Throughout human life, potentially traumatic events occur. Disrupting experiences, such as domestic violence (including sexual abuse), physical attacks, warfare or natural disasters, can leave persisting psychological distress. In a minority of those involved, symptoms persist as post-traumatic stress disorder or PTSD (American Psychiatric Association; APA, 2013). Frequently, comorbid depression, anxiety, somatic complaints and problems with psychosocial adjustment play an additional role (Van Zelst, De Beurs, Beekman, Van Dyck, & Deeg, 2006). In later life, age-specific changes may reactivate or worsen earlier symptoms. If left untreated, PTSD may present high burdens to individuals (both adults and older adults) and society (Kessler, 2000; Van Zelst et al., 2006). We also know that trauma-related symptoms increase the risks of partner-related problems and tensions within families, potentially resulting in intergenerational transmission of maladaptive interaction patterns (Danieli, Norris, & Engdahl, 2016). Finally, PTSD was found to be associated with increased risks of comorbid anxiety (Spitzer et al., 2008); cardiovascular disease (Edmondson & Cohen, 2013), and dementia (Lohr et al., 2015).

Older adults with PTSD symptoms present a growing population in society and in mental healthcare services. Due to underrecognition in primary care (Ehlers, Gene-Cos, & Perrin, 2009; Van Zelst et al., 2006) and pessimistic expectations regarding psychotherapy in later life (Laidlaw & Pachana, 2009), this population runs the risk to be underserved. Among older adults, PTSD is a serious, but frequently hidden psychiatric disorder with various potential trajectories (Bonnanno, 2004), which requires an effective and evidence-based therapy. Although the percentage of older adults suffering from PTSD appears to be lower than among younger adult groups (Reynolds, Pietrzak, Mackenzie, Chou, & Sareen, 2016), further research is needed to develop evidence based treatment approaches for this population. Such research is justified by cohort-specific symptom presentation, the frequency of comorbid disorders (Averill & Beck, 2000; Busuttil, 2004) and the different trajectories of trauma-related symptoms, requiring a life-span perspective in assessment and treatment.

To date, available controlled trials regarding trauma-focused treatment among older adults has yielded mixed results (Bichescu et al., 2007; Gamito et al., 2010; Kneavelsrud et al., 2017; Lely et al., 2019; Ready et al., 2010; Thorp et al., 2019). Consequently, international practice guidelines for the treatment of PTSD (American Psychological
Association; APA, 2017; National Institute for Clinical Excellence; NICE, 2018) could not yet specify whether recommended interventions for adult patients may be generalized to older adults. In this domain, many questions remain. Do disorder-specific interventions require an age-specific approach to show full potential effect among older adults (Böttche, Kuwert, & Knaevelsrud, 2012)? Can increased arousal exacerbate physical conditions (Thorp, Glassmann, & Wells, 2015)? Can a life-review approach (Knaevelsrud, Böttche, Pietrzak, Freyberger, & Kuwert et al., 2017) serve as a helpful adaptation for older adults? Other issues arise in psychodiagnostics. Can we rely on general cut-off scores of diagnostic instruments for older adults? Do we need adaptations in DSM-5 diagnostic criteria (APA, 2013) for older adults?

During and after therapy, clinicians may observe renewed growth among older adults. Advancing age does not predict treatment response (Sabey, Jensen, Major, Zinbarg, & Pinsof, 2018). Aging patients who gain access to treatment can achieve clinically significant treatment outcomes (Knaevelsrud et al., 2017; Lely et al., 2019; Thorp et al., 2019). Following treatment, a new understanding between (grand)parents and children may develop, potentially correcting previous intergenerational transmission of maladaptive interaction patterns (Lely, De la Rie, Knipscheer, & Kleber, 2019). For therapists, treating older adults can provide interesting and rewarding therapy experiences. Unfortunately, we often see that senior patients are missing in trauma-oriented evidence and that attention for trauma is lacking in treating older adults.

It would be a great opportunity to combine these two areas in a Special Interest Group Aging and Life Cycle within the ESTSS. We think that action is needed in the following domains: developing research on assessment and treatment of trauma in later life, sharing best practices in those areas, and ultimately working towards treatment recommendations from the international guidelines concerning interventions for older adults. The ESTSS supports the idea of creating a platform in which clinicians and researchers from all over Europe (and also other parts of the world) get to know each other, exchange ideas, collaborate, and share knowledge about trauma and older adults, using a lifespan perspective. The first activity of the ESTSS Special Interest Group (SIG) Aging & Life Cycle will be a network meeting and workshop at the ESTSS conference of 2021 in Belfast.

If you are interested, you can subscribe to the e-mail list of the ESTSS SIG Aging & Life Cycle by filling out form [here](#).


