

# Community Hospices: Posttraumatic Stress Disorder in Vietnam Veterans

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Sponsored by the  
Empowering Community  
Hospices Initiative



WE HONOR VETERANS

# Empowering Community Hospices Initiative

- Majority of hospice care for Veterans is delivered by community hospice programs
- Public Law 115–141
  - Directed VA to undertake a study on the feasibility of implementing hospice care protocols tailored to the unique needs of combat veterans, including Vietnam-era veterans, and to develop a report outlining the techniques, best practices, and support mechanisms to serve these veterans.
- Three Part Series:
  - Moral Injury
  - PTSD
  - Suicide Prevention
- PTSD and End of Life workgroup members: Nancy Bernardy, LeAnn Bruce, Mera Haloway-Paulino, Zachary Sager, Scott Shreve, Kristen Sorocco, Patricia Watson, Ryan Weller, Kat Zervas



# Objectives

*After taking this presentation, participants will be able to:*

- Identify signs of Posttraumatic Stress Disorder (PTSD)
- Explain how trauma may impact Veterans at end of life
- Discuss treatment options for PTSD specific to end of life
- Understand the similarities and differences between PTSD and other conditions
- Know how to best care for Vietnam Veterans with PTSD at the end of life



*What have been some of your experiences caring for individuals with PTSD or symptoms of PTSD at end of life?*



# What is PTSD?



**Definition:** A disorder resulting from exposure to actual or threatened death, serious injury, or sexual violence which results in a significant impairment in functioning.

**Possible events:** Combat trauma, sexual and/or physical abuse/assault, terrorist attack, serious accident, natural disaster.

*Stress reactions following a traumatic event commonly occur. If they impair functioning (i.e. work, relationships, etc) and last longer than 1 month that may indicate the presence of PTSD.*

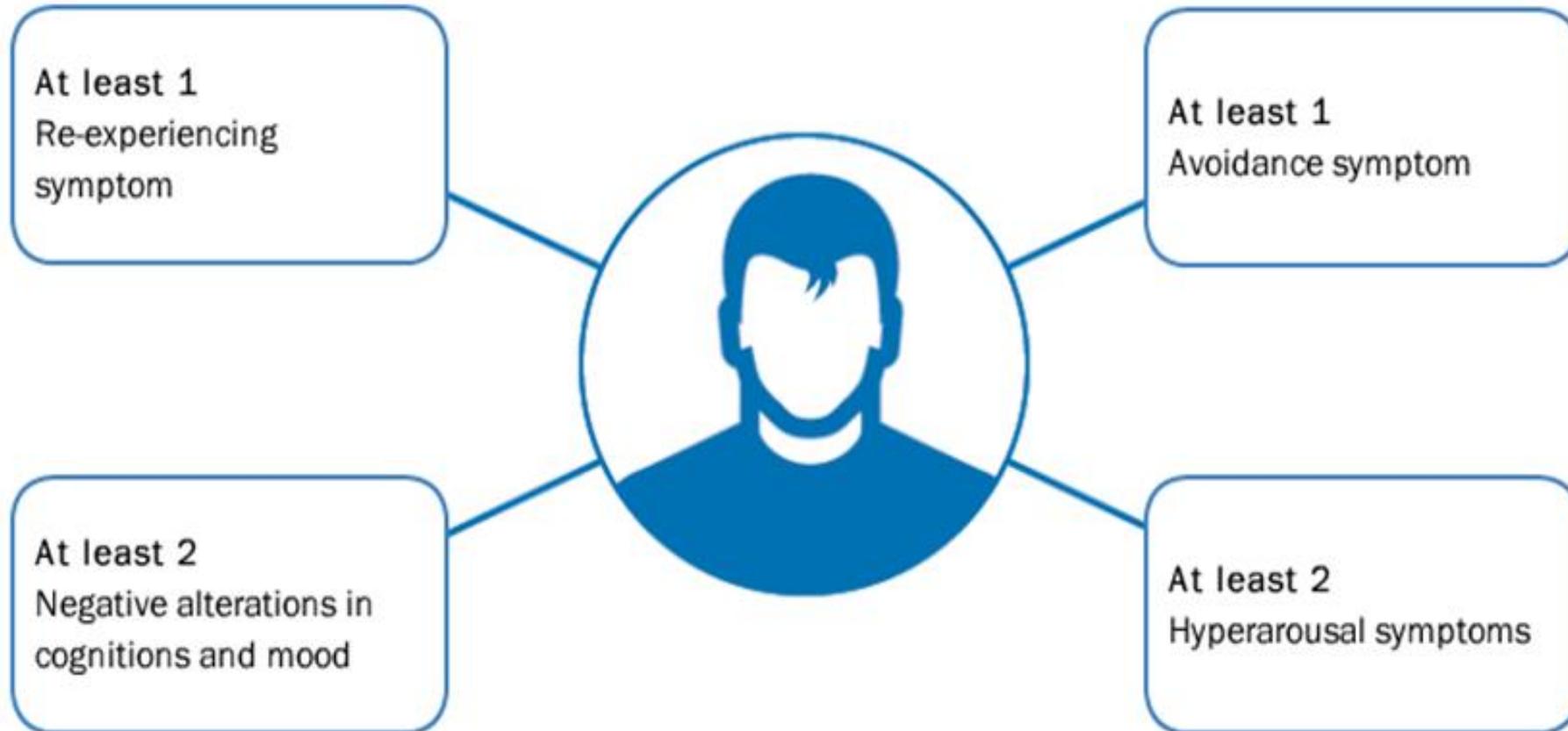
# Diagnostic Statistical Manual (DSM-5)

## Criterion A: Traumatic Event

- Directly experiencing a traumatic event
- Witnessing, in person, an event that happened to someone else
- Learning about the violent or unexpected death of a friend or family member
- Experiencing repeated or extreme exposure to aversive details of traumatic events



# DSM-5 Criterion B: Symptom Clusters



# Prevalence of PTSD

*The number of Veterans with PTSD varies by service era:*

- **Vietnam War:** About 15% were diagnosed with PTSD at the time of the National Vietnam Veterans Readjustment Study (NVAARS). It is estimated that about 30% of Vietnam Veterans have had PTSD in their lifetime.
- **Gulf War (Desert Storm):** Approximately 12% have PTSD in a given year.
- **Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF):** Between 11-20% have PTSD in a given year.

*Other Prevalence Issues:*

- Population is aging rapidly
- Rates of subclinical PTSD are high among older adults<sup>2-4</sup>:
- High rates (60%+ at 1.5 years) of PTSD from late-life exposures to trauma

<sup>1</sup>Kulka et al., 1990; <sup>2</sup>Glaesmer et al., 2010; <sup>3</sup>Schnurr et al., 2002; van <sup>4</sup>Zelst et al., 2003; <sup>5</sup>Goenjian et al., 1994;

<sup>6</sup>Hagstrom, 1995



PTSD or symptoms of PTSD  
do not often present themselves in a  
typical manner at End of Life



# Unique Features of Late-life PTSD

- Comorbid disorders are incredibly high for both younger and older adults
- Avoidance and estrangement from others may increase with age<sup>1</sup>;
- Survivor guilt and dissociation may decline with age<sup>1,2</sup>
- Older (vs. younger) Veterans with PTSD may report more somatic complaints (e.g., sleep, appetite, memory problems) and fewer symptoms of arousal, numbing, depression, hostility, and guilt<sup>3,4</sup>
- After exposure in late life, older adults (Veterans from WWII and Korea) show more hyperarousal, preoccupation, avoidance, sleep disturbance, and crying spells, but less re-experiencing symptoms than middle-aged adults<sup>5,6</sup>



<sup>1</sup>McFarlane, 1990; <sup>2</sup>Yehuda et al., 1996; <sup>3</sup>Davidson et al., 1990; <sup>4</sup>Frueh et al., 2004; <sup>5</sup>Hagstrom (1995); <sup>6</sup>Goenjian et al. (1994)

# PTSD & End of Life Concerns for Veterans



**Ways trauma can complicate end of life issues**

**Intersection of end of life issues and PTSD**

**Need for Trauma Informed Care**

# Ways Trauma Can Complicate EOL

- Living with a life threatening illness, may increase distress and symptoms of PTSD at end of life
- Normal life review may result in an increase in PTSD symptoms
- Avoidance symptoms may interfere in medical care
- Refusal of care or excessive questioning of providers' actions or distrust of authority may result
- Individuals w/ PTSD may experience decreased social support or a lack of caregivers as a result of social isolation and avoidance
- Medication management for pain can increase PTSD symptoms

[www.npr.org/templates/transcript/transcript.php?storyId=569961321](http://www.npr.org/templates/transcript/transcript.php?storyId=569961321)

Feldman & Periyakoil (2006)



# Intersection of EOL Concerns and PTSD

## *EOL Concerns*

- Reliance on family/social support
- Importance of life review, resolving unfinished business
- Need for good doctor-patient communication
- Need for acceptance of death

## *PTSD*

- Isolation and detachment
- Avoidance of trauma memories and unfinished business
- Anger, mistrust in authority, hypervigilance
- Avoidance of trauma reminders



A trauma-informed program **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma; **responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively **resist** re-traumatization.

[www.samhsa.gov/nctic/](http://www.samhsa.gov/nctic/)

## WHAT IS Trauma Informed Care?

# Identifying PTSD



## Four components of Assessment of PTSD at EOL:

1. Medical History and Records Review
2. Understanding Veteran's unique needs & risk factors
3. Observations
4. Screening questions

# Identifying PTSD: Medical History

## *Understanding Veteran's Unique Needs:*

- Military History Checklist – [Wehonorveterans.org](http://Wehonorveterans.org)
- Did you serve in the military?
- Did you see combat?
- Is there anything about your military service that still bothers you?
- What other stressful or traumatic experiences have you experienced in your life?
- What are their predisposing risk factors?

## *Collateral Reports*

- Ask family members for their assessment
- What have they noticed about Veteran's behavior?



# Identifying PTSD: Collateral Observations

- TV shows or movies related to event
- Being bathed (sexual trauma and/or intimacy issues)
- Male or female caregivers (e.g., sex of perpetrator)
- Smells (e.g., fires; certain foods)
- Sounds (songs; foreign languages; loud noises)
- Any apparent threat or physical touch



# Diagnosis and Assessment of PTSD



**We recommend** appropriate diagnostic evaluation that includes determination of DSM criteria, acute risk of harm to self or others, functional status, medical history, past treatment history, and relevant family history.



**We suggest** periodic screening for PTSD using validated measures such as the Primary Care PTSD Screen (PC-PTSD) or the PTSD Checklist (PCL).

<https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp>



# Treatment Options for PTSD in Late Life



## **Importance of Psychoeducation**

### **Psychotherapy**

### **Pharmacotherapy**



# Psychotherapy Treatment Options

**Evidence for effectiveness of  
psychotherapy and  
psychopharmacological approaches**

**Challenges with Recommended  
Psychological Treatments**

**Adaptations and Approaches in  
Hospice**



# Treatment of PTSD: Evidence

*Primary recommendation is psychoeducation*

- Helps patients understand PTSD and how it may be triggered or worsened at the end of life.

*Psychotherapy and pharmacotherapy have both been found to be effective in treating PTSD*

- However, these manualized trauma focused therapies have the best evidence over pharmacologic and other non-pharmacologic interventions for the primary treatment of PTSD.
  - Prolonged Exposure (PE)
  - Cognitive Processing Therapy (CPT)
  - Eye Movement and Desensitization Reprocessing (EMDR)



# Challenges with Recommended Treatments for PTSD Specific to Hospice

- May require too much patient stamina
- May require too much time
- Can lead to short-term distress and/or increases in symptoms initially
- Are designed for traumas that have discontinued
- Do not address end-of-life issues
- Have little role for family, caregivers
- May be less effective in older adults due to cognitive deficits



# Adaptations and Approaches in Hospice

- Trauma Informed Care
- Stepwise psychosocial palliative care model focusing on quality of life (more later)
- Life review technique – integrates trauma into complete narratives of their lives.
- Spiritually oriented psychotherapy – helps individuals find meaning in their lives.
- Complementary and Alternative approaches



Glick, Cook, Moye, Pless Kaiser (2018)

# ELEMENTS of Trauma Informed Care

- Emotional, psychological, and physical safety
- Trustworthiness and transparency
- Collaboration and mutuality
- Empowerment
- Voice and Choice
- Resilience and focus on strengths
- Sensitivity to cultural, historical, and gender issues
- Recovery oriented and person centered

[www.samhsa.gov/nctic/](http://www.samhsa.gov/nctic/)



# Modified Approaches to Provide Trauma Informed Care within Hospice Care



Case Part 1: A hospice nurse went to complete the initial intake with a Veteran referred for home hospice. Upon arriving his wife shared with the nurse that he has battled chronic PTSD since returning from Vietnam and has difficulty trusting other people.

## *Stepwise Psychosocial Staged Model for Treating PTSD at the End of Life – A Patient-Centered Approach*

- Stage I: Palliate immediate discomfort and provide social supports
- Stage II: Enhance coping skills
- Stage III: Treat specific trauma issues

**Sorocco** and Bratkovich (2018); Feldman.B., **Sorocco**, Bratkovich (2014); Based on Hyer & Woods (1998)

# Stage 1: Palliate Immediate Discomfort, Provide Social Support and Psychoeducation



Environment	Relational	Interventions
Name of provider	Knocking on door	Active listening – empathy, validation
Calendars	Announcing oneself	Reassurance
Visible clocks	Explaining purpose of visit and procedures	Assistance in solving practical problems
Nightlight	“Ask” instead of “Tell”	Psychoeducation
Minimal noise	Give options	Work with others about how to avoid triggering PTSD symptoms
Relaxed Environment	Remaining accountable to build trust	Mediate discussions with medical providers or family members
	Remaining calm	

# Modified Approaches to Provide Trauma Informed Care within Hospice Care



Case Part 2: As the hospice care team worked with the Veteran, he began having significant difficulty with increased anxiety upon waking early in the morning and finding himself alone. He had previously completed trauma treatment. The LCSW was able to review the coping skills he had previously learned during treatment and found helpful. He successfully incorporated relaxation and breathing exercises into his routine. His family was alerted to increase frequency checks to provide additional reassurance and comfort if they found him awake.

## ***Stage 2: Interventions to Enhance Coping Skills***

- Relaxation and breathing re-training
- Sleep apps
- Thought-stopping skills
- Mindfulness-based/acceptance skills
- Problem-solving interventions
- Communication/social-skills training
- Psychoeducation regarding coping skills for PTSD symptoms with patient and family

# Modified Approaches to Provide Trauma Informed Care within Hospice Care



Case Part 3: As his health declines, his symptoms appear to be worsening. He would like to engage in psychotherapy and at this point in his disease progression he is able to participate in individual sessions, but would prefer telehealth.

## ***Stage 3: Referral to Treat Specific Trauma Concerns***

- Apply traditional recommended exposure-based methods if appropriate given prognosis and energy level.
- Telehealth options
- Modified EMDR – “On-the-spot”
- “Life-review-based” exposure approach
- Spiritually oriented psychotherapy
- Complementary and Alternative approaches



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# PTSD Consultation Program

FOR PROVIDERS WHO TREAT VETERANS

## About the Consultants

- Experienced senior psychologists, psychiatrists, pharmacists, and other health professionals who treat Veterans with PTSD
- Available to consult on everything from your toughest cases to general PTSD questions

## Ask about:

- Evidence-based treatment
- Medications
- Clinical management
- Resources
- Assessment
- Referrals
- Collaborating with VA on Veterans' care
- Developing a PTSD treatment program

## Available Resources - [www.ptsd.va.gov/consult](http://www.ptsd.va.gov/consult)

- Free continuing education
- Videos, educational handouts, and manuals
- PTSD-related publications
- PTSD and trauma assessment and screening tools
- Mobile apps, and more



WWW.PTSD.VA.GOV



# Telehealth Objectives

As the capacity for VA to provide telehealth services grows, this initiative seeks to;

- Reduce the suffering of terminally ill Veterans and their families
- Build collaborative networks to promote terminally ill Veterans' access to specialized VA telemental health services in their home
- Efficiently and effectively deliver specialized care for Veterans at end of life while minimizing the burden of travel
- Empower and support community hospice teams in the delivery of hospice care specific to Veterans' needs



# Accessing Telemental Health

- VA offers telehealth services across the U.S. — including via VA Video Connect — an app that promotes “Anywhere to Anywhere” care.
- **Veterans will need to be enrolled** to receive VA telehealth services which can be initiated online at the link below or by calling 877-222-VETS (8387).  
<https://www.va.gov/healthbenefits/online/>
- Telemental Health Hubs connect mental health specialists with Veterans at sites who require same-day or urgent access to mental health services.  
[www.telehealth.va.gov](http://www.telehealth.va.gov)
- For more urgent situations, the **Veterans/Military Crisis Line at 800-273-8255** is available 24/7/365. VA enrollment is not necessary to use this resource.



# Pharmacologic Care Approaches

**Medications used to treat PTSD  
& related symptoms**

**Medications alone are not  
enough**



# Common Medications Used for PTSD

American Psychological Association Clinical Practice Guidelines recommend the following antidepressant medications for the treatment of PTSD: Sertraline, Paroxetine, Fluoxetine, and Venlafaxine



- Sertraline
- Paroxetine
- Fluoxetine
- Venlafaxine (SNRI)



# Medications to Avoid in Treatment of PTSD

VA/DoD clinical practice guideline ***suggest against*** treatment of PTSD with the following medications as monotherapy due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks:

- Quetiapine, Olanzapine, and other Second Generation Antipsychotics (except for Risperidone, which is a Strong Against)
- Citalopram
- Amitriptyline
- Lamotrigine
- Topiramate
- Benzodiazepines
- Prazosin
- Cannabis



# Pharmacotherapy Considerations for Hospice Providers

## *Hospice Represents A Period of Multiple Conflicting Priorities*

- Medications commonly avoided in PTSD treatment are commonly used in hospice care.

## *Factors to Consider when using Pharmacotherapy*

- Symptoms of PTSD can mirror common end of life symptoms.
- Expected prognosis?
- Swallowing ability of the patient?
- Tapering?
- Identifying the family as the unit of care-treatment considerations through the lens of the family.
- Medications alone are not enough



# Other Related Issues

**Later-Adulthood Trauma  
Reengagement**

**Moral Injury**

**Co-morbid Factors**



# Later-Adulthood Trauma Reengagement (LATR)

- Phenomenon occurring in older Veterans who were exposed to stressful war-zone events during early life.
- These Veterans function well into adulthood, but while facing the challenges of aging (e.g. retirement, illness) begin to reminisce and reengage with combat-related experiences.
- This reengagement presents an opportunity for post-traumatic growth and meaning making, but can also be a source of distress.
- The process of trauma reengagement is different than PTSD because avoidance, one of the key symptoms of PTSD, is absent.
- The process of trauma reengagement is an opportunity to find meaning in one's early life experiences.

Davison et al 2016; Davison et al 2006; Potter et al 2011

## WHAT IS LATR?



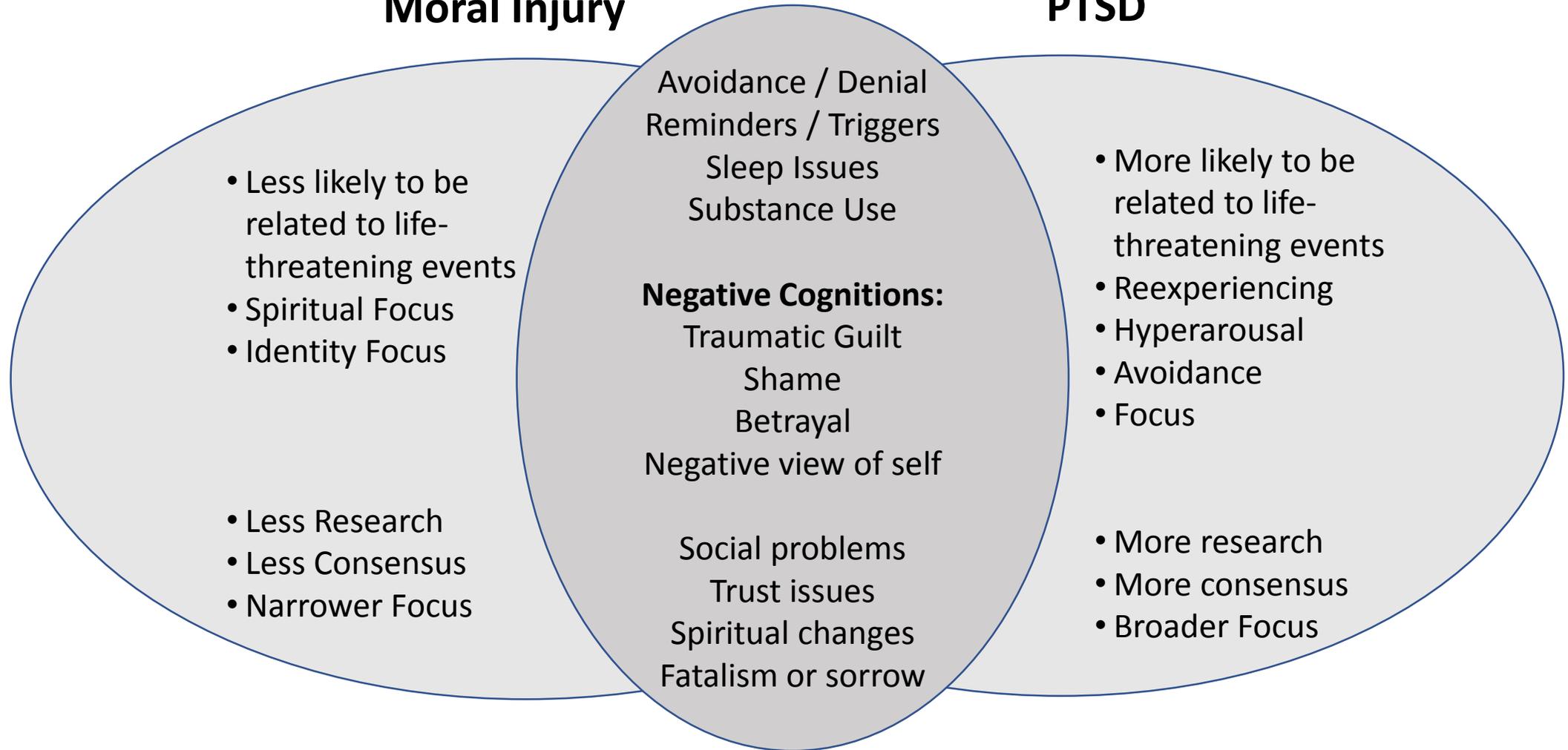
**Moral Injury** describes extreme and unprecedented life experience and the harmful psycho-spiritual aftermath of exposure to such events.

Events are considered morally injurious if they transgress deeply held moral beliefs and expectations which shatters moral and ethical expectations that are rooted in religious or spiritual beliefs, or culture-based, organizational, and group-based rules about fairness, the value of life, and so forth....  
Litz, B (2012).

# WHAT IS Moral Injury?

## Moral Injury

## PTSD



# Moral Injury / PTSD Symptom Overlap

## Moral Injury & Veterans in Later Life

Life Review reopens unresolved emotional and spiritual wounds

Feeling as if they are unable to forgive self or be forgiven

Fearing that they are not worthy of redemption

Unable to trust anyone to open up about experiences

Despair due to loss of life meaning and purpose

What can you  
do to help?



**How to ask**

**Family Support**

**Self-Care**

# Cultural Missteps in Working with Veterans



Making assumptions about their unique experiences in the military without asking them their experiences and views



Comparing any military experience to a movie



Asking if they killed anyone, or saw someone killed



Saying you understand



Trying to impose your values on military experiences or acculturation (i.e., it's more important to take care of themselves than it is to serve others)



Assuming they have PTSD or Moral Injury because of their experiences, or because of specific symptoms (i.e., have trouble sleeping, or are angry, etc.)

# Family Support and Self-Care

## *Impact of PTSD on the family*

- More marital problems and family violence
- Partners have more distress
- Children have more behavior problems

## *Importance of self-care for providers*

- Hospice care is hard work
- PTSD makes providing excellent care that much more challenging
- Actively engaging in a self-care plan is important to prevent compassion fatigue



# Selected Resources for Hospice Teams

Connect to a multitude of videos, guidance and local VA resources;

- [www.MaketheConnection.net](http://www.MaketheConnection.net)
- <https://www.mentalhealth.va.gov/communityproviders/military.asp>

**VA Suicide Risk Management Consultation Program offers free, confidential, one-on-one consultation for any community or VA provider who works with Veterans.**

- <https://www.mirecc.va.gov/visn19/consult/>

**PTSD Consultation Program (can assist with Moral and Soul Injury as well)**

- <https://www.ptsd.va.gov/professional/consult/index.asp>
- Or call (866) 948-7880

**Office of Survivors Assistance at 202-461-1077 or VA Benefits Assistance Service at 800-827-1000**

**Hospice Foundation of American: Improving Care for Veterans Self Study**

- <https://www.wehonorveterans.org/improving-care-veterans-self-study>

**VA/DOD Clinical Practice Guidelines for the Management of PTSD and Acute Stress Disorder**

- <https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf>

**VA National Center for PTSD**

- <https://www.ptsd.va.gov/>

**VA National PTSD Brain Bank**

- [https://www.research.va.gov/programs/tissue\\_banking/PTSD/default.cfm](https://www.research.va.gov/programs/tissue_banking/PTSD/default.cfm)

**We Honor Veterans**

- <https://www.wehonorveterans.org/veterans-their-needs/specific-populations/post-traumatic-stress-disorder-ptsd>



Questions or Comments