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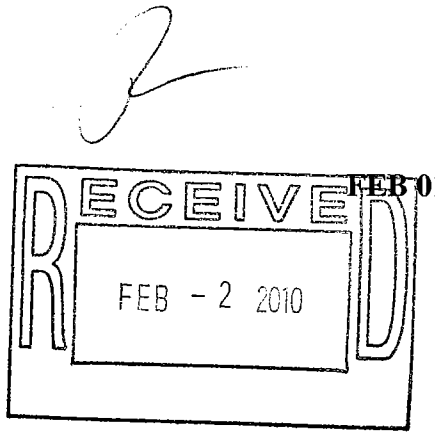

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Clinical Observations in the Treatment of World War II and Korean War Veterans with Combat-Related PTSD

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ABSTRACT. This paper provides a descriptive evaluation of group therapy for older combat veterans with severe, chronic Posttraumatic Stress Disorder (PTSD). Eight older combat veterans with PTSD participated in a long-term supportive/cognitive-behavioral therapy group. Self-report measures of psychiatric symptomatology taken at baseline and two years hence revealed no significant changes. These findings contrasted with clinician observation and informal family report, which indicated significant improvement in ability to manage symptoms, social functioning, and quality of life. Reports of improvement, despite lack of indication in outcome measures, are noted in two other reports of

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psychological treatment of PTSD in older veterans. Taken together, these independent clinical investigations 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. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2005 by The Haworth Press, Inc. All rights reserved.]*

KEYWORDS. Posttraumatic Stress Disorder, treatment, aged, veterans

The psychosocial treatment of combat-related Posttraumatic Stress Disorder (PTSD) in Vietnam Veterans has been widely discussed (e.g., Flack, Litz, & Keane, 1998; Frueh, Turner, & Beidel, 1995; Schnurr et al., 2003). Much less attention, however, has been given to the treatment of World War II (WWII) and Korean Conflict (KC) veterans. Best practice guidelines for PTSD from leading clinical scientists report that the most studied, and seemingly, the most effective interventions are the cognitive-behavioral therapies (CBT) (Shalev, Friedman, Foa, & Keane, 2000). Of the CBT interventions, the most favored modality for the treatment of combat-related PTSD with younger veterans, is group psychotherapy (Foy et al., 2000). This preference is based largely on clinical impression of more favorable outcomes, but also considers cost effectiveness, provision of essential social support, development of social skills, peer feedback, and accountability (Foy, 2001). The aim of this preliminary investigation was to describe and evaluate the effects of a long-term group therapy for older male veterans with chronic and severe combat-related PTSD. The results of this investigation, coupled with reports from two previously published group interventions, may indicate a growing need to reconsider the goals of treatment for older veterans with chronic PTSD. Additionally, consideration of new means of measurement of improvement may be required for this population.

Clearly, traumatic war experiences, such as combat or internment, can have negative implications on older veterans' physical and mental health, impair their functional status, and increase their utilization of health care services decades after exposure (Schnurr & Spiro, 1999; Schnurr & Spiro, 2000; Spiro, Schnurr, & Aldwin, 1994). Rates of PTSD in older combat soldiers and ex-prisoners of war receiving care in medical or psychiatric inpatient settings are high and range from nine

percent for those who have never sought psychiatric treatment to upwards of 80 percent for those who have obtained prior psychiatric services (Rosen, Fields, Hand, Falsettie, & Van Kammen, 1989; Blake et al., 1990). Information on the longitudinal course of PTSD in older veterans suggests that many experience a waxing and waning of symptoms across the lifespan (Zeiss & Dickman, 1989), with many experiencing intense psychiatric symptoms shortly after exposure, decline in mid-life, and increase in late-life (Port, Engdahl, & Frazier, 2001).

The demography of the United States is quickly changing, with an unprecedented upsurge in the number of older adults (U.S. Census Bureau, 2004). The veteran population is especially affected by this trend, with male veterans being older than the overall adult male population (Klein & Stockford, 2000). Male veterans aged 65 and over are expected to increase from 26 percent of the male veteran population in 1990 to more than 40 percent by the year 2010. Despite knowledge that trauma-related distress is a significant and abiding problem for many older veterans and awareness of the "graying" of veterans, not much is known about psychological interventions for these men.

There are a few, largely descriptive, case study reports of therapy for PTSD in older adult veterans in the existing literature (Hyer et al., 1990; Lipton & Schaffer, 1986; Boehnlein & Sparr, 1993; Molinari & Williams, 1995; Snell & Padin-Rivera, 1997). Two of these reports note that despite clinically observed improvement, no significant improvements were evidenced in traditional outcome measures (Boehnlein & Sparr, 1993; Hyer et al., 1990). In combination with this current study a pattern appears to emerge that may indicate a need for additional outcome measures that capture the improvements reported by older veterans and their family members.

METHOD

Participants

Eight older combat veterans were referred to the VA Palo Alto Health Care System's National Center for PTSD (NC-PTSD) outpatient clinic in San Jose, California. Seven of the eight men served in the KC and one served in WWII. Five of the men served in the U.S. Army (62.5%), two served in the Marines (25.0%), and one was in the Navy attached to a Marine Division (12.5%). Five of the veterans were Mexican-American (62.5%), two were Caucasian (25.0%), and one was

an American Indian (12.5%). Their ages ranged from 68 to 81 with a mean of 71.50 (SD = 4.17). Six of them were married (75%) and two of them were divorced (25%). Their estimated household yearly incomes ranged from $20,001 to more than $50,000.

Each veteran completed assessments of combat exposure and psychological functioning at intake. Reports of traumatic exposure were cross-validated against military records. Several of the veterans had past diagnoses of alcohol abuse or dependence but only one had current intermittent abuse.

Measures

The *Combat Exposure Scale* (CES; Keane et al., 1989) is a seven-item measure of combat exposure that includes being subjected to enemy fire, seeing dead comrades, and killing others. Items are weighted differentially according to the severity of the experience. Total scores range from 1 to 41, with higher numbers indicating greater combat exposure. The CES has established high reliability (Keane et al., 1989).

The *PTSD Checklist-Military* (PCL-M; Weathers, Litz, Herman, Huska, & Keane, 1993) contains 17 items that correspond to the Diagnostic and Statistical Manual for Mental Disorders-Fourth Edition (DSM-IV; American Psychiatric Association, 1994) criteria for PTSD. Veterans indicated the extent to which they had experienced each symptom in the past month using a 5-point scale, from 1 (not at all) to 5 (extremely). This investigation utilized the continuous severity score. The PCL-M has demonstrated good reliability and validity (Weathers & Ford, 1996).

Description of Treatment

Clinical presentation of trauma-related distress in older adults appears different than the manifestation of these disorders in younger populations (e.g., Acierno et al., 2002; Davidson, Kudler, Sunders, & Smith, 1990). For example, Vietnam veterans often report more intense psychopathology, including PTSD and depressive symptoms, than older veterans (Davidson et al., 1990). Numerous factors may influence this difference in clinical phenomenology or presentation/reporting. It has been frequently noted that older adults may misinterpret psychological difficulties as somatic complaints or may be reluctant to admit to psychological difficulties because of associated stigma of seeking mental health treatment (Falk, Hersen, & Van Hasselt, 1994). Additionally,

for the current cohort of older adults, trauma that occurred before their middle adulthood preceded the introduction of PTSD into the psychiatric diagnostic nomenclature in 1980. Thus, knowledge of trauma effects was less known and understanding and support were less available to this generation. In light of these observations, treatment was modified in a number of ways.

Importantly, each veteran was provided with a short three-to-four session course of individual therapy as preparation for group participation. The aims were to dispel stereotypes about mental health and psychotherapy, provide education about the effects of trauma including PTSD, and explain the goals of treatment. This was felt to be especially important since many older veterans do not have a contemporary psychological lexicon and have some difficulty describing their symptoms accurately and understanding the process of psychological treatment (Hankin, 1997). For example, many of these older veterans initially described themselves as "crazy" or requested "truth serum" to rid themselves of trauma-related distress. These individual sessions were also used to identify personal reminders or "triggers" and briefly introduce coping strategies (e.g., grounding) that would enable the veteran to participate more constructively in group.

The group itself had an open format in which some new members were added after it began; six men started the group the first year with two men joining during the second year. Group therapy sessions were held on a weekly basis and were 1½ hours long.

The main goals of the group were to decrease PTSD symptoms, reduce impact of PTSD symptoms on daily functioning, and increase veterans' perceived control of their trauma-related symptoms. Similar to another treatment developed for older veterans (Clower, Snell, Liebling, & Padin-Rivera, 1996), group sessions combined ongoing group support, education about trauma and its effects, and CBT skills training. These skills included active problem-solving, anxiety and anger management, positive self-talk, and cognitive restructuring of maladaptive thinking.

Because older combat veterans have often suffered from decades of isolation and alienation, they were encouraged to take a variety of steps to improve their social relations with significant others. Group sessions included an ongoing focus on rebuilding family relationships. For example, veterans were encouraged to bring PTSD educational materials home and share them with family members (Clower et al., 1996). Additionally, since these older veterans, like the more general population of veterans with combat-related PTSD, reported that their problems with anger had negatively influenced their relationships with others, skills

such as assertive communication and time-out were discussed on a continuing basis.

Also, frequently discussed during group sessions were the impact and management of developmental changes that occur in older adulthood (e.g., ill health, retirement, and bereavement). These changes can constitute stressors that may exacerbate PTSD. For example, when an older veteran became physically or psychiatrically ill and needed to be hospitalized, their PTSD symptoms often increased. Adjustment to and acceptance of these age-related changes were promoted to decrease their effect on trauma-related distress.

RESULTS

Empirical Findings

The veterans' mean score on the CES was 30.00 (SD = 5.40) with a range of 23 to 38, indicating that the average combat experience was moderate to heavy. A paired-samples *t*-test was used to determine if the mean on the pre-treatment PCL-M measure was significantly different from the post-treatment mean. Analysis showed no significant reduction in PTSD symptoms ($t(7) = .30, p > .05$). Mean pre-treatment PTSD symptom scores (M = 67.25, SD = 11.13) were not significantly higher than post-treatment scores (M = 66.25, SD = 10.94).[1]

Case Illustration

A description of one of the KC combat veterans is presented as qualitative "evidence" of improvement not indicated on traditional (or standard) PTSD self-report measures.

Mr. H was a 72-year-old, Hispanic, married, KC Army veteran who had undergone psychopharmacological treatment for chronic anxiety prior to his referral to the NC-PTSD outpatient clinic. Despite that treatment, he continued to report experiencing daily extreme distress, in particular when driving his car near mountainous terrain. Mr. H was born and raised in a large, working-class, supportive family. At 21, he was drafted to serve as a machine gunner in the infantry, where he participated in numerous military engagements that resulted in his witnessing the death of many peers. Additionally, on one occasion Mr. H was shot; however, he was sent back to combat after receiving medical treatment.

Shortly after his return to the United States, Mr. H married and found employment. Despite these developmental/social milestones, he began to experience severe and disabling psychiatric symptoms, including panic attacks, nightmares, intrusive thoughts, angry outbursts, and depression. Around this time, Mr. H also began to isolate himself from family and friends and abuse amphetamines. For over forty-five years, these symptoms severely impaired Mr. H's occupational, social, and family functioning.

More than 45 years after his discharge from the military, Mr. H sought treatment at a VA. Since pharmacotherapy was not effective, he began a course of therapy with a psychologist for the treatment of his panic attacks. This too did not alleviate his suffering and he was referred to the NC-PTSD outpatient clinic. After being diagnosed with PTSD and receiving treatment in the PTSD group milieu, Mr. H reported a significant reduction in his level of distress.

Mr. H had never previously discussed his combat experiences and he was unaware that many of his psychiatric symptoms were related to his combat experiences. Particularly, Mr. H claimed that once he made the association between being shot by a sniper in mountainous terrain and the anxiety he experienced while driving through mountains, he became better able to endure the drive. In regards to reported improvement in his interpersonal relationships, Mr. H shared with his wife and children that his combat experiences had significantly affected his life. He also began to attend social gatherings on a limited basis.

Mr. H reported few panic attacks, decreased anxiety, improved social interaction, improved communication with his wife and family, and a greater capacity to cope with intrusive thoughts regarding his combat experience. He explained that although he continues to experience PTSD symptoms, he was currently better able to manage them.

DISCUSSION

The findings from this preliminary investigation suggest that the effects of long-term supportive/CBT group for PTSD in older male veterans may not be evidenced on currently available standard paper and pencil psychiatric distress measures. Although significant measurable reductions in PTSD symptom frequency or intensity were not obtained, substantial improvements were observed in these men. One of the most important changes was that their ability to manage PTSD symptoms appeared to increase. Additionally, veterans reported improved capability to limit the impact of symptoms on mood and social functioning. While

changes in social functioning were not formally assessed, group members informally reported improved peer friendships, greater closeness with partner and/or children, and increased trust of other group members and treatment providers. These informal reports were often confirmed by collateral sources such as spouses and adult children.

These data are consistent with two other independent clinical investigations in the literature (Hyer et al., 1990; Boehnlein & Sparr, 1993). Hyer et al. (1990) described a 12-session CBT group for WWII veterans with combat-related PTSD. The treatment focused on CBT strategies of rational thinking, anxiety management, self-reward, mastery, and relaxation. Pre- and post-treatment measures included the Impact of Events Scale (IES; Horowitz, Wilmer, & Alvarez, 1979) and the Geriatric Depression Scale (GDS; Yesavage et al., 1983). No significant differences were found between groups as defined by these measures; however, subjective reports from veterans and clinician observation suggested significant improvement.

Similarly, Boehnlein and Sparr (1993) discussed group treatment of WWII former prisoners of war. Their three-stage treatment included (1) discussion of experiences prior to military service, combat experiences, and internment experiences; (2) education and dialogue regarding effects of trauma, in particular thoughts, feelings, and behaviors towards authority figures (e.g., VA and government bureaucracies); and (3) exploration of personal concerns around aging, mortality, and loss. Upon entering the group and one year later, each veteran completed the Symptom Checklist-90-R (SCL-90-R; Derogatis, 1983) and the Impact of Events Scale (IES; Horowitz et al., 1979). Pre- and post-test assessment revealed minimal change, although clinicians' reports indicated significant improvement. Additionally, significant changes were also noted by veterans and their family members.

Unfortunately, the PTSD symptom data reported in this most recent investigation also indicate little benefit from group participation. This lack of demonstration of change may be due to a variety of factors. The possibility that a lack of measured improvement was due to reluctance by veterans to compromise their financial compensation due to service connection for PTSD cannot entirely be ruled out. It is well documented that combat veterans evaluated for PTSD appear to overreport psychopathology (see review, Frueh, Hamner, Cahill, Gold, & Hamlin, 2000). However, all of these veterans were already receiving 100 percent financial service-connected compensation for PTSD from the VA.

Lack of significant symptom change may also be due to chronicity of symptoms, or insufficient type, duration, or quality of treatment. For

example, it is possible that despite the potential dangers involved in performing intensive exposure with older adults, such techniques are necessary to reduce the core symptoms of PTSD. Although this therapy included acknowledgment and validation of the impact of trauma, it did not include direct trauma-focused processing. Treatment for younger adults has often focused on repeated exposure to images or memories associated with the traumatic events (Rothbaum, Meadows, Resick, & Foy, 2000). Because the physical health of older adults is often compromised, and direct trauma processing can produce strong physiological effects such as changes in heart rate and respiration that may exacerbate existing health conditions, the benefit of using exposure in the treatment of older adults with PTSD has been questioned (Hankin, 1997; Hyer & Woods, 1998).

However, therapist observation was that the veterans experienced clinically significant improvements in management of PTSD symptoms, family functioning, anger management, and amount and quality of social contacts. These areas were unfortunately not measured via self-report assessment.

Combat-related PTSD in veterans is often chronic and difficult to treat (Boudewyns, Hyer, Klein, Nichols, & Sperr, 1997). In the multisite Department of Veterans Affairs Cooperative Study Number 420, comparison of the effects of two group treatments for PTSD in Vietnam veterans were examined utilizing symptom severity, functional status, quality of life, physical health, and service utilization as outcomes (Schnurr et al., 2003). There were no significant differences between the groups and, in general, the veterans in both groups showed little improvement in terms of any of the aforementioned areas.

It may be that front-line clinicians and clinical investigators hold an expectation of improvement for older veteran populations similar to that of younger veteran cohorts or other traumatized populations. Like younger veterans, older veterans' psychological difficulties can include re-experiencing, avoidance, and arousal symptoms of PTSD, as well as depression, anger, and social isolation. Despite these commonalities it is possible that because of the severity and chronicity of their symptoms, improvements will be more gradual or mild and are not yet sufficiently captured by current therapeutic models or measurements.

Outcomes such as symptom reduction, though important, are often not comprehensive in defining significant treatment gains. If clinical scientists only use these measures to study treatment outcome, it can appear as though the treatment has failed to produce significant or sustained improvement. Future work examining the impact of psychotherapy for

older veterans with chronic PTSD should include other clinical achievements such as stabilization/crisis resolution, initiation and maintenance of new activities, development of relationships with other veterans and clinicians, re-investment in important relationships with family or friends, and reduction in maladaptive coping (i.e., social isolation). Another area that we suspect would be indicative of treatment gains is perceived ability to manage PTSD symptoms (e.g., efficacy to cope with PTSD and other symptoms when they arise). It has also been noted elsewhere that, in treating veterans with chronic, severe PTSD, it is essential to examine the veteran's perceived improvement and satisfaction with treatment (Creamer, Morris, Biddle, & Elliott, 1999; Frueh et al., 2002).

Additionally, in examining the effects of intervention for PTSD in older veterans, there should not be a reliance on self-reported data. Clinician noted change as well as collateral feedback from significant others on improvement is essential and meaningful. Frueh and colleagues (2001) urge the trauma field to develop a broad-based maladaptive social functioning outcome measure anchored to the non-traumatized population, and in the interim, suggest a multi-method treatment outcome strategy for clinical and research purposes.

Relatively little is known about treatment and provision of mental health services for older adult trauma survivors (for review, see Cook & O'Donnell, 2005), particularly issues of ethnicity and cultural diversity. Several authors have discussed geropsychotherapists' need for cultural competence in the provision of clinical services and the barriers to recruiting and retaining ethnically diverse elders in treatment (e.g., Lau & Gallagher-Thompson, 2002). Although no modifications or adaptations of this treatment were made based on ethnicity and culture, our findings have direct applicability to this issue. Over half of the group members were of Hispanic descent, all of whom were engaged in and adherent to treatment procedures, and also benefited therapeutically.

In sum, clinically, it is our observation that older veterans with chronic, severe PTSD can make meaningful gains in supportive and CBT-based group treatment. It is of paramount importance to stress to veterans that although their chronic PTSD symptoms may not be eliminated, their ability to manage their symptoms and the quality of their lives can improve greatly. This study suggests that, in more methodologically rigorous future investigations, researchers evaluating the impact of group therapy should incorporate measurement of other essential areas. Traditional measures may not be capturing the severity and complexity of chronic PTSD. This may not be just for older combat veterans but for survivors living with chronic and severe PTSD.

NOTE

1. Four of the older veterans also completed the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the State-Trait Anger Expression Inventory (Spielberger, 1991) at intake and two years hence. Albeit partial data, these secondary analyses looking at other features associated with PTSD are consistent with the notion that improvement was not evidenced in standard self-report measurements.

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