Psychological & Psychosocial Issues in Veterans

Depression, anxiety, and delirium may cause mental, emotional, and physical suffering and disability for Veterans in palliative care. These three conditions can all be difficult to diagnose and manage and yet they can have profound effects on Veterans' quality of life and the experiences of their families. They require both medical and psychosocial approaches to their treatment. As in other aspects of palliative and end-of-life care, incorporation of appropriate members of the interdisciplinary team is crucial.

Acknowledgement

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Anxiety and Veterans

Anxiety

A state of feeling apprehension, uncertainty or fear

Anxiety causes dysfunction in Veterans and those near them and undermines quality of life and quality of care

Generalized Anxiety Disorder

A state of excessive anxiety or worry

Lasting 6 months

Impacting day-to-day activities

Panic Attack

Sudden onset of intense terror, apprehension, fearfulness, feeling of impending doom

Lasting 15-30 minutes

Usually occurring with symptoms

- Shortness of breath
- Palpitations
- Chest discomfort
- Sense of choking
- Fear of going crazy or losing control

Veterans with advanced illness and their families commonly experience anxiety over fears, therapies, their ability to live life as they have known it, and uncertainty about their future. Their distress may also be related to other physical, psychological, social, spiritual, practical, end-of-life, and loss issues that derive from the illness, or it may be a component of other syndromes, e.g., a primary anxiety disorder or an underlying panic disorder that is unmasked by serious life-threatening illness. Such anxiety symptoms may be significant but not reach the threshold for an anxiety disorder.

There are a number of definitions of anxiety and related states.

Anxiety is a state of feeling apprehension, uncertainty and fear

A generalized anxiety disorder is a state of excessive anxiety or worry lasting at least six months and impacting day-to-day activities

A panic attack is the sudden onset of intense terror, apprehension, fearfulness, or a feeling of impending doom, usually occurring with symptoms such as shortness of breath, palpitations, chest discomfort, a sense of choking, and fear of "going crazy" or losing control. Panic attacks are discrete in nature and time course, usually lasting 15 –

20 minutes.

Anxiety is common among Veterans and their families. It is often overlooked and/or not treated aggressively. Careful, proactive attention to anxiety will improve adherence to treatment, psychosocial and family stress, quality of life, and ultimately quality of dying. Counseling, complementary or alternative therapies, and medication all play a role in the management of anxiety. Therapies can be tailored to an individual Veterans' and family's needs and preferences.

Depression and Veterans

- Depressed mood
- Anhedonia (loss of interest or pleasure) in nearly all activities
- Changes in appetite or weight sleep psychomotor activity
- Decreased energy
- Worthlessness, helplessness, hopelessness
- Guilt
- Difficulty thinking, concentrating, making decisions
- Suicidal ideation or wishes to hasten death
- Somatic symptoms often not helpful in patients in palliative care

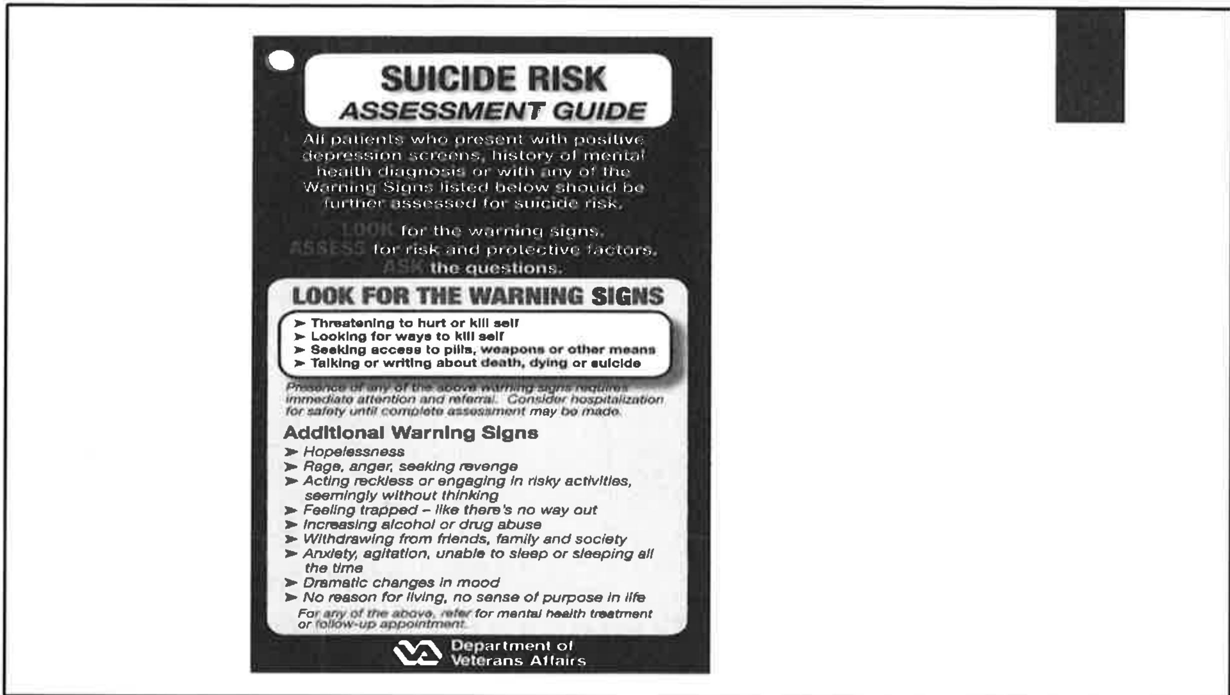
Major depression is an episode during which the patient complains or is noted to have depressed mood or the loss of interest or pleasure in nearly all activities for a period of at least two weeks

Veterans with depression also experience other symptoms including: changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. Depression may be viewed by Veterans or family members as something to be ashamed of, or as a sign of weakness. Through education, clinicians can help correct this misconception. Persistent depression is not 'normal' for Veterans with a serious illness or at the end of life. It is a myth that feeling helpless, hopeless, depressed, and/or miserable are inevitable consequences of advanced life-threatening illnesses.

Suicide and Veterans

Suicidal thoughts are an important sign of depression. It is a myth that asking about suicide will 'put the idea into someone's head.' To the contrary, allowing patients to discuss the thoughts they are having may reduce the likelihood they will actually commit suicide, particularly if the health care professional acknowledges their feelings and desires, and addresses the root causes of their distress.

Approximately 1,000 suicides occur each year among Veterans utilizing VA care, with about 5,000 suicides occur per year among all living Veterans. Veterans are twice as likely to die of suicide over time than the general population.



Assess all Veterans with depressive symptoms about thoughts and plans to commit suicide. Key questions include:
"Are you thinking about hurting yourself?"
"Are you thinking of ending your life?"
"Do you have a plan?"

Consider Veterans with recurrent thoughts of suicide or plans to be at high risk.

All Veterans who present with a history of a mental health diagnosis or with any warning signs listed below should be further assessed for suicidality. Warning signs include:
threatening to hurt or kill self, looking for ways to kill self, seeking access to pills, weapons of other means, and talking or writing about death, dying or suicide. Any of these requires immediate attention and referral to emergency services.

Additional warning signs that should prompt more in-depth evaluation include: Hopelessness; rage, anger, seeking revenge; acting recklessly or engaging in risky activities; feeling trapped like there is no way out; increasing alcohol or drug abuse; withdrawing from family or friends; drastic mood changes; and no reason for living or

sense of purpose.

PTSD and Veterans

- PTSD is an anxiety disorder that can occur after a traumatic event
- Diagnostic features:
  - Intrusive recollections of the trauma
  - Avoidant behaviors and numbing of general responsiveness
  - Hyperarousal
- Examples of traumatic events include:
  - Combat or military exposure
  - Child sexual or physical abuse
  - Sexual or physical assault
  - Serious accidents, such as a car wreck or natural disasters

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that can occur after an individual has experienced a traumatic event, such as the violence of war or a horrific accident. While combat exposure is often the trauma that leads to PTSD in Veterans, there are other types of trauma that Veterans and non-Veterans may experience including sexual trauma and natural disasters. To meet DSM-IV-TR criteria for PTSD, the individual must have experienced, witnessed, or been confronted with an event involving actual or threatened death or serious injury, or a threat to the physical integrity of the individual or others. Additionally, the individual's response to the traumatic event must involve intense fear, helplessness or horror.

Diagnostic features of PTSD fall into three categories: 1) intrusive recollections of the trauma, 2) avoidant behaviors and numbing of general responsiveness, and 3) hyperarousal. The duration of symptoms must be at least 4 weeks, and onset of symptoms can occur quickly after the trauma or be delayed for 6 months or more. These symptoms often disrupt life, making it hard to continue with daily activities. Anyone who has gone through a life-threatening or horrific event can develop PTSD.

PTSD Prevalence in Veterans

- About 30% of men and women who spent time in war zones experienced PTSD
- An additional 20 to 25% experience symptoms sometime in their lives
- More than half of all male Vietnam Veterans and almost half of all female Vietnam Veterans have experienced "clinically serious stress reactions symptoms"

War-related PTSD has been around for a long time, although it has been called by different names such as "Soldier's Heart" in the Civil War era or "Shell Shock" in the World War I and II eras.

PTSD became recognized as distinct psychological syndrome after the Vietnam War. It was more fully characterized and was included in the Diagnostic and Statistical Manual (DSM) Handbook, Third Edition, in 1980. As a consequence, many Veterans may have had symptoms of PTSD that resulted from traumatic events that occurred in WWII and other conflicts that have never been diagnosed. Older Veterans, in particular WWII and Korean War Veterans, tend to be quite stoic and humble about their wartime experiences. Many appear to have coped with their trauma by busying themselves in work and family life. For some, a re-emergence of PTSD symptoms can be experienced on retirement when they have more time to reflect on the past. PTSD symptoms can also re-emerge or become more intense at the end of life. Life review may lead some Veterans and their families to better understand the impact that undiagnosed PTSD has had on the Veteran's life and relationships. For other Veterans, life review may serve as a trigger for their trauma and worsen their PTSD symptoms.

PTSD: Death/Illness as an Activator for Veterans

- Feelings common at the end of life can activate symptoms of PTSD
- Veterans with PTSD can feel vulnerable
- Veterans can feel that they have lost control of their lives
- Veterans can feel that they can't "escape" if they are bedbound
- It can be challenging for Veterans to be around others in a congregate living situation, and with frequent interruptions by strangers
- Triggers for PTSD symptoms: Visual, auditory, other sensory, situational or emotional

Facing death in and of itself may be a strong reminder of the vulnerability that Veterans felt during combat, and this can also serve to activate symptoms of PTSD. Veterans may have faced death every day on the battle field. Facing one's own death is a powerful reminder of that experience. One's own impending death may also be a reminder of the losses faced as fellow soldiers died on the battlefield

Feelings common at the end of life can activate PTSD. This can make the Veteran with PTSD feel vulnerable and that is a powerful reminder of trauma. At the end of life, Veterans often feel like they have lost control of their life. The Veteran may have to rely on others for basic needs. They can't "escape" if they are bedbound. There may also be a potentially negative impact of coming into a hospital or hospice setting for a Veteran with PTSD. It can be very challenging at times for such people to be around others in a congregate living situation with frequent interruptions by strangers.

Triggers for PTSD symptoms can be visual, auditory, other sensory (heat, pain, shortness of breath), situational (dates/anniversaries) or emotional (anxiety, anger, fear and other intense emotions) can activate PTSD symptoms.

Substance Use Disorders and Veterans

- Of Veterans who access VA Health Care each year, approximately ½ million are diagnosed with Substance Use Disorder
- Prevalence of heavy drinking and other substance use are at least as high among Veterans compared to non-Veterans
- Pain, depression, and other mental conditions are associated with increased likelihood of substance use
- Alcohol and other substance use can interfere with effective palliative care (e.g., adherence)

Veterans as a group have a higher rate of substance use and abuse in some areas than the non-Veteran population. Substance Use Disorders (SUD) correlates with many of the psychosocial issues discussed in this presentation It may be an unhealthy coping mechanism (self-medication) in response to PTSD or depression. Exposure to combat is highly correlated to SUD. In addition, SUD is correlated with homelessness, difficulty maintaining employment, and impairment in family and social functioning. All of these may also then correlate with suicidal thoughts and behaviors.

Substance Use Disorders for End-of-Life Care and Veterans

- Substance Use Disorders may complicate the management of palliative care with Veterans
- Pain management becomes complex
  - Veterans with SUD many have a lower tolerance to physical pain
  - Veterans with SUD may have a high tolerance for pain medications
- It is important to work closely with the Veteran to develop treatment plans that minimizes abuse risk and diversion

SUD may complicate the management of Veterans who are cared for in palliative and end-of-life care settings. Untreated addiction may make adherence to a treatment plan near the end of life difficult. This is particularly true with regard to pain management. Higher doses of opioids for pain control may be needed due to increased tolerance to the medication. In addition individuals with addiction often have a lower tolerance of physical pain. Veterans should never be denied adequate pain relief for their physical symptoms at the end-of-life due to a present or past history of SUD. However, it is important to work closely with the Veteran to develop treatment plans that minimize abuse risk and diversion.

In general, the following key points should be recognized among Veterans in palliative care who may be struggling with substance use disorder:
Substance use disorder is at least as prevalent among Veterans as in the general population, especially among those with current pain, depression or other mental health conditions.
Palliative care teams should inquire about alcohol and other substance use in all palliative care patients and work with VA mental services when substance use disorder is identified as complicating palliative care.
Veterans who suffer from substance use disorder should still be provided effective pain

management, including opioids when indicated. They may require higher doses and closer monitoring but they should still receive pain relief.

COMFORT HOSPICE
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Thank you!

PLEASE REMEMBER TO FILL OUT YOUR TRAINING EVALUATION