of female veterans over the age of 55 revealed that 13% reported a military sexual assault (Edison, 2019). Furthermore, sexual assault among gender and racial minoritized people is higher than the general military population (Schuyler et al., 2020; Breslin et al., 2022). According to a US Department of Defense annual report, the number of sexual assaults keeps increasing year after year (United States Department of Defense Sexual Assault Prevention and Response Office, 2023). It is likely that the rates of sexual assault are higher than reported, as many service members do not report the assault to the Department of Defense or in studies due to shame, avoidance, and/or reprisals (Human Rights Watch, 2015). Of the service women surveyed who reported sexual assault, Breslin et al. (2019) found that “38 percent indicated experiencing events consistent with professional reprisal, 51 percent indicated experiencing events consistent with ostracism, and 34 percent indicated experiencing events consistent with maltreatment.” (RAND, n.d.-a, para. 4).

In addition to military sexual trauma, many service members are exposed to trauma through discrimination based on race, gender, sexual orientation, and sexual identity. As a result of, or by means of, discrimination and harassment, racial and gender minoritized groups experience disproportionately higher rates of military disciplinary action and Other Than Honorable (OTH) discharges than the general military population (Christensen & Tsilker, 2017; Swords to Plowshares, 2021). For example, a report by Christensen and Tsilker (2017) revealed that across all service branches, “black service members were substantially more likely than white service members to face military justice or disciplinary action” (p. i). Additionally, under previous laws, disclosing non-heterosexual preferences and non-cisgender identity, and engaging in same-sex sexual acts on and off base was subject to disciplinary action and OTHs. Reporting or experiencing discrimination and/or military sexual trauma leads many service members to receive less than a fully honorable discharge (Swords to Plowshares, 2021). Receiving an Other Than Honorable (OTH) discharge can have lasting repercussions as it may remove a veteran’s eligibility for medical and financial benefits needed to support civilian life and aging (Benefits Assistance Service, 2014).

**Combat and non-combat service members such as medical, administrative, logistics, and IT personnel may be exposed to trauma during training, non-combat operations, disaster recovery, and humanitarian assistance.**

Another substantial risk factor for the development of PTSD among military veterans is deployment (VA, National Center for PTSD, n.d.-e). The VA estimates that, “PTSD is 3 times
more likely among Veterans who deployed compared to those who did not" (VA, National Center for PTSD, n.d.-e, para. 5). This is because deployment can involve active combat, living in a combat zone, and/or separation from family and social supports. Active combat can exposure service members to traumatic physical injuries such as traumatic brain injuries, amputations, and ingestion of toxins (VA, n.d.-b; Stansbury et al., 2008; VA, n.d.-c). Approximately 10% of military veterans have injuries, most of which were acquired during combat (Morin, 2011). Between 2000 and 2021 alone, more than 450,000 military members were diagnosed with a traumatic brain injury (TBI) (CDC, 2022).

Additionally, combat may expose service members to psychologically traumatic events and circumstances such as witnessing serious injuries, seeing others die, or being in life-threatening situations (VA, National Center for PTSD, n.d.-h). Service members who do not serve in combat roles but are deployed to combat zones may be exposed to trauma by hearing stories of traumatic events and living in an environment of heightened stress and limited social supports (Gibbons et al., 2012). This stress is compounded by the nature of military service, whereby service members have diminished personal liberty, self-determination, and privacy; and are often isolated from civilian society, social support networks such as family and friends, and community resources. Service members who experience assault or discrimination may have to remain in the same physical space as the perpetrator, and/or report to and work with perpetrators who are in their chain of command.

As a result of trauma exposure, discrimination, and harassment, many service members experience MI. As explained in the previous section, MI occurs in response to acting or witnessing behaviors in traumatic or unusually stressful circumstances that go against an individual's values and moral beliefs (Norman & Maguen, n.d.). During these events or circumstances, “people may perpetrate, fail to prevent, or witness events that contradict deeply held moral beliefs and expectations.” (Norman & Maguen, n.d., para. 1). Some examples of morally injurious events include when a service member must follow orders to use force when civilians may be present, or when a service member witnesses assault or discrimination. It is estimated that approximately 42% of veterans experience moral injuries (Maguen & Norman, 2022), and that this can result in the development of PTSD, adverse health conditions, and suicidality (VA, 2021; Koenig et al., 2019).

Service members may experience poor physical and mental health outcomes due to trauma exposure and the development of PTSD. Studies have shown that PTSD among service members is associated with greater likelihood of developing a wide range of physical health conditions such as cardiovascular illness, sleep disorders, respiratory conditions, osteoporosis, migraine, diabetes, and cognitive decline (Jankowski, 2016; El-Gabalawy et al., 2018; Yaffee et al., 2010; Qureshi et al., 2010). Many service members who have PTSD also have traumatic brain injuries. As explained by James et al. (2014), “these disorders often co-occur with 44% of individuals with a history
of [mild] TBI also meeting criteria for PTSD” (p. 357). The occurrence of TBIs can both lead to the development of PTSD as well as exacerbate PTSD symptoms. Alarmingly, studies reveal that military veterans with PTSD have nearly two times the likelihood of developing dementia compared to those veterans without PTSD (Yaffee et al., 2010; Qureshi et al., 2010). PTSD among service members is also associated with a significantly higher risk of developing anxiety, depression, and suicidality (RAND, n.d.-b; VA, 2022b). Veterans are one and half times more likely to die by suicide than non-veterans (DeAngelis, 2022). PTSD prevalence among veterans is also associated with health risk behaviors such as alcohol and substance abuse (VA, National Center for PTSD, n.d.-g) or impulsivity and risk-taking behaviors (James et al., 2014). These behaviors can further exacerbate symptoms of PTSD and associated health conditions.

While veterans and service members have a need for health and social services, few seek care. For example, less than half of military veterans in need of mental health services seek care (Boykin, 2022). Many older veterans have a history of trauma, and a fraction receive the care and support they need. Limited care for veterans can be attributed to multiple factors including bureaucratic obstacles and social isolation. After military service, most veterans are eligible for services through the VA. However, many veterans use private health care or go without care, as seeking services through the VA can involve a lot of red tape, services may not be available at convenient locations or times, veterans may have limited knowledge of eligibility, and the VA may not cover all needed services (Mission Roll Call, 2023). With regard to PTSD treatment in particular, veterans who seek support for PTSD and related health conditions must go through a claims process to prove that their trauma and related health conditions are a result of military service (VA, 2022c). This claims process can take months or years to complete, and some legitimate requests are denied (VA, 2023). The separation status of veterans, or the way in which they left the military, also plays a significant role in eligibility for VA services. As previously mentioned, some service members receive an OTH discharge because of experiencing or reporting assault and discrimination. Receiving this OTH discharge removes their eligibility from receiving VA medical and financial support.

Another factor impacting the utilization of services is loneliness among veterans with and without PTSD. A study by Kuwert et al. (2014) revealed that 44% of veterans feel lonely some of the time and 10.4% of veterans feel lonely most of the time. This study also showed that older age as well as trauma history increased feelings of loneliness. Social isolation and loneliness can be a result of trauma exposure, can increase PTSD symptoms and related health conditions (Wilson...
et al., 2018; Kintzle et al., 2018), and make it more difficult to seek care (Graham, 2022). In addition to trauma exposure, drivers of loneliness and social isolation include separation from military service and difficulty transitioning to civilian life. A study by Wilson et al. (2018) found that about “[h]alf of U.S. veterans report feeling they don’t belong in society after separation from military service” (Graham, 2022, p. 1). After leaving the military, veterans may have trouble relating to civilians, struggle to adjust to their new civilian identity, lose touch with former fellow service members, and face stigma about mental and physical health diagnoses (McElhinny, 2021).

As veterans age, they may become more reliant on their family and friends for care. However, caregiving for veterans with prior trauma exposure and PTSD may be more complicated. First, some veterans may have strained relationships with family and friends as a result of military service. Almost half of service members who have been deployed report that their service has been a strain on family relationships (RAND, n.d.-b). These strains may be heightened for caregiving relationships for veterans with PTSD. A study by Shepherd-Banigan et al. showed that caregivers of veterans with PTSD have elevated levels of burden, stress, and financial strain when compared to caregivers of veterans without PTSD (Shepherd-Banigan et al., 2020). There are further negative consequences for caregivers of veterans with PTSD and dementia (Pinciotti et al., 2017).
3.9 Individuals with Disabilities

According to Centers for Disease Control and Prevention [CDC] (2020a), approximately 25% of Americans, or 61 million, report living with a disability. The CDC (2020a) explains that “a disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions)” (para. 1). These conditions may be related to birth (e.g. down syndrome, spina bifida, cerebral palsy), development (e.g. autism, attention deficit hyperactivity disorder), injury (e.g. TBI, stroke, paralysis), and/or health conditions (e.g. diabetes, arthritis, lung disease) (PPOT, n.d.; CHADD, 2018; CDC, 2023c; CDC, 2016; Cleveland Clinic, 2021; Disability Benefits Center, 2023). These disabilities may affect a person’s hearing, vision, cognition, movement, mental health, communication, and relationships, and may increase the difficulty of self-care and independent living.

Of all age groups, older adults experience the highest frequency of disability, as 44% of those 65 years of age and older live with a disability (CDC, 2023a). This is unsurprising as health, aging, and disability status are closely related. Among individuals 65 and older, disabilities most commonly affect mobility and hearing. Approximately 11% of people 65 and older have a disability that impacts their ability to live independently, and approximately 6% have a disability affecting their ability to care for themselves (CDC, 2023a). As the American population ages, the number of older adults with disabilities is projected to grow (Joint Center for Housing Studies of Harvard University, 2016).

Having a disability may be associated with decreased health which may, in turn, lead to further disabilities (NCBDDD, 2022). Individuals with disabilities are more likely than those without disabilities to experience health conditions such as arthritis, asthma, cancer, pulmonary disease, stroke, and diabetes (CDC, 2020b). As individuals with disabilities age, they are more likely to experience these and other health conditions. Depression, anxiety, and suicidal ideation are also more common in individuals with disabilities (Brown, 2023; CDC, 2023b; Smith et al., 2019). Adults with disabilities are four times more likely to experience mental distress and three times more likely to experience suicidal ideation compared to those without disabilities (CDC, 2023b; Czeisler et al., 2021; Cree et al., 2020). Mental and physical ailments may be compounded by social isolation. According to Emerson et al. (2020), “[p]eople with disability experienced loneliness, low perceived social support and social isolation at significantly higher rates than people without disability.” (p. 1). Disabilities may result in social isolation which may further exacerbate disability (Blanton, 2020).

44% of those 65 years of age and older live with a disability
Disability status often interplays with other aspects of an individual’s circumstance such as race, geography, educational attainment, and income. According to the CDC’s Disability and Health Data System (DHDS) (2023a), American racial and ethnic minoritized populations experience disabilities at a higher rate than White Americans. American Indians or Alaska Native individuals are most likely to report having a disability, followed closely by those who identify as multiracial (Bialik, 2017). Black or African Americans also have a higher likelihood of having a disability compared to White Americans (Goyat et al., 2016). The DHDS also reveals that disability is unevenly distributed across geography. The highest rates of disability were found primarily in the south and include Puerto Rico, Kentucky, Mississippi, West Virginia, Arkansas, Louisiana, Oklahoma, Alabama, and Tennessee (CDC, 2023a).

Those living with disabilities tend to have lower levels of employment and household income. According to the United States Bureau of Labor Statistics, individuals with disabilities experience unemployment at 7.6% which is more than double the rate of Americans without disabilities (United States Bureau of Labor Statistics [BLS], 2023). Additionally, 30% of people with disabilities work part-time, double the rate of people without disabilities. These trends align with lower income. As revealed by the United States Census Bureau through the 2019 American Community Survey (ACS), the median annual income for households that include an individual with disabilities was $50,300 (Erickson et al., 2023).

This compares to a median annual income of $70,784 for households without individuals with disabilities (Semega & Kollar, 2022). Compounding the low levels of income and employment are the increased costs of care. It is estimated that households containing an adult with a disability require 29% more income to maintain the same standard of living as households without individuals with disabilities (Morris et al., 2021). These expenditures can include “medical and pharmaceutical care, mobility equipment or assistive technologies, and caregiving services” (Morris et al., 2021, p. 158). Adjusting for this additional cost, 35% of households with individuals with disability are at the federal poverty line. These trends are likely to increase with age as income sources diminish and the need for care and its associated cost increases.

Disability does not only affect income, but also the prevalence of trauma. Trauma and disability have a bidirectional relationship, meaning that exposure to traumatic events or circumstances can lead to disability, and having a disability may make individuals more vulnerable to trauma exposure. This connection was explored by Byers et al. (2015), who found a strong association between the prevalence of PTSD and disabilities among older adults. According to their study, older adults with persistent PTSD symptoms that extended into later life were more likely to experience one or more disabilities. Exposure to a traumatic event such as hate crime, active combat, sexual assault, or domestic violence may leave individuals with chronic health conditions which can affect their ability to see, hear,
Exposure to traumatic events or circumstances can lead to disability, and having a disability may make individuals more vulnerable to trauma.

Individuals with intellectual disabilities may have limited knowledge, social skills, and verbal skills needed to report crimes to the authorities, seek supportive services, and process trauma (Wilcox, n.d.; The Arc, 2011).

The realities of living with a disability may affect the types of health and social services needed, as well as how services are accessed and utilized. Those with disabilities may need housing support, in-home medical services, home modifications, caregiving, socialization, and access to community resources. However, not all services are physically accessible for the blind, deaf, and mobility challenged. While the Americans with Disabilities Act (ADA) requires providers of services to accommodate those with disabilities, many health care facilities have not made the necessary updates to their equipment, policies, or physical spaces (Keary, 2014). Accessing care is further challenged by discrimination of service providers based on disability status. A study by Lagu et al. (2022) found that physicians may discharge early or avoid seeing patients with disability because of the need to make accommodations for their care, attitudes toward people with disabilities, and/or limited knowledge, skill, or experience working with people with disabilities.
Even when services are accessible, individuals with disabilities may not be able to access and utilize them due to affordability. In 2021, approximately 20% of individuals with disabilities were unable to see a doctor in the previous year due to the cost of care (CDC, 2023a). Many adults and older adults with disabilities need paid caregivers to support them with tasks of daily living. However, paid caregiving costs are high and there are shortages in the direct care workforce. Additional barriers to care for individuals with disabilities include limited information about services, bureaucratic obstacles, fear of privacy invasion, social stigma, limited direct care workers and other providers trained to serve those with disabilities (Bear et al., 2020). These barriers to care are compounded by age and the effects of trauma.
4. Family Caregivers

4.1 Family Caregiver Background

There are many definitions for family caregivers developed by civil society and advocacy groups, academia, health care systems, and government. However, they all share a common feature: family caregivers are the backbone of long-term care in the United States. A family caregiver is a family or chosen family member, partner, or friend who provides a broad range of assistance to an adult or older adult with a chronic, disabling, or serious health condition. Family caregivers are not professionally employed to care for their loved one, may or may not have prior experience in caregiving, and can live with or separately from those they care for. This responsibility may be short-term, long-term, or indefinite.

According to a 2020 study by the AARP and National Alliance for Caregiving [NAC], it is estimated that one in six Americans, or about 42 million American adults, are caring for someone 50 or older, up 16% since 2015. Not only is the family caregiver population growing, but also the number of family caregivers caring for multiple individuals is increasing. In 2020, approximately one quarter of family caregivers cared for two or more individuals, a statistic up 18% from 2015. These trends are anticipated to continue as the older adult population booms, healthcare costs rise, and the direct care workforce struggles to bounce back from the COVID-19 pandemic (AARP & NAC, 2020).
Family caregivers provide their loved ones with a wide range of support from dressing and bathing to emotional companionship, administering medication, or carrying out medical or nursing tasks (Committee on Family Caregiving for Older Adults et al., 2016). Family caregivers generally support with the following activities:

- **Supporting daily activities.** This can include dressing, getting in and out of bed/chairs, helping to bathe or shower, feeding, getting to and from the toilet, and dealing with incontinence and diapers.

- **Completing chores.** This can include transportation, housework, grocery shopping, errands, and preparing meals.

- **Providing emotional and social support.** This can include supporting loved ones coping with medical diagnoses, processing changes associated with aging, and providing companionship.

- **Providing financial and legal end-of-life planning.** This can include managing bank accounts, setting up wills and estates, and making decisions on behalf of their loved ones through powers of attorney.

- **Advocating for their loved one’s care.** This can include negotiating with healthcare providers and insurance companies.

- **Coordinating medical treatment and care.** This can include arranging or supervising paid care or providing transportation to medical services.

- **Performing complex medical and nursing tasks.** This can include administering medications, giving injections, changing dressings, managing pain and medications, helping with assistive devices, preparing food for special diets, performing wound care, and operating medical equipment.

In 2021, it was estimated that the support provided by family caregivers amounts to 36 billion hours annually. This annual care is valued at $600 billion, more than annual spending in the United States on out-of-pocket healthcare costs ($433 billion) and total spending on long-term care costs ($531 billion) (Reinhard et al., 2023).

The reliance on family caregivers in the United States is multi-faceted. At its core is a mismatch between the amount of long-term care needed by older adults and the amount of care available. More Americans are living longer as medical advances are saving the lives of thousands who require lifelong care for disabilities or chronic illnesses (Talley & Crews, 2007). Approximately 48% of older adults in the United States have difficulty carrying out activities of daily living without assistance (Freedman & Spillman, 2014). Of those older adults who require assistance, 95% receive some type of help with daily activities from family or close friends and 66% rely solely on family caregivers (Freedman & Spillman, 2014; National Center on Caregiving [NCC], 2003). These statistics are anticipated to grow as the older adult population ages. Between 2016 and 2060, the population of older adults above the age of 85 is anticipated to triple and the population with Alzheimer’s disease is expected to more than double (Mowry, 2022).
Simultaneously, the size of the long-term and direct care workforce lags. While the size of the direct care workforce is anticipated to increase more than any other occupation in the country, there is a shortage of individuals to fill these positions, and the number of direct care workers is significantly lower than the direct care needs of older adults (PHI, 2022; Mowry, 2022). This lag is due to the high stress and low wages associated with direct care jobs. According to a report by PHI (2022), because of low wages, part-time hours, limited opportunities for career advancement, and a lack of benefits, “40% of direct care workers live in low-income households, and 43% rely on public assistance, such as Medicaid, food and nutrition assistance, or cash assistance” (p. 2). Compounding these challenges, direct care workers are often family caregivers themselves.

With the limited availability of paid caregivers, America’s older adults increasingly rely on family caregivers who are primarily female, and of lower socio-economic means. While there is a growing trend for males to take on family caregiver tasks, women still comprise two-thirds of the family caregiver population (National Alliance for Caregiving & EmblemHealth, 2010). Approximately 44% of family caregivers live in households under twice the federal poverty level (Ho et al., 2005). This is especially true of racial and ethnic minoritized populations who experience poverty at higher rates.

Family caregivers are increasingly young and diverse. Family caregivers are becoming younger as millennials begin to comprise a greater portion of family caregivers. In 2019, this group of millennial caregivers represented 30% of the family caregiver population. This generation of caregivers has unique needs as they are ‘sandwiched’ between caring for both a younger and older generation (Reinhard et al., 2023; Wolff et al., 2018). These ‘sandwiched’ caregivers are also likely to continue working while providing care for the two generations (Reinhard et al., 2023; Friedman et al., 2017, Lei et al., 2022). The growth of this younger generation of caregivers shifts the overall composition of the family caregiver population. Additionally, in 2020, 14% of family caregivers were Black or African American, 17% were Hispanic or Latin American, and 5% were Asian American (AARP & NAC, 2020). Simultaneously, there is an increasing recognition of non-traditional family structures because of demographic shifts and social progress (Reinhard et al., 2019). LGBTQ+ family caregivers account for 9% of caregivers in the United States (Reinhard et al., 2023).
4.2 Family Caregiver Stress

While family caregiving may be experienced differently across demographic groups, family caregivers share common challenges. Family caregiving can be strenuous, difficult, and complicated, albeit rewarding work that can take an economic, physical, and social toll on family caregivers.

Caregiving responsibilities often take a toll on the ability of caregivers to maintain employment. Many family caregivers must reduce or forgo paid work to prioritize caregiving responsibilities. Research from the Harvard Business School uncovered that nearly one third of American workers reported that they must give up their jobs to prioritize caregiving responsibilities (Fuller & Raman, 2019). According to the Reinhard et al., (2019), forgoing employment can result in both short- and long-term financial risks including “losing salary and eventual Social Security and retirement benefits, needing to draw from personal retirement savings, diminishing career opportunities, and worse overall financial well-being” (p. 8). Since the COVID-19 pandemic, finding daytime care for older adults or young children is increasingly difficult, and their jobs may not provide adequate supports or benefits such as paid leave (Reinhard et al., 2023; Weber-Raley, 2019, Lei et al., 2022). This is especially true of ‘sandwiched’ caregivers that currently face employment challenges at higher levels due to their compounded caregiving responsibilities. It is predicted that an increasing share of future family caregivers will remain in the workforce for longer, facing the dual demands of employment and caregiving responsibilities (The Rosalynn Carter Institute for Caregivers, 2022).

In addition to reduced employment, family caregivers are often responsible for some or all the financial costs of those they care for. This can include costs associated with daily life, home modifications, paid home care, and medical bills. According to an AARP study (2016), family caregivers, on average, spent $7,000 annually to take care of their loved one. Family caregivers reported covering these expenses by tapping into personal savings, retirement savings, or reducing savings contributions (Reinhard et al., 2019).

For some family caregivers, losing employment means a loss or reduction in health insurance coverage. According to Ho et al. (2005), family caregivers were more likely than their non-caregiver peers to forgo filling a prescription; skip visiting a specialist; miss a doctor-recommended medical test, treatment, or follow-up visit; or experience a medical issue without seeing a doctor. This is partly due to the reduced affordability of medical costs and in part due to the decreased rate of family caregiver self-care and health maintenance behaviors (Ho et al., 2005; Schulz & Sherwood, 2008). Sixty-three percent of family caregivers report worsening of eating habits, and 58% report worsening exercise habits because of caregiving responsibilities (Caregiver Action Network, n.d.). This results in decreased health outcomes for family caregivers. One in ten family caregivers report that caregiving responsibilities have caused their physical health to worsen (Family Caregiver Alliance [FCA], n.d.-a). And almost half of family caregivers report having chronic health conditions, a rate double that of non-caregivers (FCA, n.d.-a). Family caregivers also report heightened levels of physical exhaustion, depression, and anxiety compared to non-caregivers.
Caregiving can also take a toll socially by changing caregiver relationships and increasing social isolation. Caregiving tasks can change the dynamics of a caregiver’s relationship with those for whom they care as these tasks are inherently intimate, challenging, and emotionally stressful. Clothing a parent, bathing a spouse, or managing the pain of a loved one places strain on relationships. Providing care for a loved one can also be isolating, as caregivers may feel alone in their responsibilities, and that no one would be able to understand their situation. Some family caregivers may be removed from the routines and habits they depend on to socialize. Others may need to provide round-the-clock care to their loved one and do not have time to socialize, unwind, or rejuvenate. This social isolation can lead to reduced health and well-being of caregivers (FCA, n.d.-b).

Studying and accounting for caregiving stress is critical to addressing the health and well-being of older adults with a history of trauma. Studies show that the illness of a spouse can affect the health of their caregiving partner (Christakis & Allison, 2006). For example, spousal caregivers of older adults with Alzheimer’s are more likely to experience declines in health than non-caregivers (Alzheimer’s Association, 2023). These declines in health can affect the ability of a family caregiver to continue providing their loved one with the support they need to remain in their home. As demonstrated by Talley and Crews (2007), the decline in health among family caregivers is the leading cause of institutionalization of their loved ones. Conversely, studies have shown that care recipients are less likely to be institutionalized when their caregivers have access to supportive relationships and resources (Talley & Crews, 2007).

4.3 Family Caregiving and Trauma

Providing care for a family member or friend with a history of trauma can increase the complexity associated with their care. In addition to the responsibilities mentioned above, family caregivers of older adults with a history of trauma can find themselves managing the existence, reemergence, or exacerbation of trauma-related emotions and behaviors in their loved one. Family caregivers are often on high alert for their loved one’s trauma triggers, and are often called on by service professionals to manage their loved one’s fears, anxieties, and distrust of health care providers.

Although it is a prevalent issue, there is a dearth of research on the impact of trauma on family caregiving. The few studies on the topic relate to the field of veteran care. Many wounded, injured, or disabled veterans rely on family caregivers for daily care and support (Ramchand et al., 2014). Like the support provided to non-veterans, family caregivers of veterans report increased challenges and stress associated with caregiving responsibilities. Family caregivers of veterans with PTSD can feel like they live “in an atmosphere of constant chaos” (VA, National Center for PTSD, n.d.-b, para. 11) as they are not only managing their loved one’s care but also their trauma response. Thus, veteran caregivers experience higher levels of physical and emotional distress, and financial strain than non-caregivers (Shepherd-Banigan et al. 2020). These caregivers also report more workplace problems than other caregivers and are at increased risk for social isolation and depression than other caregivers (Strong, 2018; VA, n.d.-a).
There are several reasons that caregiving for an older adult with a history of trauma may be more challenging than caregiving in the general older adult population. First and foremost, symptoms of trauma and PTSD can be difficult to manage for the individual experiencing them as well as for family caregivers. Family caregivers may not know how to soothe the distress, anger, confusion, or panic as their loved one experiences flashbacks, nightmares, or intrusive thoughts. Family caregivers may also not know how to respond to trauma-related behaviors such as avoidance, hypervigilance, and isolation. These emotions and behaviors add another layer of complexity when a caregiver seeks to help their loved one with medical tasks, performing daily chores, or end-of-life planning.

Second, as mentioned previously, individuals with a history of trauma have a higher likelihood of experiencing declines in physical, cognitive, and mental health. For example, trauma exposure is associated with a higher prevalence of lung disease, dental problems, fibromyalgia, chronic fatigue, cardiovascular disease, gastrointestinal disorders, endocrine disorders, and headache disorders (Spitzer et al., 2011; de Oliveira Solis et al., 2017; Rouxel et al., 2016; Häuser et al., 2013; Dansie et al., 2012; McFarlane, 2010; Salleh, 2008). Thus, family caregivers of older adults with a history of trauma are likely to care for individuals with higher rates of medical issues. Individuals with a history of trauma may have multiple health conditions and those health conditions may be more difficult to manage.

A health condition that is both more likely and more difficult to manage among individuals with a history of trauma is dementia. Trauma exposure can lead to cognitive decline as Alzheimer’s disease and other dementias are more likely among individuals with a history of trauma (Mohlenhoff et al., 2017; Yaffee et al., 2010). Conversely, cognitive decline can cause trauma symptoms to evolve and become more challenging to treat. Some older adults experiencing Alzheimer’s disease or other dementias may focus on retelling traumatic events, display verbal or behavioral aggression, anxiety, and confusion, or resist care. Compared with caregivers of people without dementia, caregivers for individuals with dementia are twice as likely to indicate substantial emotional, financial, and physical difficulties. Evidence suggests that the stress of providing dementia care increases caregivers’ susceptibility to disease and health complications (Alzheimer’s Association, 2023).

Third, and compounding the challenge previously explained, individuals with a history of trauma may avoid professional medical care. Trauma can lead to a distrust of authority and health care providers. This can form a reluctance to use healthcare...
systems for fear of being misunderstood, blamed, or retraumatized, which may be acute among individuals who experienced trauma in medical and healthcare settings. This shifts a greater burden of care onto family caregivers, who must perform additional, complex medical tasks.

Finally, trauma can place a strain on caregiving relationships. By the very nature of family caregiving, tasks can be intimate as individuals bathe, cloth, and feed their loved ones. It may be difficult for a care recipient to allow someone into their personal space and build a trusting relationship with their caregiver. Compounding these feelings, the very act of receiving care can be triggering for some. Smell, touch, sound, taste, and caregiving situations can trigger memories or emotions from previous trauma, both for the care recipient and the family caregiver. It is important to remember that just as care recipients may have a history of trauma, their caregivers may as well. These challenges may place strain on relationships between older adults with a history of trauma and their family caregivers as both parties navigate dynamics associated with trauma.

The complexities associated with caring for someone with a history of trauma can affect the health and well-being of family caregivers. Caregivers exposed to their loved one’s history of trauma can be vulnerable to vicarious trauma, compassion fatigue, and burnout. Caregiving can become a traumatic experience, resulting in trauma symptoms among caregivers such as increased anxiety, depression, and hypervigilance. The additional physical and psychological demands of caregiving for an older adult with a history of trauma may also decrease health maintenance behaviors and increase social isolation, financial strain, and physical and mental exhaustion. As a result, family caregivers of those with a history of trauma may experience deterioration to their health at a rate higher than those who care for older adults without a history of trauma.

4.4 Service Access and Utilization

Those providing for their loved one’s care have a diverse range of needs including information and training, increased service eligibility and affordability, emotional and social support, and culturally competent and responsive services. Family caregivers of older adults with a history of trauma also need information and resources on how to provide PCTI care and manage trauma-related conditions. These needs as well as other needs of family caregivers are outlined in the National Strategy to Support Family Caregivers. Released by ACL in 2022, this strategy provides recommendations for increasing awareness and outreach, advancing partnerships, strengthening services and supports, ensuring financial and workplace security, and expanding research in service to family caregivers (ACL, 2022).
Without addressing these needs, many family caregivers will continue to go without the tools and resources needed to care for themselves and their loved ones.

Many family caregivers find themselves without the information and training needed to care for their loved ones. This includes information and training on how to keep their loved one safely at home, completing forms and paperwork, managing their own emotional and physical stress, end-of-life decision-making, and performing care tasks (AARP & NAC, 2020).

Many family caregivers receive little to no training before performing complex medical and nursing tasks such as administering medication, pain management, and wound treatment. And most family caregivers do not receive information about how to provide care that accommodates for their loved one’s history of trauma. According to the AARP and NAC (2020), while two-thirds of family caregivers note a need for additional information related to caregiving, “fewer than 3 in 10 [caregivers] say a health care provider, such as a doctor, nurse, or social worker, has asked them about what they needed to care for their recipient” (p. 76). Less than that, only 13% of family caregivers reported that a healthcare provider asked them about their personal needs as a caregiver (AARP & NAC, 2020). Often health and social service professionals fail to identify a care recipient’s family caregiver and thus do not integrate them into their loved one’s care plan.
Family caregivers may also have limited information about existing services. However, even when family caregivers identify the services helpful to them, many find that they are not eligible, or that services are unaffordable. Approximately one quarter of family caregivers of older adults over the age of 50 report difficulty accessing affordable services for their loved ones (AARP & NAC, 2020). This includes accessing affordable meals, transportation, in-home care, home modifications, and child and adult daycare. Many services are limited in scope and geographic availability and are available primarily to those with very low incomes rather than caregivers (National Academy for State Health Policy [NASHP], 2022). Even those who are eligible may struggle to navigate bureaucratic barriers. For example, some family caregivers may be eligible to be paid for performing caregiving tasks but many struggle to navigate the Medicare, Medicaid, and health insurance systems to receive financial compensation (Fisher, 2020).

Complicating the issue of service access is the current state of the direct care workforce. Even when caregivers use family caregiver services, they may need the help of a direct care worker to aid in their loved one’s care. However, there are limited direct care workers, as the industry is struggling with low pay, limited training, emotionally and physically challenging work, and high rates of burnout. Family caregivers may struggle to find a direct care worker that is able to provide PCTI care and that is a good and affordable fit for their loved one’s needs, language requirements, and care preferences. To address this crisis, the United States Federal Government and stakeholder organizations such as ACL, The United States Department of Labor (DOL), Centers for Medicare and Medicaid Services (CMS), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) are introducing a variety of initiatives (ACL, 2023b). These initiatives aim to increase and improve training, recruitment, retention, and professional development for direct care workers as well as strengthen policies and services and support offered to them. While these initiatives are promising, the small amount of direct care workers shifts a great amount of caregiving responsibilities to family caregivers.

Almost 40% of family caregivers of older adults report feeling that respite services would be helpful, while only 14% of family caregivers have access to respite services.

The stress associated with caregiving responsibilities, navigating the network of services, and learning how to care for their loved one, takes a toll on the social and emotional well-being of family caregivers. Social and emotional well-being can be improved through peer support and respite services (Office for People with Developmental Disabilities [OPWDD], n.d.). By connecting with peers, family caregivers can gain confidence, reassurance, and comradery.
This can reduce feelings of social isolation and loneliness, and connect family caregivers to others who can help. Complementing the emotional support found through peer networks, family caregivers need time and space to heal and rejuvenate. Respite services are critical to providing caregivers time away from their care recipient to recharge and take care of their own health and well-being. Almost 40% of family caregivers of older adults report feeling that respite services would be helpful, while only 14% of family caregivers have access to respite services (AARP & NAC, 2020). Contributing to the limited use of respite services is that many family caregivers believe that caring for themselves takes them away from providing essential care for their loved one. Others may think that seeking help is a sign that they are failing in their caregiving duties, bringing up feelings of guilt or shame. Without social and emotional supports, family caregivers can become isolated from the social networks and connections that can help them access and utilize care.

Even when family caregivers manage to navigate systems of care and afford services for themselves and their loved ones, they may find that these services are not culturally competent or culturally responsive. Family caregivers may find that services may not be available in their preferred language or provide culturally relevant support. For example, culturally relevant family caregiver therapy for American Indian groups may focus on reminiscent therapy and storytelling, and linguistically accessible therapy for Latin or Hispanic American family caregivers would be provided in Spanish (Trualta, n.d.; Diverse Elders Coalition, 2021). By providing culturally competent and responsive support, diverse family caregivers will have access to information, caregiving services will become more inclusive, and family caregivers of all backgrounds may be more likely to access and utilize services.

**Family Caregiver Self-Identification.** Individuals who identify with the role of family caregiver are more likely to seek out supportive services, have greater connection and belonging in the community, and gain confidence in their caregiving responsibilities (O’Connor, 2007; Caregiver Action Network, n.d.). Despite the numerous benefits of self-identification, only about 20% of family caregivers identify as such (AARP, 2001). Some may be hesitant to identify themselves as a family caregiver as it requires recognition and acceptance of their loved one’s health status. Others may avoid identifying as a family caregiver as this may be at odds with their cultural background. In some cultures, family caregiving is included in the identity of being someone’s spouse, parent, or child. Family caregiver services must be flexible and inclusive to appeal to everyone with family caregiving responsibilities, regardless of how they self-identify.
Conclusion

Trauma plays a significant role in how Americans age. By the time Americans reach older adulthood, most have experienced one or more traumatic events. In fact, it is estimated that as many as 90% of Americans will experience a traumatic event in their lifetime such as violence, disaster, or war (Kilpatrick et al., 2013). This trauma exposure can leave indelible scars that last a lifetime, impacting an individual’s health and well-being as they age. While trauma exposure can result in resilience in aging, it can also be the root cause of a variety of physical and mental health conditions that complicate the aging process and make family caregiving even more challenging. As the population of Americans aged 65 and older increases, it is imperative that trauma is reconceptualized as a life course issue and one that can and must be addressed in the aging services sector.

Using the PCTI approach, all those involved in aging services can ensure older adults with a history of trauma and their family caregivers get the care they need and deserve. PCTI care is a holistic approach to service provision that promotes the dignity, strength, and empowerment of individuals with a history of trauma by incorporating knowledge about the role of trauma into agency programs, policies, and procedures (Eisinger & Bedney, 2018). PCTI care combines the principles of person-centered care (self-determination, choice, empowerment, and individual preference) with the principles of trauma-informed care (safety, trust and transparency, peer support, collaboration and mutuality, empowerment and choice, and cultural competency) (SAMHSA, 2014). By infusing these principles throughout all functions of an organization, aging service professionals and volunteers can support the health and well-being of everyone who relies on their care. Whether or not a provider knows that a person has a history of trauma, the PCTI approach can help.

As the population of Americans aged 65 and older increases, it is imperative that trauma is reconceptualized as a life course issue and one that can and must be addressed in the aging services sector.
Making PCTI care widely available for all older adults and family caregivers requires the collective effort of all those involved in aging service provision. Infusing the PCTI approach into care delivery cannot be done by direct services providers alone. Improving the availability, access, and quality of PCTI care requires all those involved in aging service to work together regardless of sector, geography, professional specialization, or seniority. Doctors, nurses, advocates, government officials, social workers, transportation workers, lawyers, policy makers, funders, philanthropists, and researchers all have a vital role to play. The recommendations below provide some ideas of ways to advance PCTI care in the aging services sector.

1. **Research issues of trauma, aging, service needs, and PCTI care.**
   To design evidence-based interventions, make data-driven decisions, and tailor services to diverse populations, it is essential that professionals have rigorous research on which to rely. To do so, those working in aging services should collaborate to uncover and close gaps in the literature on aging, trauma, and PCTI care. This includes researching service needs of diverse populations and developing innovative models for PCTI care.

2. **Raise awareness and understanding about aging with a history of trauma and how PCTI care can help.**
   To provide PCTI care to all older adults, aging service professionals and volunteers must learn about the role of trauma in the aging process and understand the core tenants of the PCTI approach. This can be achieved by adding the topics of aging, trauma, and PCTI care into advocacy campaigns, academic curricula, staff onboarding, and continuing professional education.

3. **Raise awareness and understanding about the experiences, trauma triggers, trauma prevalence, and service needs of diverse communities.**
   Older adults with a history of trauma and their family caregivers are not homogeneous groups. It is essential to understand the way in which subsets of each community experience trauma, how that trauma affects their aging process, what their unique service needs are, and how to best implement PCTI approaches into their care. This can be done by sharing and learning from individual and communal stories of trauma, asking individuals about their service needs and preferences, and maintaining cultural humility. While it may not be possible for everyone to know the nuances of every community, professionals and volunteers must remain curious about the ways in which people from diverse backgrounds experience trauma.
4. Deepen organizational capacity to provide PCTI care.

To improve the quality of PCTI care and to ensure it is available to all, aging service organizations must infuse PCTI principles into every aspect of their organization’s work. This includes working with staff, volunteers, board members, and members of the community to ensure an organization has the resources, infrastructure, PCTI knowledge and skill, organizational climate, and partnership capacity necessary to provide PCTI care. Additionally, foundations, philanthropies, and other grant makers must fund aging services organizations to develop and implement PCTI programming.

5. Build and strengthen PCTI care partnerships.

Ensuring that PCTI care becomes the standard approach to aging service provision is not possible without bridging silos within and across communities, sectors, and professions. Those engaged in aging service can strengthen their ability to provide PCTI care by learning from one another, creating robust referral networks, and partnering to learn, educate, and provide PCTI services. Simultaneously, professionals can strengthen communities by connecting older adults with a history of trauma and their family caregivers across diverse backgrounds. By building partnerships across organizations and communities, professionals can provide multiple, interconnected paths to healing and resilience.

6. Remove barriers for PCTI service access and utilization.

To ensure that all can benefit from PCTI services, those working in aging service must reduce social, physical, informational, and bureaucratic barriers to care. Professionals and volunteers must work together to champion systemic change and create structures, policies, and institutions that are welcoming to all members of the community. To do so, support must be available regardless of an individual’s location, identity, disability, or history of trauma. Information about services must be clear, organized, and easily available.

7. Reduce stigma about trauma and service utilization.

For increased utilization of PCTI services, it is essential to reduce public and personal stigma about trauma. This can be done by educating the public about the prevalence of trauma, highlighting the importance of services, and demonstrating support for older adults with a history of trauma and their family caregivers. Those working in aging services can do so through public awareness campaigns, normalizing public discussion of trauma, and creating physically and psychologically safe environments for older adults with a history of trauma and their family caregivers.
Conclusion

When implementing these recommendations, no action is too small. Every step that helps advance PCTI care is one that advances the entire field of aging services. A nursing home volunteer can learn about the role of trauma in their community. A social worker can teach colleagues about the PCTI approach. A lawyer can integrate the PCTI approach into end-of-life planning. Just as no action is too small, no action is too big. The aging services sector is made up of thousands of organizations, professionals, and volunteers who have the collective power to establish PCTI care as the standard approach to service delivery. Each step made towards expanding and improving PCTI care ensures that all those with a history of trauma receive safe, inclusive, and empowering services that support their health and well-being.
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