TREATING POSTTRAUMATIC STRESS DISORDER AMONG AGING VETERANS: WHAT WORKS?

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TREATING POSTTRAUMATIC STRESS DISORDER AMONG AGING VETERANS: WHAT WORKS?

A Research Project
Presented to the Faculty of California State University, San Bernardino

In Partial Fulfillment of the Requirements for the Degree Master in Social Work

by Heather Renee O'Dell Lewis

June 2016
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ABSTRACT

Posttraumatic stress disorder (PTSD) is a serious condition with debilitating symptoms which affects military veterans and has been understudied in the older population. Aside from treating the veterans of the Vietnam War and World War II, as service members from more recent conflicts age, the mental healthcare system needs to be able to treat them with empathy and effective therapies. As there is a need for future research focusing on this population, this paper reviews the current literature and utilizes Grounded theory to further the research related to PTSD in aging veterans. A selection of mental health clinicians with experience treating this population were interviewed and the results discussed. Those therapists who work for the Department of Veterans Affairs (VA) most often use Cognitive Behavioral Therapy to treat their clients, with Prolonged Exposure Therapy being the next most popular therapeutic modality. Those clinicians who are separate from the VA are able to employ therapies such as Cognitive Restructuring or blend theories to meet the precise needs of individual veterans. Also addressed are the differences and commonalities in PTSD symptoms between veterans of different conflict eras. Based upon these interviews, suggestions were made for changes to the treatment of military-related PTSD.
ACKNOWLEDGEMENTS

I would like to thank everyone who made it possible for me to reach this level of education. Six years ago I didn't dream that I would be conducting my own research and about to graduate with my Masters degree.

To those clinicians who shared their valuable time with me and gave me informative and thought provoking interviews. You inspire me with your passion to continue forward with this vital research.

To all of my professors, teachers, and instructors; without you sharing your knowledge and guiding me along this often difficult path, none of what I have accomplished could have happened.

To my family and friends who have suffered through three degrees with me, culminating with my MSW, I appreciate you all more than I can ever say. You mean the world to me.
DEDICATION

This paper is dedicated to all U.S. military veterans who have struggled with PTSD. Particularly those who came from an era before it was being diagnosed and treated. We cannot change the past but we can learn from it and improve for future generations.
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CHAPTER ONE

INTRODUCTION

Problem Statement

The purpose of this study is to gain a better understanding of what treatments are most effective in addressing posttraumatic stress disorder (PTSD) among aging military veterans. When compared with other older Americans, “veterans generally have poorer health profiles...including subjective well-being...[and] posttraumatic stress disorder...” (Yang & Burr, 2015, p. 1). In spite of the fact that, as of 2013, 43% of the total living military veteran population are aged 65 years or older, research into how PTSD specifically affects older adults is lacking (Pietrzak & Cook, 2013; Lunney, Schnurr, & Cook, 2014). Furthermore, PTSD is believed to be underreported in older generations of veterans. There are several theories as to what factors may contribute to this dearth of data. Older veterans may be reticent to discuss or feel unable to discuss their wartime experiences. They may also not believe that past combat experiences are relevant to their present difficulties. Additionally, and partly symptomatic of PTSD itself, this population may have dealt with the intrusive thoughts, nightmares, or anxiety by avoiding situations that might trigger them or denying that they are experiencing problems altogether (Bonwick & Morris, 1996). Last, prior to 1980, many veterans from World War II (WWII) were previously misdiagnosed with “anxiety neurosis, depressive neurosis,
melancholia, anti-social personality, or even schizophrenia” (Langer, 2011, p. 52).

The demand for PTSD treatment will continue to rise as the current veteran population ages (Institute of Medicine, 2014). Additionally, those older veterans with previously treated or with untreated PTSD may have been triggered by the Gulf and Iraq Wars (Brooks & Fulton, 2010). Although the Department of Veterans Affairs (VA) and Department of Defense (DOD) have expended a great deal of effort and funding to develop PTSD treatments for younger veterans, determining the impact of PTSD on the older veteran population and devising effective therapeutic modalities still merits further research. If too much time passes after an individual has experienced multiple, prolonged trauma, as was the case with many veterans of the Vietnam War, he or she may develop severe, chronic PTSD which is especially resistant to treatment and may require multiple treatment interventions (Ehlers et al., 2010). “Studies conducted 20 years and 50 years post-conflict have shown that war veterans suffer from PTSD for decades after war” (Nivala & Sarvimaki, 2015, p. 493).

Purpose of the Study

The purpose of this study is to gain a better understanding of what treatments are most effective in addressing PTSD among aging military veterans. Posttraumatic stress disorder is defined in the most recent revision of the
Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as “a history of exposure to a traumatic event that meets specific stipulation and symptoms from each of four symptom clusters: avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity” (PTSD: National Center for PTSD). As the members of our military who have been deployed to Iraq and Afghanistan and returned with specific psychological needs enter older adulthood, our mental healthcare system needs to be able to address them in a compassionate and effective manner. With an ethical commitment to culturally competent practice and to treating the person-in-environment, social workers are especially well suited to this task (Carrola & Corbin-Burdick, 2015). “Social workers are essential in helping veterans deal with emotions, challenges, and navigation of new circumstances” (Franklin, 2009, p. 165). Veterans, alongside social workers, can discuss their goals, explore various treatment options, and decide which treatments would be of most benefit for them. This can cultivate a greater commitment to treatment, motivate them in taking an active part in their mental healthcare, and increase the likelihood of them successfully recovering from PTSD (Mott et al., 2014).

As no two people are exactly the same, the VA and DOD should have an array of group therapy options to ensure the adequate care of our service member’s and veteran’s mental and physical health. Group therapy is an effective way to treat veterans with PTSD because it aids group members in rebuilding trust, allows the sharing and norming of symptoms and experiences,
offers various different modalities to suit individual needs, and is cost effective for the DOD, VA, and private payer. Research has shown the efficacy of several variations on trauma-centered group therapy for those clients able to directly address the trauma, in addition to supportive groups for those who need alternative, non-trauma-centered therapy (Ehlers et al., 2010).

Significance to the Field of Social Work

The social work profession would be enhanced were this topic explored further. Posttraumatic stress disorder has far-reaching ramifications for the veteran, his or her family, and for society as a whole. While the veteran experiences trauma related to his or her military service and resulting PTSD, so does his or her family (Bonwick & Morris, 1996). This secondary trauma can result in the life courses of spouses and children being negatively affected (Weiss et al., 2012). “To effectively intervene with military personnel, veterans, and their families, social work professionals need a military-informed approach to guide evidence-based assessment and treatment in a military context” (Wooten, 2013, p. 713). Congress authorized $48 billion to be allocated to the VA in 2010 in order to treat veterans of all generations (Yang & Burr, 2015). Based on the 2014 Institute of Medicine (IOM) report mandated by the National Defense Authorization Act for 2010, both the VA and DOD are required to provide the high-value treatments for military veterans and current service members suffering with PTSD. In an effort to meet these goals and treat those service members
affected, the VA has “…focused on the well-being of veterans across the adult life course” (Yang & Burr, 2015, p. 1). The IOM committee recommended that both the VA and the DOD invest in evidence-based therapies with established treatment protocols. In addition to these evidence-based therapies, pilot programs of new services will be allowed as long as they are properly evaluated for efficacy and effectiveness (Institute of Medicine, 2014).
CHAPTER TWO
LITERATURE REVIEW

Introduction

This chapter will review what the literature says regarding the symptoms and types of PTSD, how the disorder interacts with variables such as the aging process, and the various psychological treatments available. A discussion of the theories guiding the conceptualization of this study will complete the chapter.

Posttraumatic stress disorder is defined in the DSM-5 as a collection of specific symptoms directly related to a history of trauma or series of traumatic events that disrupts the individual’s normal life patterns (PTSD: National Center for PTSD). Symptoms for military veterans generally fall into “…two primary categories: (a) intrusion-overreaction, characterized by re-experiencing the traumatic event through reoccurring thoughts and dreams, disturbance of sleep patterns, hypervigilance, and strong emotions; and (b) denial or avoidant responses, characterized by reduced responsiveness…and feelings of detachment” (Lawson, 1995, p. 32). Although humans have long been aware of the effects of trauma, and combat in particular, on the human psyche it is only recently in our history that we have seen it as a condition that could be addressed by society and have taken steps to treat it effectively. Sustaining combat wounds, witnessing the deaths of fellow soldiers, or killing enemy
soldiers in combat can all be significant psychic traumas for veterans (Barnes & Harvey, 2000).

PTSD in Older Veterans

There are two common types of PTSD seen in older military veterans that will be addressed in this review (Busuttil, 2004; Bonwick & Morris, 1996). The first is previously treated PTSD which reemerges as the veteran reaches a later stage in life. Posttraumatic stress disorder may be retriggered by a physical illness or disability, retirement and accompanying loss of income, or a declining social network; all common social and psychological stressors associated with older age (Busuttil, 2004; Langer, 2011; Lunney et al., 2014; Pietrzak & Cook, 2013). A declining ability to physically work out excess stress can deprive a veteran of the coping mechanisms and distraction techniques which were previously successfully keeping their PTSD symptoms in check (Bonwick & Morris, 1996). “Physical illness may psychologically and physiologically resemble the initial wartime trauma”, thus retriggering the PTSD (Bonwick & Morris, 1996, p. 1074). Retirement can trigger previously treated PTSD or exacerbate untreated PTSD as the individual has more time to repeatedly focus on past traumatic events without the interactive social support network that the work environment provided (Bonwick & Morris, 1996; Cook, O'Donnell, Moltzen, Ruzek, & Sheikh, 2005). “…Other precipitants [of PTSD] include the deaths of friends…children becoming autonomous, and divorce” (Langer, 2011, p. 54).
The second PTSD type is delayed onset posttraumatic stress disorder; although this type is less likely a complete delay in symptoms so much as it is a delay in recognizing them combined with decreased coping or distracting outlets (Institute of Medicine, 2014; Bonwick & Morris, 1996). This type of PTSD can manifest itself post-retirement or with disability status as the veterans has more time to think and fewer responsibilities to mask posttraumatic ideation. There exists disagreement among researchers and clinicians as to whether PTSD increases, decreases, or remains constant as a person transitions into older age (Busuttil, 2004). Posttraumatic stress disorder symptom expression and severity in older adults may very well be different than what is noted in younger adults with the disorder (Lunney et al., 2014; Cook et al., 2005). According to Bonwick and Morris (1996), intrusive symptoms may lessen but avoidance and estrangement can increase as the veteran ages. The prevalence of PTSD also varies depending on the veteran’s generation and period of military service. The “…variation in experience of trauma is also likely to occur at the level of group, generation…” (Hautamaki & Coleman, 2001, p. 165). In order to best develop a treatment plan for older veterans, clinicians and researchers need to examine the “…long-term consequences and effects of military service and wartime experiences on aging” (Nivala & Sarvimaki, 2015, p. 493).
Theories on Treatment

When treating chronic PTSD, some clinicians, “…suggest a shift in focus and outcome solely from amelioration of PTSD symptoms to include optimization of function, minimization of disability, or improvement in quality of life” (Cook et al., 2005, p. 82). It may not be possible to completely relieve the client of his or her PTSD symptoms and in recognizing this, the clinician should focus on assisting their client in improving his or her life functioning. It is also important to obtain feedback from the veteran’s family and friends regarding changes in client function during and after the treatment period. “…It is possible that because of the severity and chronicity of their symptoms, improvement will be more gradual or mild…” (Cook et al., 2005, p. 89). As previously noted, the PTSD diagnostic criterion in the DSM-5 may need to be reexamined with regard to whether it is appropriately applied to older adults suffering from chronic PTSD symptoms (Lunney et al., 2014). Additionally, treatment for PTSD in older veterans may also take longer than for younger veterans (Busuttil, 2004). According to Shea and Zlotnick (2002), the type of therapeutic treatment recommended for those suffering from PTSD can vary depending on: (a) the type and duration of the trauma, (b) the client’s symptoms which he or she finds most disrupting to his or her life, (c) any comorbid disorders, and (d) “the nature of the client’s current physical and social environment” (p. 871). Bonwick and Morris (1996), mention that veterans who have gone as much as 50 years without adequately exploring the traumas that led up to their PTSD can still benefit from therapy.
Developing a Thorough Assessment

“The assessment of…PTSD may be particularly challenging in older adults because of cognitive or sensory decline, comorbid…disorders, or generational differences in the willingness to disclose psychiatric symptoms” (Lunney et al., 2014, p. 144). Busuttil (2004) strongly advocates that the most effective way to accurately assess older adults for PTSD and comorbid conditions it to perform a more thorough and extensive clinical assessment than one would conduct with younger adults. Without a thorough and proper assessment and diagnosis, the older veteran population may continue to suffer from untreated or undertreated mental illnesses (Busuttil, 2004; Bonwick & Morris, 1996). Lunney et al. (2014), suggest that clinicians utilize structured interviews and self-reporting checklists with older adults. Older adults may experience somatic symptoms of mental illness or be reluctant to seek out mental health treatment due to its stigmatization (Cook et al., 2005). The expression of each somatic and psychological disorder may change and overlap one another in older veterans who have lived for decades with PTSD and its various comorbid conditions. Clinicians also tend to rate their older client’s symptoms as less severe than does the client him- or herself, especially with regard to psychological numbing, hyperarousal, and avoidance behaviors (Lunney et al., 2014). This disconnect may necessitate a reexamination of the DSM-5 PTSD criterion to account for these differences seen in older adults (Hyer, Stranger, & Boudewyns, 1999).
Generational Differences Among Older Veterans

**World War II**

These soldiers comprised a generation raised during the Depression Era, in a time that discouraged complaining about one’s situation, and accepted the use of alcohol to cope with emotional pain. Veterans of this time period present a typical pattern to their life-long struggle with PTSD (Langer, 2011). While engaged in wartime conditions, these soldiers initially coped relatively well with stressors. It was when they arrived home that their symptoms would present and escalate for a period of approximately five years. During their middle adult years, PTSD symptoms would be submerged by the responsibilities of working and raising families. It is on entering older adulthood, and especially post-retirement, that the veteran’s symptoms too often reemerged. Comorbid conditions, such as depression, can develop during this time as well (Bonwick & Morris, 1996; Cook et al., 2005; Langer, 2011).

**Korean War**

The Korean War was an unpopular, sometimes forgotten conflict, and those soldiers that fought in it did not fare as well physically or mentally as did those from WWII (Hautamaki & Coleman, 2001). The lack of public support elicited from the civilian population when the military personnel returned from Korea to the U.S. could have negatively affected the mental health of those suffering from PTSD from that point forward (Brooks & Fulton, 2010). In research published by Brooks and Fulton in 2010, veterans of the Korean War
had 31% higher likelihood of having emotional problems interfere with their ability to manage daily activities. In the ‘oldest old’ category, Korean veterans 85 years and older had a greater need of mental health services from the VA as well as poorer overall mental health statuses (Brooks & Fulton, 2010). According to research conducted by Yang and Burr (2015), these veterans reported having lower levels of life satisfaction and more depression.

**Vietnam War**

The National Vietnam Veterans Readjustment Study in 1986-88 which included 3,016 veterans found that the lifetime prevalence of PTSD was 31% for men and 27% for women (Langer, 2011; Hautamaki & Coleman, 2001). While researchers have debated the exact numbers, there is no doubt that Vietnam War veterans faced greater difficulties reintegrating back into society after returning than did veterans from WWII and the Korean War. Due to the political atmosphere prevalent in the U.S. when the veterans returned home, most felt unwelcome to talk about their experiences, losses, and traumas (Barnes & Harvey, 2000). The negative perception that many Vietnam veterans had of their military service has been linked with less psychological resiliency (Pietrzak & Cook, 2013). The psychological effects of negative self-perception as a result of military service appear to sustain its impact on veterans as they age. In the Barnes and Harvey (2000) study, 65% of Vietnam veteran participants stated that they had current PTSD symptoms compared with 20% of the WWII veteran participants.
Treatment Modalities

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) and Cognitive Processing Therapy (CPT) are effective in treating PTSD (Busuttil, 2004) by teaching coping skills such as: anxiety and anger management, positive self-talk, cognitive restructuring, and active problem-solving (Cook et al., 2005; Ehlers et al., 2010). Offering the veteran better coping strategies to replace his or her maladaptive ones can be beneficial as well (Hautamaki & Coleman, 2001). According to Cook et al., (2005), the goals in CBT should aim to: “…decrease PTSD symptoms, reduce impact of PTSD symptoms on daily functioning, and increase veterans' perceived control of their trauma-related symptoms” (p. 85). This therapy encourages clients to review the accuracy of their dysfunctional cognitions and challenge any inaccuracies the veteran may realize (Sloan et al., 2012). Cognitions negatively affected by trauma fit within one of “five domains – safety, trust, power/control, esteem, and intimacy” (Castillo et al., 2014, p. 32). Cognitive Behavioral Therapy and Cognitive Processing Therapy also focus on breaking the cognitive dissonance which can lead to moral injury. This is due to the veteran’s experience of fundamentally being a good person who did what he or she had to in order to make it through the extreme stresses of wartime conditions (Langer, 2011).
Group Therapy

Ehlers et al. (2010), state that combining CBT with group therapy synergistically amplifies CBT’s therapeutic benefits with the social support structure offered by other veterans also suffering with PTSD. This therapeutic approach has been shown to be especially beneficial for the most complex and difficult to treat PTSD cases. Cook et al., (2005), recommend that veteran clients attend several sessions of individual therapy focused on education regarding PTSD and comorbid conditions, the importance of group work, and the treatment goals prior to attending group therapy. This plan of therapy can be especially beneficial for older veterans, who due to generational differences may not be familiar with psychological terms that younger adults take for granted (Cook et al., 2005). Mutual aid group therapy is effective in treating veterans with PTSD by increasing client opportunities for rebuilding trust, demonstrating a universality of experiences and symptoms, and maximizing staff resources in an already overburdened care system. Military veterans with PTSD are more likely to find trusting others difficult and, therefore, to be socially isolated as a result (Sloan, Bovin, & Schnurr, 2012). One of the benefits of participation in a group therapy environment is the opportunity to build trust and social connections with others facing similar issues within a safe and structured atmosphere (Williams et al., 2014). Social support has been positively correlated with PTSD recovery (Carrola & Corbin-Burdick, 2015) in providing a safe environment where veterans and service members can relearn trust and process their experiences and
feelings. Group therapy also recreates the camaraderie on which older veterans generally thrived during their wartime experiences and allows them to discuss both the positives and negatives of those times (Bonwick & Morris, 1996).

Within the therapy group, members come to realize that they are not alone in the trauma they have experienced that they are not unusual, weak, or broken. This universality normalizes their PTSD symptoms and “…the disconfirmation of a client’s feelings of uniqueness is a powerful source of relief” (Yalom & Leszcz, 2005, p. 6). Additionally, group therapy allows one or two clinicians to treat between six to ten clients during a ninety minute session as opposed to the traditional one-to-one ratio of individual therapy. Concomitant with a significant increase in demand for veteran’s mental health services, outpatient services need to be more cognizant of efficiency and resource allocation (Castillo et al., 2014). “Older cohorts of men who served in the military may benefit from policies and services that promote more opportunities for social integration and strong social support networks” (Yang & Burr, 2015, p. 1).

**Prolonged Exposure Therapy**

Prolonged Exposure Therapy (PE) is one of the more successful PTSD therapeutic methods. The client is gradually exposed to fearful stimuli linked to his or her trauma through methods such as writing, talking about an incident in group therapy, or confronting places or things which remind the client of the trauma (Rauch et al., 2012). Virtual Reality Exposure Therapy (VRE) is a type of PE that uses computer generated images to simulate the environments and
traumas that may trigger veterans suffering from PTSD (Ready, Gerardi, Backscheider, Mascarao, & Rothbaum, 2010). The efficacy of PE is supported by research from the IOM (2014) and found to work well for younger veterans and active-duty military personnel but still requires further studies with older veterans. Those who have lived with PTSD for decades may find it difficult to stay engaged in the stressful albeit therapeutic process for a sufficient period of time. It may also be challenging to convince older veterans to participate in this type of therapy as they did not grow up surrounded by technology and may not be as comfortable with its use as are younger veterans (Ready et al., 2010).

**Account-Making Model**

Barnes and Harvey (2000) suggest that the Account-Making Model (AMM) might be useful for older veterans struggling with PTSD. Their research indicates that veterans who shared personal stories of combat experiences with trusted friends and family reported that the sharing process greatly helped them.

People often effectively deal with major loss over time by developing an account, or story, pertaining to the loss. The story explains the loss, as best one can explain it, and provides descriptive information about events surrounding the loss that capture the meaning...for the individual...how he or she processed it in terms of feelings, thoughts, and social interaction (Barnes & Harvey, 2000, p. 169).

The final step in AMM is for the individual to share their life story with those that are closest to them. This may include a verbal or written testimony of their
experiences and the meanings that they have attributed to them. Clinicians can assist their clients with this process by asking them specific questions related to the experiences: what the veteran felt their greatest loss was and how they have dealt with it, about any vivid dreams or memories that they have, and how other losses in their life fit with the traumatic loss or experience (Barnes & Harvey, 2000). “It is crucial for both individual and group resilience, how the individuals and the group can make sense of a crisis situation and endow it with meaning” (Hautamaki & Coleman, 2001, p. 169).

Finland’s Success in Treating PTSD

A review of international efforts to prevent and treat PTSD in military veterans suggests that Finland stands out among other nations as having made support for its WWII veterans into a national mission of social support.

The collective nature of the war and the resulting feeling of community spirit appear to have provided social supportive networks- a kind of secure base in terms of Bowlby’s attachment theory-which helped the soldiers to endure and cope with the stresses of warfare (Hautamaki & Coleman, 2001, p. 172).

The ‘Disabled War Veterans Association’ was created in 1940 by returning Finnish veterans in order to care for one another and their affairs. Following the rule that ‘one does not abandon one’s brother’, they offered medical care and social and vocational rehabilitation to disabled military veterans. Approximately
90% of the disabled Finnish veterans were able to find meaningful work, generally had high senses of well-being, and had adapted well to aging (Hautamaki & Coleman, 2001). Those who did suffer from post-WWII PTSD were supported and encouraged to work through it and process the trauma by sharing their experiences with others. Additionally, the Finnish WWII veterans considered it their duty to society to discuss their wartime experiences with younger generations so that they understood the realities of war and struggle. WWII veterans in Finland have less than a 10% prevalence rate of PTSD, including returned POWs and the most severely combat traumatized veterans (Hautamaki & Coleman, 2001).

Theories Guiding Conceptualization

Ecosystemic Model

One of the key concepts in social work is that individuals must be viewed in a holistic way, or through the lens of person-in-environment. Ecosystems theory can be applied and “…used to describe and analyze people and their other living systems and their transactions” (Zastrow & Kirst-Ashman, 2013, p. 20). Systems theory looks at the interactions between the individual and those he or she has relationships with. In order to best understand how PTSD affects older veterans one must use both ecosystems and systems theories; thus application of the Ecosystemic Model is useful. According to this model, a veteran’s worldview after entering military service is influenced by his or her
“ethnic value system”, level of assimilation into military culture, combat experiences, and worldview prior to military service. This resulting new worldview has a reciprocal relationship with the development of PTSD and its continuance. Additionally, the interactions between the veteran and his or her community and family creates a continuous feedback system whereby these systems affect the course of the stress disorder and the PTSD affects the systems (Weiss et al., 2012). “Cumulative risk factors that ‘pile up’ from…pre-deployment, deployment, and post-deployment could constitute risk chains that have additive and interaction effects with current and subsequent risk factors and protective processes” (Wooten, 2013, p. 706). The Ecosystemic Model allows for the examination of how a veteran’s ethnicity, gender, and military rank may make him or her more vulnerable to developing PTSD. Another factor that must be acknowledged and is taken into account by this model is how military culture may discourage its members from seeking assistance for mental health issues (Weiss et al., 2012).

**Erikson’s Life Stages**

Adulthood is the seventh of Erik Erikson’s life stages and brings with it the crises of generativity versus stagnation. This is the time period when adults decide what they want their life to mean, if they will have children, and where they will focus their life energy. Posttraumatic stress disorder during this stage is generally followed by a pattern of comorbid disorders including alcoholism, generalized anxiety disorder, panic disorder, and depression (Bonwick & Morris,
Impairment[s] in social functioning… present considerable barriers to [the] psychosocial reintegration and recovery” of veterans with untreated or undertreated PTSD (Williams, 2014, p. 337) causing great frustrations during this stage.

Encompassing older adulthood, integrity versus despair, is the time period when individuals review their lives and feel either satisfaction or regret with the decisions they have made (Hooymann & Kiyak, 2011, p. 217). Previously treated posttraumatic stress disorder or PTSD that has been concealed by the tasks of middle adulthood often flares to life during this stage. Those veterans that have invested much of their self-esteem in their work find this post-retirement period especially challenging. “A life without meaning leaves plenty of room for PTSD—as well as other psychiatric disorders, such as depression, anxiety, and substance abuse- to fill” (Langer, 2011, p. 54).

Peck’s Developmental Tasks

Building on Erikson’s developmental theory, Robert Peck, described his theory on the three main developmental tasks that older adults face. Ego differentiation, the first task, says that when people reach this stage they must redefine their roles as something other than the roles they had held for the majority of their adult lives. He or she is a retired veteran, may now be the parent of an adult child, and possibly even a grandparent as opposed to being fully employed and raising children. “…‘Ego integrity’ in late life is the result of successfully exploring and resolving earlier and current identity issues…as the
aging person faces up to the challenge of finite reality” (Hautamaki & Coleman, 2001, p. 171).

While navigating the second of Peck’s tasks, the older adult must recognize that his or her aging body no longer possesses the physical capabilities it did when he or she was younger. In order to master body transcendence versus body preoccupation, and continue on a sustained path of human growth, the elderly veteran must develop new coping and adaptive strategies. Veterans who successfully navigate this stage must redirect their interests so that they are more in line with their declining physical abilities while taking advantage of the wealth of knowledge and experience accumulated over a lifetime in and out of military service. Finnish WWII veterans considered it their societal duty to pass their stories and knowledge on to younger generations (Hautamaki & Coleman, 2001).

According to Peck, the final developmental stage involves the adult coming to terms with his or her inevitable death. If the positive contributions that an individual has made to society can be expressed and acknowledged, that individual can experience ego transcendence and make peace with the thought of their eventual death. An individual who continually questions whether his or her life had (and has) any meaning, however, will likely view his or her approaching death as a source of stress and anxiety (Zastrow & Kirst-Ashman, 2013, p 646). Vietnam veterans who have a significantly negative perception of their military experiences may especially have difficulties in coping with this
phase of their lives (Pietrzak & Cook, 2013).

Summary

In summary, it seems obvious that effectively treating PTSD in aging veterans can be challenging and take longer than with veterans of more recent conflicts. Which generation the veteran hails from can also have a large impact on his or her reactions to trauma and is supported by the Ecosystemic Model. In addition, clinicians need to readjust how they assess this population and allow for sub-threshold diagnoses. Whether the PTSD has been previously treated and resurfaced later in life in response to a particular stressor or removal of a coping mechanism or the onset was delayed, social workers may need to consider using different therapies than they would with younger veterans. As previously stated, with chronic PTSD treatment goals may need to focus on symptom reduction as opposed to extinguishment.

There are a variety of therapy modalities available to veterans, however, older adults seem to benefit from beginning with individual CBT/CPT and progressing to group therapy. In this context they can experience a sense of belonging, rebuild trust with others, and learn about the universality of their symptoms amongst other veterans and in a safe environment. Prolonged Exposure Therapy or VRE tends to not work well with veterans who are older, even while it is extremely effective with those who deployed to Operation Enduring Freedom, Operation Iraqi Freedom, or Operation New Dawn.
(OEF/OIF/OND). Following AMM and gradually sharing their stories with trusted family, friends, and mental health professionals has proven to be very successful with veterans and has been demonstrated at a national level in Finland. Even with these insights there remain a great many questions as to which therapy model has the greatest effectiveness with which generation of veterans. With greater numbers of military personnel arriving back in the U.S. suffering from PTSD the social work field as a whole needs to anticipate the best treatment for this population upon their reaching older adulthood.
CHAPTER THREE
METHODS

Introduction

The purpose of this proposed study is to gain a better understanding of what treatments are most effective in addressing PTSD among aging military veterans. In order to do this the researcher conducted semi-structured interviews with six mental health clinicians who have experience treating veterans 65 years and older who have been diagnosed with military service connected PTSD. Using Grounded Theory (GT) each participant’s views on the efficacy of the various treatments they provide to their patients were explored. Each interview was audio recorded and transcribed verbatim by a professional transcription service. These transcripts were coded, analyzed, and examined by the researcher in order to explore the most effective therapies to treat aging veterans with PTSD.

Study Design

In order to explore in-depth the various treatment modalities being utilized with older veterans with PTSD, the use of qualitative research design was necessitated. Qualitative research data was obtained directly from clinicians serving the population in question. This allowed for the gathering and organizing of trained clinicians’ insights into their clients’ experiences as well as the themes
affecting these clients’ treatments. In particular, this research utilized GT which works to capture peoples’ experiences as they see it. Grounded Theory is a general research method which is helpful when a researcher is beginning to explore a particular issue utilizing a qualitative format. Nivala and Sarvimaki (2015), found GT useful when they studied the aging Finnish WWII population. As with these researchers, there was a general script of open-ended questions which allowed the clinician interviewees discretion as to where the interview led. Follow-up questions were asked when appropriate and on an individual basis. The interview questions were tested for reliability and validity. In addition, the researcher took notes during the interviews to ensure that all topics were fully explored, to collect ideas for areas of further study, and as a recall aid later in the process. The researcher collected, coded, and categorized the data to formulate a theory on what types of PTSD treatments are most helpful to older adult veterans.

Limitations

The most glaring limitation of this study is that it relies on information gathered from the clinicians treating the veterans and was not gathered from the population itself. Although this allowed for outside observation from the clinicians treating the patients, the researcher did not have the opportunity to verify the accuracy of these observations with the veterans themselves. A second limitation is how the sampling was conducted. Although snowball sampling allowed for personal introductions from one participant to the next, this may have
caused the results to suffer from unknown biases. The researcher also found it challenging to gain the cooperation of local VA clinicians in order to complete this research.

**Hypothesis**

Although VRE, a type of PE, has been embraced by both the VA and DOD as well as being effective with younger veterans, those who are 65 years and older are not very accepting of this therapy (Ready et al., 2010). Based on the previously mentioned research, it was theorized that aging veterans will derive the greatest benefit from beginning to treat their PTSD symptoms with individual CBT/CPT and progressing to group therapy (Busuttil, 2004; Cook et al., 2005; Ehlers et al., 2010). It was also believed that AMM that was so successful in Finland can have just as large an impact on those veterans in the United States (Barnes & Harvey, 2000). Additionally, it was believed that PTSD symptoms in the older veteran population present differently than those in younger veterans and therefore require a more careful assessment with these differences in mind.

**Sampling**

Participants were selected using purposeful sampling strategy, a method used in qualitative research to include only those participants who have particular characteristics related to what the study is examining. Subject sample was limited to mental health clinicians who hold one of the following degrees or titles: (a) Masters of Social Work (MSW); (b) Marriage and Family Therapist (MFT); (c)
Psychologist; or (d) Psychiatrist. Each participant was either currently treating veterans with PTSD or has treated this population within the previous five years. The use of this selection criteria ensured the collection of up-to-date information and that the observations from the mental health clinician participants were less biased than those of the patients themselves.

Each interview participant was given an identification code in order to protect their confidentiality. Interview recordings were maintained on a USB flash drive and labeled with individual participant codes. The recorded interviews were kept in a locked storage container to maintain confidentiality.

In order to recruit clinicians to interview various routes of contact were pursued. The researcher contacted the local chapter of the National Association of Social Workers (NASW) and forwarded a brief synopsis of this research and other pertinent information to the local representative. This was followed by attending the local NASW monthly meeting in Redlands, CA on November 2, 2015. The request for clinician interviews was presented to those in attendance and additional names to contact at the VA were collected. Other VA clinicians were brought to the researcher’s attention by a mutual connection in the California State University, San Bernardino campus (CSUSB) student counseling center as well as the university community at-large. A posting on Facebook was also employed in order to increase the likelihood of locating participants. These clinicians were emailed with the same information provided to the NASW as well as being followed up with phone calls. A snowball sampling method was utilized
with those clinicians that participated in this research and further clinician contacts were generated.

Data Collection and Instrument

As a graduate level student researcher, the qualitative interviews were conducted either in-person or over the phone from February 2016 to April 2016. Six clinicians who treat or have treated veterans with military-related PTSD were included as participants. These interviews were recorded using digital audio recording equipment and later transcribed by a professional transcription service. These interviews lasted between 20 and 45 minutes and followed a prescribed interview protocol (Appendix A). The interview process began by the clinicians providing basic demographic information which assisted in establishing rapport with the interviewer and verifying the clinician’s experience with the population in question. The next section of questions related to the interviewee’s generalized experience treating military veterans diagnosed with military-related PTSD. The third section of the interview protocol was only used if the four therapeutic modalities specifically addressed in this study had not previously been discussed during the interview. The interview was completed with follow-up questions related to anything that has not been previously discussed and asked the interviewee if he or she had anything to add.

Interview recordings were maintained on a USB flash drive and labeled with individual participant codes. The recorded interviews were kept in a locked
storage container to maintain confidentiality. After the interviews were transcribed to text, the transcripts were reviewed, and themes were identified and coded. These themes were then broken down into sub-themes as needed.

Themes include: differences and similarities between generations of veterans, clinician’s approach to and type of treatment offered (e.g., CBT/CPT, PE, EMDR, AMM), and treatment at VA clinic versus outside facility. As the clinicians have been professionally trained to monitor the symptoms of their patients through questions, observation, and the administration of tests, the researcher should be able to rely on their descriptions of their patient’s symptoms before, during, and after treatment. For each type of therapy, the clinician interviewee was asked as to how their patients responded to that particular modality. When analyzing the data the following questions were considered. How does each type of therapy affect older veterans? What changes can be made to the current VA and DOD systems to enable better prevention and treatment of PTSD?

Procedures

As previously stated, interview participants were solicited through networking with the NASW, postings on Facebook, and personal connections within the CSUSB community. The researcher contacted each clinician that was suggested and inquired as to whether they would participate in a 20 to 45 minute interview. Whether the contact agreed to participate or not, they were asked if
they knew of any other mental health professional fitting this study’s inclusion criteria who might be interested in being interviewed. The interviews took place at either the clinician’s professional office or over the phone and followed a semi-structured interview protocol (Appendix A). These six clinician interviews took place during the 2016 winter and spring academic quarters. The researcher conducted and recorded the interviews, and analyzed the resulting information. The recorded interviews were transcribed by a professional transcription service. The data analysis included a review of the clinician interview transcripts and an identification of major themes that arose. These themes were then broken down into sub-themes as needed.

Protection of Human Subjects

This is no anticipated harm that will come as a consequence of this study. Interview participants were required to read and accept an informed consent (Appendix B) prior to the study and debriefed (Appendix C) immediately following the interview. As the identities of the clinician participants are to be kept confidential, the records and recordings of this study have been kept private. In any sort of report that is made public no personally identifying information of the participants will be released. The research records were kept in a locked box and only the researcher had access to them. The audio recordings of the interviews were destroyed after being transcribed; within two months of their being recorded.
Data Analysis

Using open coding, the researcher reviewed the transcripts of the clinician interviews and examined what was discussed. The themes discovered were then labelled and compared to one another. These main themes were then broken down into sub-themes as many times as necessary. Thematic interpretations were sought as well as underlying patterns and trends. Using these data, conclusions were drawn and applied to the research questions.

It was expected that there would be differences in how veterans from various generational cohorts reacted to different types of therapy. The researcher theorized that veterans 65 years and older would be less tolerant of PE than younger veterans and would receive more therapeutic relief from CBT/CPT combined with group therapy.

Summary

This study was designed to develop a greater understanding of which common treatments for PTSD are most effective for aging military veterans. Qualitative data was collected by conducting six semi-structured interviews with mental health providers (e.g., MSW, MFT, Psychologist, or Psychiatrist) who have experience working with veterans with military service connected PTSD. Study participants who met the inclusion criteria were recruited by the researcher approaching the local NASW membership, posting an interview request on Facebook, speaking with personal contacts in the CSUSB community, and using
the snowball sampling method. During these 20 to 45 minute confidential interviews the efficacy of various treatments that the clinician in question uses to treat his or her clients with PTSD was explored. As the interviewee’s personal information is known only to the research it was theorized that clinicians would provide more candid answers in spite of the interview being audio recorded. These answers were transcribed by a professional transcription service and the audio recordings were destroyed within two months of being created. After these transcripts were coded and analyzed the data was examined for connecting themes and underlying patterns. Based upon these result a theory on the most effective therapies in order to treat aging veterans with PTSD was suggested.
CHAPTER FOUR
RESULTS

Introduction

The results section of this paper will review the demographics of the clinicians who were interviewed as part of this research and present what was discovered. These findings include differences and commonalities between generations of veterans, clinician’s approach to and type of treatment offered, and suggested changes for future treatment of military-related PTSD.

Participant Demographics

The following participant demographic data was recorded by the researcher: age, gender, level of education and/or license held, clinical work setting, years of experience treating veterans with PTSD, and percentage of older veteran client caseload diagnosed with PTSD. Interview participants included six mental health clinicians of which three have a Masters of Social Work (MSW) degree, one has a Doctorate in Social Work (DSW), and two have Doctorates in Psychology. Three of the clinicians are also Licensed Clinical Social Workers (LCSW) with a fourth clinician in the process of attaining her license. All participating mental health professionals currently treat military veterans diagnosed with PTSD. Subjects are female with an age range between 35 to 64 years and a mean age of 56-years-old. They have been treating
veterans with PTSD for between four and fifteen years with a mean average of nine years. All of the clinicians have, at one time, been employed as therapists with the VA. Three of the mental health professionals are currently working for the VA, two are now in private practice, and one is currently treating clients in a public university clinical research setting. Each of the study participants was familiar with CBT/CPT, PE, and group therapy. None of them had heard of AMM. When the researcher explained the AMM protocol and history, three of the six clinicians said it sounded like it was similar to narrative therapy and that they would be open to using it in treating the population in question. Of the older veteran clients being treated by the clinicians, 76% of the veterans were reported as having been diagnosed with PTSD. Interview response themes were broken down into the following sub-themes: differences and commonalities between generations of veterans, clinician’s approach to and type of treatment offered, and suggested changes for future treatment of military-related PTSD.

Presentation of the Findings

Differences and Commonalities Between Generations

All six of the clinicians agreed that veterans with PTSD, while sharing many common symptoms, do not uniformly manifest identical maladaptive behaviors. These symptoms can include: avoidance behaviors, paranoia, anger, depression, an inability to feel or express emotions, hypervigilance, moral injury, substance abuse issues, and suicide attempts. These individuals have often
been unable to discuss their problems with those closest to them and their therapist may be the first person the veteran has opened up with. These symptoms, however, are not present in all veterans nor are they equally problematic in all those effected. Additionally, depending on the era that the veteran belongs to, their triggers can differ.

There are also demonstrated differences specific to the war that the veteran participated in. Triggers for flashbacks and nightmares can also differ depending on what type of environment they were exposed to. The sounds of crickets can be deeply disturbing to Korean War veterans (Participant 2, personal communication, March 3, 2016). Those veterans of both the Gulf War and OEF/OIF/OND with PTSD can have flashbacks and fear-based avoidance surrounding driving, freeways, and debris on the side of the road (Participant 1, personal communication, March 5, 2016). This is due to the frequent attacks on military convoys in Iraq and Afghanistan.

One of the greatest differences between those veterans of the Vietnam War and WWII as compared with those who were in OEF/OIF/OND and the Gulf War is the knowledge of what services are available through the VA as well as their inclination to pursue that assistance (Participant 1, personal communication, March 5, 2016). Older veterans are often unaware that the symptoms they are experiencing are related to PTSD and that the VA has programs to help them recover (Participant 4, personal communication, February 29, 2016). Members of younger veteran cohorts more frequently know about these programs although
they may still be unwilling to seek out the help or understand how their difficulties relate to their wartime exposure (Participant 2, personal communication, March 3, 2016). Veterans who have lived with PTSD for the majority of their adult lives can be skeptical of the helpfulness of therapy or feel hopeless that they will ever experience a relief from the symptoms (Participant 1, personal communication, March 5, 2016). Of those clinicians that have worked with the current generations of veterans, each agreed that, overall, the Vietnam War veterans have experienced the greatest challenges. Their PTSD is often compounded by the rejection of the American public they experienced when they returned home from their military service (i.e., “the homecoming”), feeling that they were lied to by the U.S. government, and the maladaptive coping strategies that they have developed in the face of the untreated traumatic disorder (Participant 1, personal communication, March 5, 2016). Many of them have substance abuse issues and are separated from society. In an interview on February 29, 2016, an LCSW treating veterans at a specialty VA clinic stated, “I think they’re probably the most injured group. They are gonna be the ones that are very difficult to treat…” There have been an influx of this generation of veterans to the VA due to their aging and retiring from the workforce. Between this and illness or the natural aging process decreasing their coping mechanisms and distractions, their PTSD symptoms are rising to the forefront (Participant 2, personal communication, March 3, 2016).

When your avoidance game is good and you work really hard and you
stay busy, you feel like you’re able to manage it. When they have all this idle time, all their symptoms are flooding back and they’re coming in to see us more than ever now (Participant 1, personal communication, March 5, 2016).

According to one-third of interviewed clinicians, Vietnam War veterans also experience higher levels of moral injury, shame, and guilt as compared with other generations. This could be due to their having killed individuals traditionally viewed as non-combatants as well as not being able to act out against those fellow American soldiers who inflicted crimes against innocent Vietnamese citizens (Participant 4, personal communication, February 29, 2016).

World War II and Korean War veterans “…haven’t dealt with it [PTSD] because they’re from an era that that wasn’t discussed, and it was like ‘suck it up, soldier, move on’. That was the attitude of their commanding officers, and they took that attitude right through into life” (Participant 4, personal communication, February 29, 2016). Veterans of this generation often report feeling conflicted because their traumatic wartime experiences are in direct opposition to the hero’s welcome they received when arriving back home. Now that some of these veterans are developing dementia as well as losing their independence and coping mechanisms their PTSD symptoms are resurfacing (Participant 2, personal communication, March 3, 2016). This clinician, who treats geriatric veterans, stated that those working with this population need to take into account conditions related to the aging process as well as PTSD. This
coincides with what prior research states regarding this cohort.

**Clinician’s Approach to and Type of Treatment Offered**

Those research participants who are employees of the VA are restricted to specific evidence-based PTSD therapies they may employ when treating their veteran clients. The most common modality utilized in this environment is CBT or CPT. Additional individual therapies include PE and EMDR. Group therapy is available at certain VA facilities as well as at many of the organizations focused on aiding veterans. Those therapists operating in non-VA facilities can utilize other PTSD treatments such as CR, or Neurofeedback. None of the participants were familiar with AMM, although two of the six stated that it shared commonalities with narrative therapy which can be useful with older veterans who react poorly to trauma-focused therapies.

The goals of CPT as described by one VA clinician, “…is to put a buffer between their [veterans] thoughts and emotions and their behaviors, so it changes- it reduces isolation, it reduces self-blame” (Participant 1, personal communication, March 5, 2016). She went on to state that the clinicians work with veterans to analyze the trauma behind the PTSD in order to evaluate the control they had over what happened and dissolve dysfunctional beliefs. This can be especially helpful when a client is experiencing high levels of anxiety and avoidance behaviors. During this interview, the participant stated that as avoidance helps to maintain the disorder it is a symptom which is important to address. Half of the clinicians agreed that older veterans may have difficulty
grasping the cognitive aspects of CBT/CPT or gaining awareness of their dysfunctional beliefs. It can also be retraumatizing and requires that the client remember to apply in their daily life the therapeutic steps taught to them during treatment.

Prolonged Exposure therapy helps veterans reengage in their lives by facing the traumas behind the PTSD. Half of the clinician participants felt that the younger veteran cohorts seem to be more open to this therapy. It can be effective in all groups, however, as long as the client is open-minded and willing to commit to the treatment regimen. A specific technique utilized by an LCSW with prior VA experience is to have the veteran record him- or herself talking about the trauma and listen to it every day between individual weekly therapy sessions (Participant 1, personal communication, March 5, 2016). Another clinician strongly felt that PE constitutes malpractice and that as further research is conducted on military-related PTSD, it will be phased out in favor of less traumatic modalities (Participant 6, personal communication, April 14, 2016). Although it has been used successfully with Vietnam veterans, many older prior military members may be reluctant to attempt it as they feel that it could worsen their PTSD symptoms.

According to the research participants, group therapy for veterans with PTSD consists mainly of short-term PTSD coping skills and symptom management groups, psychoeducational groups, trauma-specific groups, and programs designed by the DOD such as Seeking Safety. Among the clinicians
included in this study there were mixed opinions as to the efficacy of group therapy. These groups can reestablish the camaraderie that the veterans experienced and relied upon during their military service (Participant 2, personal communication, March 3, 2016). One clinician with over 15 years of experience cautioned against peer-led PTSD groups, stating that “…they [the veterans] get into this negative, repetitive processing of what they’ve been through, instead of moving forward” (Participant 4, personal communication, February 29, 2016). All participants, however, agreed that properly run groups used for increasing positive socialization and in conjunction with individual therapy can be helpful in combating loneliness and isolation.

Eye Movement Desensitization and Reprocessing (EMDR) is more popular with younger veterans than with older ones (Participant 4, personal communication, February 29, 2016). It deviates from traditional talk therapy and does not require the client to discuss their traumatic experiences. The two therapists who utilize it place great confidence in its efficacy and benefit to their veteran clients. When asked to describe how the treatment works during a February 29, 2016 interview, one of the VA LCSWs said that EMDR, “…remaps the brain and how they [veterans] process it [the trauma].” Another clinician said that she believes that EMDR does a more thorough job of addressing the PTSD symptoms than does CBT or CPT (Participant 5, personal communication, April 27, 2016).

Still in the research phase for treating veterans with PTSD, one of the
clinicians has had success treating her clients using Cognitive Rehabilitation (CR), also known as Neurofeedback. This therapy recognizes that PTSD does not manifest uniformly in all patients and that the retelling of one’s trauma can be retraumatizing for the client. The intake, assessment, and intervention for CR are all computer-based and require less interaction between the veteran and the clinician. According to the clinician, this modality requires 40 individual, 30-minute sessions, twice per week. “…We can effect long-term positive change in a much shorter period of time, with less trauma than the more traditional counseling approaches…with any veteran and diagnosis of PTSD” (Participant 6, personal communication, April 14, 2016).

Regardless of which therapeutic modality a clinician employs, there are treatment approach commonalities which all of the study participants agreed were of vital importance. Building rapport was specifically mentioned as being the most important therapeutic technique by 75% of research participants. Without the trust between veteran and therapist, little work can be accomplished, although rapport is less important when participating in CR than in the other types listed in this paper. Clinicians should go out of their way to be nonjudgmental as they have not been in their client’s situation and likely do not understand the stress related to wartime experiences (Participant 4, personal communication, February 29, 2016). They should also use validation and attempt to normalize their veteran client’s PTSD symptoms. Motivational Interviewing (MI) was reported as being used by two-thirds of the participants in
addition to mindfulness. All the MSW and LCSW clinicians stated that they use strengths-based and client-centered approaches in an attempt to maintain their client’s dignity. This represented four of the six clinicians. Especially when treating a client who has been coping with PTSD symptoms for long periods of time, patience and compassion are vital (Participant 1, personal communication, March 5, 2016).

Changes for the Future

In order to more proactively treat military-related PTSD in the younger veteran cohorts, all six of the clinician interviewees felt that specific changes should be enacted. Foremost, the VA and DOD need to develop a better discharge process prior to military personnel separating from service. “…More emphasis on helping veterans navigate back into the civilian side with the component of, ‘This is what PTSD is…this is what it look like. If you experience this, this is how you get help” (Participant 1, personal communication, March 5, 2016). An LCSW suggested in a March 3, 2016 interview that service members should be required to have two weeks of psychoeducation related to PTSD and other issues they could face post-separation. She stated that this should be followed by once-a-month counseling appointments at their local VA facility.

Dovetailing with this, all research participants agreed that leadership within the various branches of the military need to work towards destigmatizing mental health treatment both during and following an individual’s service. In doing so, there would be fewer veterans attempting to live with their daily functioning
negatively constrained by PTSD and little idea of why their lives changed so drastically.

For those older veterans suffering from PTSD, all the clinicians felt that less traumatic therapeutic modalities should be allowed in addition to giving therapists more leeway in how long they keep a particular client in therapy. The three participants who currently work at VA locations stated that they felt hampered by what treatments are allowed by the VA and DOD and that veterans are expected to progress through treatment on a specific and limited time schedule. These clinicians agreed with the current paper that therapist should be able to mold PTSD treatment regimens to a veteran’s specific needs, openness for treatment, and personality. From what the interviews uncovered, only when a veteran has a comorbid diagnosis of dementia are clinicians allowed more latitude (Participant 4, personal communication, February 29, 2016).

Half of the interviewees specifically mentioned that they felt mental- and physical healthcare providers should perform more in-depth initial assessments, inquiring as to whether a patient is a veteran and exploring childhood histories. In agreement with the Ecosystemic model, one clinician said, “There is a correlation between anyone with PTSD and historical issues other than the presenting trauma” (Participant 5, personal communication, April 27, 2016). Providers should also ask about substance use/abuse and behavioral health issues as these need to be addressed prior to a veteran commencing treatment for PTSD (Participant 4, personal communication, February 29, 2016).
CHAPTER FIVE

DISCUSSION

Introduction

The purpose of this study was to gain a better understanding of what treatments are most effective in addressing PTSD among aging military veterans. Posttraumatic stress disorder can affect an individual's functioning in profoundly negative ways. This can include the veteran's marriage and family life, cause a lack of or improper emotional response to stimuli, and lead to substance abuse and suicide. The results generated by this investigation underline the importance of further research into treating this population as well as changes to the current treatment structure offered by the VA and DOD.

Discussion

According to those clinicians involved in this research, veterans suffering from military-related PTSD can exhibit avoidance behaviors, paranoia, anger, depression, an inability to feel or express emotions, hypervigilance, moral injury, substance abuse issues, and suicide attempts. One of the most common similarities is that the treating clinician may be the first person the veteran was able to discuss their symptoms and traumatic experiences with. Oftentimes, these individuals have been unable to discuss them with their spouses, family, or friends.
The age of the veteran can also correlate with that individual’s knowledge of the disorder itself and what treatments are available to them through the VA. The most recent cohort of veterans is more likely to know about these programs. Older veterans may not buy into the belief that therapy has anything to offer them in regards to alleviating their symptoms. They could also feel that they must remain stoic despite their coping strategies no longer working or being maladaptive. Compounding the difficulty of treating PTSD itself are the additional challenges posed by the aging process and any comorbid conditions.

The Department of Veterans Affairs policy restricts which therapies its clinicians may use to treat PTSD, though standard therapeutic techniques such as rapport building, empathy, active listening, and validation are used by all clinicians. Modalities that are permitted by the VA include CBT/CPT, PE, and EMDR. Select facilities may also allow various types of group therapy. Outside of the VA and DOD, therapists have been utilizing other PTSD treatments such as Cognitive Rehabilitation or Neurofeedback. None of the participants were familiar with AMM.

To better serve their veteran clients, participants offered four specific suggestions that they would like to see implemented within the VA and DOD. Primarily, PTSD and VA services education for military personnel during their discharge process need to be reevaluated. Although the older generations of veterans cannot be retroactively educated, the upcoming cohorts will benefit from this change. Simultaneously, leadership within the various branches of military
service need to encourage their personnel to seek out proper care when experiencing mental health issues without fear of negative consequence to their careers. Third, clinicians need to be extended greater trust with the case management of their veteran clients. This includes being allowed more leeway in treatment modalities in addition to the number of sessions clinicians are able to offer clients. Finally, interviewees felt that mental- and physical healthcare providers should perform more in-depth initial assessments, inquiring as to whether a patient is a veteran and exploring childhood histories. This will increase the likelihood that providers uncover comorbid behavioral health conditions or substance abuse issues that require further treatment and services. These can deeply effect and complicate the veteran’s PTSD recovery process.

Recommendations for Social Work Practice, Policy, and Research

“That would probably be the biggest step, providing more treatment while they’re in service, post-deployment, destigmatizing during the service time, and getting together a good discharge plan which has the component of PTSD education and how to access services” (Participant 1, personal communication, March 5, 2016). This is especially important for military personnel who have spent the majority of their adult lives in the service. It was suggested by the same LCSW that there needs to be an increase in the numbers of military social workers, both veteran and civilian, to help with this transition process.
Four of the six participants felt that social workers and other mental health providers need to aid veterans in letting go of the label “veteran with PTSD” and separate their core identity and personality from the symptoms they are experiencing. “We need to be better at telling veterans this is not necessarily a permanent condition. It is something you can overcome. You don’t have to drag that diagnosis with you to your grave” (Participant 4, personal communication, February 29, 2016). This particular clinician felt strongly that further research and treatment of PTSD could assist current and future generations of veterans in living more successful lives after their military service.

In agreement with the clinician who offers CR, the researcher feels that further investigation needs to be given to non-traumatic PTSD therapies. The VA and DOD need to include modalities for those veterans who are unlikely to be able to withstand directly confronting or discussing their trauma until well into their treatment. As military culture values stoicism and “sucking it up”, to expect an individual to make a complete change simply because they are not an active member of the service and be open to discussing the events leading up to their PTSD is not reasonable.

Conclusions

The VA, DOD, and others addressing military-related PTSD need to make changes to ensure better treatment of veterans with PTSD, especially those who are older and have lived with the disorder for decades. “Their belief system’s
turned upside down. Then they see the world differently, they see themselves
differently, and they see others differently. So it impacts everything about who
they are and their place on this earth” (Participant 1, personal communication,
March 5, 2016). There are various types of treatments for PTSD available,
however, the VA and DOD only allow those that they consider to be backed with
substantial evidence and practice. Cognitive Behavioral Therapy is the most
popular and widely-practiced type of therapy with EMDR and PE gaining in
popularity. Group therapy is only available at certain VA facilities and clinicians
have differing opinions on its usefulness in treating the symptoms of PTSD.
Outside the VA, individuals are free to participate in CR and, if necessary, devote
a greater period of time to recovering from PTSD.

Healthcare and mental health providers need to ensure that initial
assessments with patients are in-depth and include questions regarding veteran
status, childhood history, and comorbid behavioral health conditions. Military
personnel need to receive education regarding PTSD causes, symptoms, and
treatment throughout and following their separation from service. From the top
down, leaders within the various branches of armed service should place greater
emphasis on destigmatizing mental health treatment for active military personnel
and veterans. Without further research and making these vital changes to the
system itself, veterans of the U.S. military run an unnecessarily high chance of
developing PTSD due to the nature of their service to their country and fellow
military personnel.

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Further research into the specifics related to PTSD in older military veterans is necessitated by needs of the Vietnam War, Korean War, and WWII veterans. Additionally, the Gulf War and OEF/OIF/OND veterans will require further VA services as they age into older adulthood. Future studies should more closely review the effectiveness of trauma-based versus non-trauma-based therapies for older veterans. Modalities such as CR and Neurofeedback which potentially minimize retraumatization deserve additional examination and potential approval by the VA.
APPENDIX A

CLINICIAN INTERVIEW PROTOCOL
[After consent is obtained from the participant]

Thank you for agreeing to be part of this study. This interview is about the most effective treatment modalities when working with aging military veterans effected with posttraumatic stress disorder connected to their military service. If at any point my questions are unclear, please feel free to ask for clarification. If you feel uncomfortable and wish to discontinue this interview you may do so at any point during the process.

I am going to begin with a few general questions followed by specific questions related to treating veterans with PTSD.

Demographics:
1. What is your age?
2. What is your level of education? Your license?
3. How would you describe the environment in which you provide mental health services? (e.g., VA, private clinic, public health clinic)
4. How long have you been working with veterans?
5. What percentage of your caseload includes veterans who are 65 years and older? With a military service related PTSD diagnoses?

Clinical Work with Veterans with PTSD:
6. What is your therapeutic approach to treating those veteran clients with PTSD?
7. How would you best describe your approach to working with aging veterans?
8. Have you noticed any differences in symptoms between veterans of the different conflicts?
9. What would you consider to be the most important things to remember when treating veterans with PTSD?
10. Which veteran clients with PTSD do you find the most challenging to treat? Why and what do you recommend in treating them?
11. What changes in treating PTSD would you like to see in the order to more effectively treat the OEF/OIF/OND veteran cohort as they age?

Specific Treatment Modalities for PTSD:
[The following questions will be asked if they have not already come up during the interview]
12. Have you used Cognitive Behavioral Therapy (CBT) with your older veteran clients?
13. How effective have you found it to be?
14. How have your clients responded to it?
15. What common themes have you encountered while using CBT with this population?
16. What is your experience running PTSD groups in order to treat these clients?
17. Some researchers say that group therapy is not effective while others say that it encourages socialization and healing in veterans. Based upon what you have seen in practice, where do you stand on the efficacy of group therapy for PTSD?
18. The DOD states that Prolonged Exposure therapy (PE) is a front-line treatment for PTSD. Have you practiced this therapeutic modality?
19. Does the age of the veteran play a part in how effective PE is? Are older veterans open to trying this therapy?
20. Are you familiar with the Account-Making Model (AMM) used to treat PTSD? What do you know about it?
21. Have you used it with older veterans? If you have not, would you ever attempt it with your clients?
22. Are there any other treatments that you have utilized in treating your PTSD clients that we have not discussed?
APPENDIX B

PARTICIPANT INFORMED CONSENT
INFORMED CONSENT

You are being asked to take part in a study reviewing the types of therapies and techniques used with military veterans who have service-related posttraumatic stress disorder (PTSD). I am specifically focusing on veteran’s who are 65-years and older. You have been selected to be interviewed because of your professional credentials and experience treating this population in a mental health setting. Please read this form carefully and ask any questions you may have before agreeing to take part in the study. This study has been approved by the School of Social Work subcommittee of the CSUSB IRB.

What this study is about: The purpose of this study is to gain a better understanding of what treatments are most effective in addressing PTSD among aging military veterans.

What I will ask you to do: If you agree to be in this study, I will conduct an interview with you. The interview will include questions about your level of education and professional license, your experiences treating veterans with PTSD in a mental health setting, your opinions of how effective various modalities are, and how you approach different types of clients within this population. The interview will take between 20 and 30 minutes to complete. With your permission, I will also like to audio-record this interview.

Risks and Benefits: No anticipated harm will come as a consequence of this study. Participation in this study may increase the awareness of the subject of treating PTSD in aging veterans. Others may benefit in the future from the information I find in this study.

Compensation: You may receive a $5 gift card to Starbucks in appreciation of your participation.

Your answer will be confidential: The records and recordings of this study will be kept private. In any sort of report I make public I will not include any information that will make it possible to identify you. Research records will be kept in a locked box; only I will have access to the records. I will destroy the audio recordings of the interview after it has been transcribed, which I anticipate will be within two months of its taping.

Taking part if voluntary: Take part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide to take part, you are free to withdraw at any time.
If you have any questions: The researcher conducting this study is Heather Lewis. Please ask any questions you have now. If you have questions later, you may contact Ms. Lewis' thesis advisor and professor in the California State University, San Bernardino Social Work department, Dr. Rosemary McCaslin at 909-537-5507 or rmccaslin@csusb.edu

You may request a copy of this form to keep for your records.

Statement of Consent: I have read the above information, and received answer to any questions I asked. I consent to take part in this study. In addition to agreeing to participate, I also consent to having the interview audio-recorded.

Your mark ____________________________ Date ________________

This consent form will be kept by the researcher for at least two years beyond the end of the study.
APPENDIX C

DEBRIEFING STATEMENT
The purpose of the interview you just completed is to gain a better understanding of what treatments are most effective in addressing PTSD among aging military veterans. In this study by Heather Lewis various facets affecting the treatment effectiveness and severity of PTSD in veterans was considered. These variables can include: (a) the generational cohort the veteran is from; (b) PTSD type; and (c) therapy modality. I was particularly interested in the perspective of the clinicians treating this population as they provide a less biased view.

Thank you for your participation. If you have any questions about the study, please feel free to contact Professor Rosemary McCaslin at 909-537-5597 or by email at rmccaslin@csusb.edu.

If you would like to obtain a copy of the group results of this study a completed copy of this thesis will be available on the CSUSB website within one year.
REFERENCES


