National Center for Post-Traumatic Stress Disorder

2001, Volume 10, Issue 2 ISSN-1052-7168

Clinical Quarterly

Menlo Park/Palo Alto * Boston * Honolulu * West Haven * White River Junction

NOTICE OF CORRECTION TO SCURFIELD (2001) ARTICLE

Chalsa M. Loo, Ph.D.

In the most recent issue of the Clinical Quarterly, Volume 10 (1), we published a cover article, written by Raymond Scurfield, DSW, entitled "Positive and Negative Aspects of Exposure to Racism and Trauma: Research, Assessment and Treatment Implications." After the article appeared in print, we received information suggesting that it had not given proper credit to Chalsa M. Loo, PhD and other members of her research team — John A. Fairbank, PhD, Libby O. Ruch, PhD, Daniel W. King, PhD, Lily Adams, RN, MA, and Claude M. Chemtob, PhD. Dr. Scurfield was also a member of the team.

We conducted a very careful review of this information and asked three neutral reviewers, outside the VA system, to examine all documents and information related to this publication. The reviewers unanimously concluded that the article did not provide sufficient credit to Dr. Loo for her leadership, theory, and contributions to this effort and to the other members of the research team. Dr. Loo has been principal investigator on a VA merit review grant "Asian American Vietnam Veterans Race-Related Study," funded 1996-1999, that supported the pioneering, difficult, and complex research effort to understand and document the traumatic effects of racism and race-related stressors experienced by veterans. This research on Asian American and Pacific Islanders with PTSD has been a very important advance in our field.

Content in the Clinical Quarterly article (p. 1-3, sections "Other Selected Literature Review" "Conceptualization of race-related experiences") contained material and format similar to a manuscript that has been accepted for publication in a forthcoming issue of Psychological Assessment (13:4) entitled "Measuring Exposure to Racism: Development and Validation of a Race-Related Stressor Scale (RRSS) for Asian American Vietnam Veterans," by Loo, Fairbank, Scurfield, Ruch, King, Adams, and Chemtob. Also proper citation was omitted in the section "The DSM, Culture, and Race" (p. 1) to an article by Loo, Singh, Scurfield, and Kilauano "Race-related stress among Asian American veterans: A model to enhance diagnosis and treatment" in Cultural Diversity and Mental Health (1998, 4:2, pp. 75-90).

For the record, it is important to mention that on May 25th, Dr. Scurfield stated that he "was remiss in not acknowledging several attributions regarding (his) article" and expressed his "most sincere apologies for these omissions".

We regret any confusion that publication of the Clinical Quarterly article may have caused readers and offer our sincere apologies to Dr. Loo and members of her team.

Bruce H. Young, LCSW
Editor-in-Chief

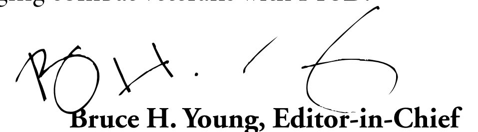
INSIDE THIS ISSUE

Opportunities for Growth in Survivors of Trauma 23
Aging Combat Veterans in Long-Term Care 26
New Directions 31
Early Intervention: A Clinical Forum 33
NC-PTSD Clinical Training Program 35
NC-PTSD Education and Support Services 36

FROM THE EDITOR...

The tragic nature of trauma can make it uncomfortable for survivors and clinicians alike, to think about how traumatic events might provide opportunities for psychological "growth." However, with respect to survivor loss, pain, and suffering, many individuals who have endured traumatic experiences report having gained new and valued perspectives related to self-identity, priorities, relationships, spirituality, etc. Noted accounts of personal transformation include the works of Victor Frankl (1), Edward Wood Jr. (2) William Mahedy (3), and Arthur Egendorf (4). Knowing *when* and *how* to address potential developmental benefits resulting from traumatic experience is, nonetheless, a sensitive and challenging task for clinicians. In this issue of the Clinical Quarterly, Richard Tedeschi, Lawrence Calhoun, and Brian Engdahl discuss the process of posttraumatic growth and the therapeutic elements that help survivors reconstruct meaning and develop adaptive cognitive schemas.

In a previous issue of the Clinical Quarterly, Danieli (5) eloquently described many of the difficulties Holocaust survivors experience as they age, including experiencing the sense of abandonment, isolation, and loneliness as a recapitulation of having been shunned and dehumanized. Danieli also noted that combat veterans similarly stigmatized may be at risk for such recapitulation. Krystal (6) has also discussed how old age may intensify "posttraumatic constellations." As Joan Cook, Erin Cassidy, and Joe Ruzek note in this issue, the projected number of Vietnam veterans aged 65 and over will require an increased need for geriatric care within the VA. The prevalence of PTSD in aging veterans receiving geriatric care will increase correspondingly and challenge care providers to understand potential environmental stressors as well as behavioral problems associated with the disorder. In their forward-thinking article, Cook, Cassidy, and Ruzek identify potential stressors that might be encountered in nursing homes and delineate several key training issues for nursing home care of aging combat veterans with PTSD.



Bruce H. Young, Editor-in-Chief

References

1. Frank, V. (2000). Man's Search for Meaning. Boston: Beacon Press. (Hardcover ed.)
2. Wood, E. (1991). On Being Wounded. Golden, CO: Fulcrum Publishing.
3. Mahedy. W. (1986). Out of the night: The spiritual journey of Vietnam vets. New York: Ballantine Books.
4. Egendorf. A. (1985). Healing from the war: Trauma and transformation after Vietnam. Boston: Houghton Mifflin Co.
5. Danieli, Y. (1994). As survivors age: Part 1. National Center for PTSD Clinical Quarterly, 4, 1-7.
6. Krystal. H. (1981). Integration and self-healing in posttraumatic states. Journal of Geriatric Psychiatry, 14, 165-189.

NATIONAL CENTER FOR PTSD

Executive Director
Matthew J. Friedman, M.D., Ph.D.
VAMC/ROC White River Junction
Vermont 05009

Education and Clinical Laboratory Division
Fred Gusman, M.S.W., Director
VAMC, Palo Alto, California 94304

Behavioral Science Division
Terence Keane, Ph.D., Director
VAMC, Boston, Massachusetts 02130

Women's Health Science Division
Lynda King, Ph.D., Acting Director
VAMC, Boston, Massachusetts 02130

Pacific Islands Division
Fred Gusman, M.S.W., Chief of Operations
Honolulu, Hawaii 96813

Neuroscience Division
John Krystal, M.D., Director
VAMC, West Haven, Connecticut 06516

Northeast Program Evaluation Center
Robert Rosenheck, M.D., Director
VAMC, West Haven, Connecticut 06516

NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER

Clinical Quarterly Staff

Editor-in-Chief: Bruce H. Young, L.C.S.W.
Managing Editor: Josef I. Ruzek, Ph.D.
Executive Editor: Fred D. Gusman, M.S.W.
Associate Editors: Eve B. Carlson, Ph.D.; Gregory A. Leskin, Ph.D.
Assistant Editor: John Aboytes, B.A.
Design & Production: Bruce H. Young

Please feel free to contact us at the Education Division: FTS 463-2673/2494; commercial number 650-493-5000 ext. 22673/22494; or E-mail: ncptsd@bruceyoung.net
Please address all correspondence to: Editor, National Center for PTSD Clinical Quarterly, VA Palo Alto Health Care System, 795 Willow Rd (352E117), Menlo Park, CA 94025

OPPORTUNITIES FOR GROWTH IN SURVIVORS OF TRAUMA

RICHARD G. TEDESCHI, PH.D., LAWRENCE CALHOUN, PH.D., & BRIAN ENGDAHL, PH.D.

The deleterious effects of traumatic events are well documented, and include physical injuries of victims, fears raised in these victims, their families and neighbors, and the physical and social destruction that violence visits on societies. Certainly, the literature on posttraumatic stress disorder has clarified the ways that trauma can effect many realms of physiological, psychological and interpersonal functioning. Along with these effects of trauma, there are others that have been less commonly described, i.e., the ways that trauma may act as a catalyst for personal transformation. In fact, it appears that between ten and ninety per cent of traumatized individuals in research studies report that they have experienced some benefits from coping with the aftermath of trauma, an experience we have called "posttraumatic growth" (1,2). The range of reports is substantial due to the fact that different traumas and populations may operate differently, and most studies have not paid special attention to this aspect of trauma experience. But the changes themselves have a common pattern. The changes include positive developments in interpersonal relationships and one's spiritual life, a sense of personal strength, new pathways for one's life, and changes in personal philosophy (3).

The process of posttraumatic growth

The same aspects of aftermath of traumatic experiences that set into motion the development of symptoms of PTSD may also be responsible for posttraumatic growth (PTG) outcomes. A central element to both appears to be the shattering of schemas, or worldviews that have provided a frame of reference for self-worth, the benevolence of others, trust, safety, and meaning. Without these fundamental understandings and predictions operating, life seems less understandable, more frightening, and it becomes difficult to decide how to proceed (4-7). Traumatic experiences often leave these schemas shattered, and years after surviving the events, people may continue to struggle with reconstructing schemas that accommodate the experience. Reconstruction can allow for reduction of emotional distress and coping success. Additional changes are possible when the reconstruction of schemas produces a view of the world and related behavior that the survivor perceives as beneficial, not only in managing the trauma, but in living life more fruitfullythan it was lived prior to the trauma (3). In order to facilitate worldviews or schemas, distress and various symptoms of psychological disorder among survivors of trauma, careful attention to trauma survivors' descriptions of their post-trauma experience may also reveal PTG. The clinician or other persons who provide support have the ability to listen to the retelling of the stories of trauma, and also the attempts to piece together a sensible way of understanding oneself, one's purpose, and how to live life in the aftermath of the trauma according to the meanings that are being constructed. This can be a time consuming process, necessitating patient listeners. For trauma survivors who have the good fortune to have such supportive persons available shortly after the traumatic events, this process can occur within months after the trauma. For others, the process might be delayed for years. For example, when this topic was brought up specifically in a group therapy meeting of World War II combat veterans, several kinds of responses emerged:

...pain and distress produced by highly stressful events must be satisfactorily managed before growth can be experienced and acknowledged

"I'm more resilient; I bounce back from things well (you had to in combat)."

"I became more self-reliant and independent."

"I learned how to handle emergencies, to be innovative and creative under stress."

"I really became sensitive to the underdog, because I had learned what it meant to be crapped on."

These acknowledgments of strength then became the basis for further discussion of the character and wisdom of the group members, producing pride that helped to balance the traumatic effects of their wartime experiences. Perceiving PTG helps to give a sense of meaning and purpose to what would otherwise be simply painful.

Continued on page 24

Facilitating posttraumatic growth

In order to encourage clients to pay attention to growth aspects of their posttraumatic experience, clinicians can implement a number of intervention strategies. We have described these in detail elsewhere (8), emphasizing that PTG is a common element of clients' experience, and that our job is not to create it but to facilitate it. Following is a brief sketch of some clinical considerations.

Clinical interventions must work within the client's belief system, with sensitivity to cultural nuances that are likely to include existential or spiritual dimensions. Although this is currently a clinical truism, some clinicians may be somewhat uncomfortable when clients focus specifically on spiritual themes or explicitly religious matters (9). Spiritual schemas can permit the creation of meaning for traumatic events (10) and they can also provide unique avenues for the individual's psychological growth. In order to allow the maximum benefit from schema change in this area, the clinician must have the flexibility to tolerate the questioning, doubt, and change in the spiritual and religious realm, as the survivor of trauma moves beyond an old belief system to a revised one. The clinician may be working within an evolving belief system, and may not have any sense of what the "final version" may be. The therapist must be willing to act as a "midwife" in this process (11). This role suggests a supportive expert who respects the survivor's ability to naturally manage the difficult process.

The clinician must be prepared for and willing to support the client's perceptions of growth. Whether the client discovers or constructs (12) positive change, the clinician needs to support the perception of growth when it occurs. Although the issue of "positive illusions" is a matter that produces academic debate (13), "positive illusions" (14) can be useful for clients in the process of PTG. One of the still unanswered research questions is the degree to which "growth" involves measurable changes in behavior, beyond self perceptions. But from a clinical perspective, it seems desirable to support a client's perception that he or she is now a different and better person, even if the individual has not measurably altered observable behavior. Those behavioral changes may come later, and the clinician can engage the survivor in discussions of how the changes may be shared. In many of the cases, clients seem determined to share the gifts of their experience with others, giving purpose and meaning to their suffering.

Even if PTG can be engendered by intervention, the clinician should not attempt to rush it. The overwhelming pain and distress produced by highly stressful events must be satisfactorily managed before growth can be experienced and acknowledged. Even for persons whose difficulties have not exposed tothem to danger, for example parents who are bereaved by the loss of a child, early clinical work should be focused on helping the individual manage high levels of psychological distress.

The key issue here is one of the proper timing of the proper intervention. What seems clear for the domain of posttraumatic growth is that for most persons, the clinician should not be looking for, nor leading the client to focus on, possibilities of posttraumatic growth in the immediate aftermath of a traumatic event. As the individual's coping mechanisms restore some degree of psychological equilibrium and reduce some of the most extreme distress, then the clinician needs to be alert to the possibility of helping the client identify areas of growth. We wait until clients make mention of changes themselves, and at first offer gentle reflections.

A semantically minor, but clinically important, issue is how the clinician chooses to talk about and help the client articulate the traumatic antecedents, or in the view of many clients, the cause of the individual's experienced growth. It is important to use words that clearly locate the arena of growth as the struggle with the event, not necessarily the event itself (8). For example, Harold Kushner, who described several elements of growth resulting from his own struggle with loss, was very clear in indicating that there was nothing inherently good in his son's death, and that he would gladly give up this growth in return for his son (15).

...the clinician must have the flexibility to tolerate the questioning, doubt, and change in the spiritual and religious realm, as the survivor of trauma moves beyond an old belief system to a revised one.

The description we have given of the clinician's role may indicate a rather passive presence during the process of growth. This is true to a great degree, but there are times when firmness and challenge are needed. This is especially true when distress returns, as it will repeatedly during this process. The survivor must be reassured that the therapist remains steadfast through the fears and the uncertainties. This is established early one when the clinician shows a willingness to hear horrific details of the trauma itself, and even find out more. For example, the clinician may act as an initial viewer of autopsies, photographs, court records, or other material that the survivor isn't ready to consider on their own. The clinician becomes a credible source of safety so that during the time of reconsidering the fundamentals of life structure and meaning, the survivor is able to endure doubt, experimentation, and the added distress this may bring. The therapist is willing to ask the difficult questions without flinching.

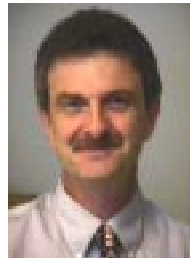
It may be evident that such work demands courage on the part of both the clinician and the survivor. We also recognize that not all trauma survivors report growth outcomes, and this growth is not necessary for successful living. However, PTG is anything but superfluous. It can provide trauma survivors with energy, purpose, and meaning. Since distress can remain part of the picture, and lives without reconstructed belief systems can seem without direction or purpose, the stage can be set for further difficulties in years to come. Therapy that allows survivors of trauma to experience personal transformations can help consolidate treatment gains and avoid future difficulties.

Although growth is most likely after some period of initial distress reduction, we have also integrated our focus on posttraumatic growth into critical incident stress management (16). During the psychoeducation that occurs in typical debriefings, clinicians should recognize the opportunity to point out that symptoms of posttrauma distress are far from universal, and that there are frequently experiences of growth that are reported by survivors of similar events. Just as in psychotherapy settings, the clinician who is oriented toward growth can highlight the aspects of the aftermath that can be recognized as benefits: closer relationships, an appreciation of life, a sense of strength and "survivorship," spiritual development, and consideration of new purposes and possibilities for oneself.

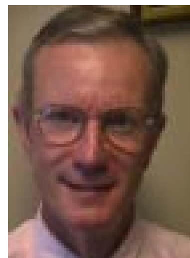
Finally, we should point out that clinicians often experience a vicarious version of posttraumatic growth by working with trauma (17). As we accompany our clients while they struggle and search, we can reap some of the benefits ourselves. After all, we experience some of the emotion of it, we share the task of developing the revised worldviews, and we join in the celebrations of the wisdom that can be revealed.

References

1. Calhoun, L.G., & Tedeschi, R.G. (2001). Posttraumatic growth: The positive lessons of loss. In R. A. Neimeyer, (Ed.), Meaning reconstruction and the experience of loss (pp. 157-172). Washington, DC: American Psychological Association.
2. Tedeschi, R.G., & Calhoun, L.G. (1996). The posttraumatic growth inventory: measuring the positive legacy of trauma. Journal of Traumatic Stress, 9, 455-471.
3. Tedeschi, R.G., & Calhoun, L.G. (1995). Trauma and transformation: Growing in the aftermath of suffering. Thousand Oaks, CA: Sage.
4. Epstein, S. (1990). The self-concept, the traumatic neurosis, and the structure of personality. In D. Ozer, J.M. Healy, Jr., & A.J. Stewart (Eds.), Perspectives on personality (Vol. 3, pp. 63-98). Greenwich, CT: JAI Press.
5. Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. Social Cognition, 7, 113-136.
6. Janoff-Bulman, R. (1992). Shattered assumptions. New York: The Free Press.
7. McCann, I.L., & Pearlman, L.A. (1990). Psychological trauma and the adult survivor: Theory, therapy, and transformation. New York: Brunner/Mazel.
8. Calhoun , L.G., & Tedeschi, R.G. (1999). Facilitating posttraumatic growth: A clinician's guide. Mahwah, NJ: Lawrence Erlbaum Associates.
9. Shafranske, E.P. & Malony, H.N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. Psychotherapy, 27, 72-78.
10. Pargament, K.I. (1990). God help me: Toward a theoretical framework of coping for the psychology of religion. Research in the Social Scientific Study of Religion, 2, 195-224.
11. Vaughan, F., Wittine, B., & Walsh, R. (1996). Transpersonal psychology and the religious person. In E.P. Shafranske (Ed.), Religion and the clinical practice of Psychology (pp. 483-509). Washington, DC: American Psychological Association.
12. Neimeyer, R.A., & Stewart, A.E. (1996). Trauma, healing, and the narrative employment of loss. Families in Society: The Journal of Contemporary Human Services, Special Issue: Constructivism in Social Work Practice, 360-374.
13. Colvin, C.R., & Block, J. (1994). Do positive illusions foster mental health? An examination of the Taylor and Brown formulation. Psychological Bulletin, 116, 3-20.
14. Taylor, S.E., & Brown, J.D. (1988). Illusion and well-being: A social psychological perspective on mental health. Psychological Bulletin, 103, 193-210.
15. Viorst, J. (1986). Necessary Losses. New York: Fawcett.
16. Calhoun, L.G., & Tedeschi, R.G. (2000). Early posttraumatic interventions: Facilitating possibilities for growth. In J.M. Volanti, D. Paton, & C. Dunning (Eds.), Posttraumatic stress intervention: Challenges, issues and perspectives (pp. 135-152). Springfield, IL: Charles C. Thomas Publishers.
17. Arnold, D., Calhoun, L.G., Tedeschi, R.G., & Cann, A. (August, 2000). Vicarious transformation in psychotherapy with trauma survivors. Poster session presented at the annual convention of the American Psychological Association, Washington, DC.



Richard Tedeschi, Ph.D. is Professor of Psychology at UNC Charlotte, and a Licensed Psychologist specializing in bereavement and trauma. He has published three books on posttraumatic growth.



Lawrence G. Calhoun is a clinical psychologist who is Professor of Psychology at UNC Charlotte, NC. He is co-author of Trauma and Transformation (1995), Facilitating Posttraumatic Growth (1999), and of numerous professional papers.

Brian Engdahl, Ph.D. is a counseling psychologist at the Minneapolis VAMC. He provides services to brain and spinal cord-injured veterans, and to combat veterans and former prisoners of war, particularly those who served in WWII and the Korean War.

AGING COMBAT VETERANS IN LONG-TERM CARE

JOAN M. COOK, PH.D., ERIN L. CASSIDY, PH.D., & JOSEF I. RUZEK, PH.D.

The demographic profile of the United States population is rapidly changing and the most striking alteration is the unprecedented shift in the number of older adults. The number of individuals living into older adulthood is increasing and this graying of America is very clearly seen in the veteran population. Based on the Bureau of Census data 2000, the veteran population is even more affected than the general population, with male veterans being older than the overall adult male population (1).

Among male veterans, approximately 38 percent are 65 or over and 1.5 percent are 85 or over (1). World War II (5.9 million) or the Korean Conflict (4.1 million) veterans comprise the majority of these estimations. These percentages are projected to drastically increase as Vietnam era veterans age. Currently, Vietnam era veterans make up the largest service group (8.1. million), accounting for about one-third of all veterans. This means that male veterans aged 65 and over are expected to increase from 26 percent of the male veteran population in 1990 to over 40 percent by 2010 to about 50 percent in 2020. The projected changes in the size and characteristics of the U.S. veteran population illustrate the demand for increased geriatric care services within the Veterans Administration (VA).

Increasing Care Needs

It is widely accepted that military experiences, such as combat exposure or internment, can be traumatic to physical and mental health. The resulting psychological problems can include pervasive apprehension, anxiety, depression, detachment, hostility, alienation, social isolation, confusion, and difficulties in memory, attention and concentration problems. In addition, symptoms of Post-Traumatic Stress Disorder (PTSD), such as re-experiencing of the traumatic event (in the form of intrusive memories, nightmares, or physiological reactivity), avoidance of cues associated with the traumatic stressor, numbing of general responsiveness, and increased arousal can also occur..

...cognitive abilities may not support the use of self-management strategies that require retention of new information about PTSD and coping tools...

The VA has indicated that 52 percent of World War II and 35.2 percent of Korean War veterans were exposed to combat (2). Estimates of rates of PTSD in older combat soldiers and ex-prisoners of war, from medical or psychiatric inpatient settings, are high (3,4). Data from a large epidemiological study of Vietnam veterans, the National Vietnam Veterans Readjustment Study, found that approximately 15 percent of all theater veterans and 36 percent of veterans exposed to high levels of combat reached criteria for lifetime PTSD (5).

...Rather, specific behavioral techniques that have been shown to reduce problem behaviors in general nursing home samples may also improve management of problem behaviors related to PTSD.

At present, the prevalence of PTSD in older adult veterans living in nursing homes or extended care units is unknown. In addition, evidence regarding the co-morbidity of or relationships between dementia and PTSD is lacking. However, even in the absence of accurate information, it is safe to say that planning for the influx of veterans with these problems, especially those entering VA long-term care settings, is crucial. Our current knowledge base and training programs are not yet equipped to cope with the potential increased demand for services. Given the growing demand for VA care for this group, it is important to be able to provide appropriate services, especially since older persons often remain in long-term care over many years.

Special Challenges in Working with Aging Veterans with PTSD

Older people who have survived trauma may have special needs in long-term care settings (6). A few case studies of older adults with exposure to combat or other non-military related traumas suggest that illness, loss of significant others, and retirement, as well as hospitalization or institutionalization, may interact negatively with unresolved trauma to maintain or re-awaken psychological distress in later life (7-11). Interestingly, it has also been suggested that dementia processes may exacerbate underlying PTSD symptomatology.

Johnston (12) presented three case studies describing veterans and their families who, despite evidence of recent cognitive decline, sought help only after a violent outburst had occurred. In each case, the violence was associated with a recent increase in war-related nightmares, increased physiological hyperreactivity (e.g., startle), and anxiety in response to trauma cues.

Once admitted to long-term care, combat veterans may encounter a range of trauma-related stimuli or "triggers" that may elicit PTSD symptoms and general distress. For example, television news coverage of traumatic events, the sounds of other patients in distress, interpersonal conflict, and specific staff behaviors (e.g., arbitrary use of authority or excessive control, the speaking of foreign languages) may all act as triggers, depending on the past experiences of the patient. For women veterans, the presence of male strangers (or those who go unrecognized despite a regular presence on the unit) or physical contact may bring up emotions originally associated with sexual assault. As another example, physical restraint may act as a reminder of POW captivity experiences or other violent encounters. Examples of triggers, behavioral responses likely to be associated with PTSD, and possible interventions can be seen in Table One.

PTSD and Agitation

Up to 93 percent of residents in the general nursing home population demonstrate agitated behaviors and engage in indirect self-harm (13,14). Clinical observations indicate that, while in long-term care, some veterans with histories of combat exposure exhibit more physically and verbally aggressive behaviors than those who were not in combat. This is important as nursing home staff report that physical and verbal aggressions are among the most difficult behavioral problems in these settings (15).

Agitation has been defined as verbal, vocal, or motor behavior that is either appropriate behavior but repeated frequently, or inappropriate behavior that suggests lack of judgment (16). According to Cohen-Mansfield (13), there are three subtypes of disruptive agitated behaviors: 1) aggressive behaviors, which typically include hitting, kicking, scratching, and biting; 2) physically non-aggressive behaviors, which include pacing, wandering, and repetitious mannerisms; and 3) verbally agitated behaviors, such as complaining, shouting, and screaming. These subtypes are differentially related to cognitive impairment, physical and mental health, personality, and environmental factors (17). For example, in a cross-sectional survey of 402 nursing home residents (18), one predictor of pacing was previous exposure to life-threatening experiences (primarily exposure to the Holocaust or Russian pogroms). However, these researchers did not find a significant relationship between exposure to trauma and physical or verbal agitation.

Indirect self-destructive behavior is defined as an act of omission or commission that causes self-harm leading indirectly to death over time, such as refusal to eat or take medications (14). In VA patients hospitalized on an Intermediate Care Unit, these behaviors were significantly related to a number of variables including personal losses experienced, satisfaction with hospital, and life satisfaction (19).

Here at the National Center for PTSD in Menlo Park, California, we are currently examining the prevalence of PTSD and sub-threshold PTSD in a sample of veterans in a nursing home and an extended care unit. In addition, we are empirically examining the relationship between PTSD, agitation, and indirect self-harm in these veterans. We hypothesize that a PTSD diagnosis or sub-threshold PTSD will be associated with higher rates of disruptive agitated behaviors, especially those related to anger. Irritability and anger are common symptoms found in cases of combat-related PTSD, and among younger Vietnam veterans, PTSD is associated with increased rates of violence. Younger veterans with PTSD have been found to be more likely to exhibit violent behaviors than individuals from the general population, veterans without PTSD, and other psychiatric patients (20). We also suspect that some episodes of disruptive behavior may be, in fact, precipitated by exposure to trauma reminders, although staff and patients may fail to recognize this connection.

Management of PTSD in the Long-Term Care Setting

It is unlikely that staff of long-term care treatment settings are prepared to recognize PTSD in their patients. Most will have received little training about trauma and its impact. When PTSD is present, it will often resemble more familiar and common problems encountered in elderly populations, such as depression and other anxiety disorders. Therefore, management of PTSD will first involve staff training in the taking of trauma history, PTSD assessment, and differential diagnosis. It is likely that PTSD-related education will be welcomed by staff, because the agitation and indirect self-harm behaviors noted above often frustrate and "burn out" caregivers. These behaviors require excessive staff time, which takes away attention from other patients. Disruptive behavior in nursing homes can also create staff conflict and team dysfunction, and detract from the overall quality of care (21).

Once a diagnosis of PTSD is made, there are management tools to help staff and patient. A chief strategy may be the identification and subsequent elimination, avoidance, or minimization of trauma cues. For example, military attire and presence of related symbols can easily be removed from a patient's room, and likely minimized in certain common areas. If a trigger is unalterable, interventions can involve modification of patient behaviors and the training of their caregivers.

Table 1. PTSD related triggers and interventions

Category of Behavior	Triggers	Possible Behavioral Responses	Interventions
People	* Uniforms, hats, pins * Authority figures, demands to maintain structure * Ethnicity * Others in distress * Unpatriotic behavior	* Agitation * Verbal aggression * Physical aggression * Exacerbation of PTSD symptoms (flashbacks, nightmares, etc.)	* Remove trigger * Remove patient from environment * Minimize exposure to trigger
Environment	* Anniversary dates * Noises * People speaking other languages * Intercom announce-ments; loud speaker * VA hospital * Military personnel * Lack of privacy	* Depression (crying, isolating, non-participa-tive) * Acute anxiety response * Increase in requests for help/attention * Verbal aggression * Physical aggression	* Minimize/eliminate trigger * Explain announce-ments face-to-face in simple terms * Consider patient preferences in ward decorations and activities * Provide psychologi-cal support resources regularly and as needed
Personal Care	* Approached from behind * Isolation * "Show of force"	* Resistive to care regime/ non-compliant * Combative during care * Verbal aggression * Physical aggression * Depression	* Announce yourself when approaching a patient * Approach patient in a calm non-confron-tive manner * If patient is aggres-sive, give time-out until he or she has calmed down

The patient's cognitive resources (e.g., level of dementia) and ability to process incoming information are key factors in choosing these alternative approaches. In cognitively intact veterans, interventions may be similar to those used in PTSD specialist treatments (e.g., veterans can be educated about PTSD, taught to seek social support, and helped to cope more effectively with their symptoms). However, cognitive decline may mean that cognitive abilities may not support the use of self-management strategies that require retention of new information about PTSD and coping tools. Rather, specific behavioral techniques (e.g., stimulus control and reinforcement procedures) that have been shown to reduce problem behaviors in general nursing home samples (22) may also improve management of problem behaviors related to PTSD.

Other research has demonstrated that training of nursing home staff in behavior management can be effective in decreasing agitation (23). We suspect that staff education about PTSD may lead to an earlier identification of those patients at risk, an increase in staff understanding of PTSD and empathy for patients, and the chance to provide caregivers with a toolbox of strategies for effective management. For example, helping staff recognize that a PTSD patient is aggressive due in part to military training and combat experiences may help staff to react with less negative judgment about the patient.

Future Directions

The epidemiology, phenomenology, assessment, neuropathology, and psychosocial and psychopharmacological treatment of PTSD as it manifests in the long-term care environment, as well as its interaction with the dementias, all merit future attention. In practical terms, it will be important to determine the impact of PTSD on the quality of life of the aging veteran and the problem behaviors encountered by staff, along with ways of reducing trauma-related problems. The effects of military trauma reach well beyond the confines of the specialist mental health clinic, and, given the coming increase in numbers of veterans receiving long-term care, as well as the potential for stressors associated with aging to exacerbate post-traumatic stress symptoms, research, clinical innovation, and staff training related to PTSD in the long-term care environment will all be necessary to prepare for the future.

References

1. Klein, R., & Stockford, D. (2000). The changing veteran population: 1990-2020. Office of Assistant Secretary for Policy and Planning. Department of Veterans Affairs, Washington, DC.

2. Department of Veterans Affairs. (1989). Survey of veterans III. Washington, DC: Author.

3. Blake, D.B., Keane, T.M., Wine, P.R., Mora, C., Taylor, K. L., & Lyons, J.A. (1990). Prevalence of PTSD symptoms in combat veterans seeking medical treatment. Journal of Traumatic Stress, 3, 15-27.

4. Rosen, J., Fields, R.B., Hand, A.M., Falsettie, G., & Van Kammen, D. P. (1989). Concurrent posttraumatic stress disorder in psychogeriatric patients. Journal of Geriatric Psychiatry and Neurology, 2, 65-69.

5. Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R. L., Jordan, B. K., Marmar, C. R., & Weiss, D. S. (1990). The National Vietnam Veterans Readjustment Study: Tables of findings and technical appendices. New York: Brunner/Mazel.

6. Harel, Z., & Noelker, L.S. (1995). Severe vulnerability and long-term care. In Z. Harel & R. Dunkle (Eds.), Matching People with Services in Long-Term Care (pp. 5-24). New York: Springer Publishing Company.

7. Adams, K.B., Mann, E.S., Prigal, R.W., Fein, A., Sounders, T. L., & Gerber, B.S. (1994). Holocaust survivors in a Jewish nursing home: Building trust and enhancing personal control. Clinical Gerontologist, 14, 99-117.

8. Hamilton, J.D. & Workman, R.H. (1998). Persistence of combat-related posttraumatic stress symptoms for 75 years. Journal of Traumatic Stress, 11, 763-768.

9. McCartney, J.R. & Severson, K. (1997). Sexual violence, post-traumatic stress disorder and dementia. Journal of the American Geriatrics Society, 45, 76-78.

10. Moye, J. (1997). PTSD in long-term care. Clinical Gerontologist, 18, 84-88.

11. Pary, R., Turns, D. M., & Tobias, C. R. (1986). A case of delayed recognition of posttraumatic stress disorder. American Journal of Psychiatry, 143, 941.

12. Johnston, D. (2000). A series of cases of dementia presenting with PTSD symptoms in World War II combat veterans. Journal of the American Geriatric Society, 48, 70-72.

13. Cohen-Mansfield, J., Marx, M.S., & Rosenthal, A.S. (1989). A description of agitation in a nursing home. Journal of Gerontology, 44, M77-M84.

14. Conwell, Y., Pearson, J., & De Renzo, E.G. (1996). Indirect self-destructive behavior among elderly patients in nursing homes. The American Journal of Geriatric Psychiatry, 4, 152-163.

15. Fisher, J.E., Fink, C. M., & Loomis, C.C. (1993). Frequency and management difficulty of behavioral problems among dementia patients in long-term facilities. Clinical Gerontologist, 13, 3-12.

16. Cohen-Mansfield, J., & Billig, N. (1986). Agitated behaviors in the elderly. I: A conceptual review. Journal of the American Geriatrics Society, 34, 711-721.

17. Cohen-Mansfield, J., & Deutsch, L.H. (1996). Agitation: Subtyping and their mechanism. Seminars in Clinical Neuropsychiatry, 1, 325-339.

18. Cohen-Mansfield, J., Werner, P., Marx, M.S., & Freedman, L. (1991). Two studies of pacing in the nursing home. Journal of Gerontology: Medical Sciences, 46, M77-83.

19. Nelson, F.L., & Farberow, N.L. (1976). Indirect suicide in the elderly, chronically ill patient. Psychiatria Fennica, Suppl., 125-139.

20. McFall, M.E., Fontana, A., Raskind, M., & Rosenheck, R. (1999). Analysis of violent behavior in Vietnam combat veteran psychiatric inpatients with posttraumatic stress disorder. Journal of Traumatic Stress, 12, 501-517.

21. Kikuta, S. C. (1991). Clinically managing disruptive behavior on the ward. Journal of Gerontological Nursing, 17, 4-8.

22. Landreville, P., Borders, M., Dicaire, L., & Verreault, R. (1998). Behavioral approaches for reducing agitation in residents of long-term care facilities: Critical review and suggestions for future research. International Psychogeriatrics, 10, 397-419.

23. Cohn, M. D., Horgas, A. L., & Mariske, M. (1990). Behavior management training for nurse aides: Is it effective? Journal of Gerontological Nursing, 16, 21-25.

Joan M. Cook, Ph.D. is currently a postdoctoral fellow at the National Center for PTSD in Menlo Park and the Geropsychiatry Department at the VA Palo Alto HCS. She will continue her clinical and research interests in PTSD in older adults as part of the clinical faculty at the Philadelphia VA/University of Pennsylvania.

Erin L. Cassidy, Ph.D. is currently a Research Associate in the Department of Psychiatry at Stanford University School of Medicine and coordinator of the Aging Treatment Studies Program at the VA Palo Alto HCS. Her clinical and research interests involve affective disorders in older adults, evaluation and management of dementia, and the relationship between dementia and other medical and psychiatric conditions.

Josef I. Ruzek, Ph.D., is Associate Director for Education at the Education and Clinical Laboratory Division of the National Center for Post-Traumatic Stress Disorder, at the VA Palo Alto HCS. He is responsible for provision of PTSD-related training and support services for VA specialized PTSD program staff and other health care providers within the nationwide VA health care system.

NEW DIRECTIONS

Matthew J. Friedman, M.D., Ph.D.
Executive Director, NC-PTSD

Two years ago, during a review of the National Center's program priorities we realized that our expertise in the assessment and diagnosis of PTSD could substantially assist both veterans and the Department of Veterans Affairs address nationwide concerns about the accuracy and consistency of Compensation and Pension (C&P) examinations for this disorder.

Thousand's of US service personnel have suffered from PTSD including, but not limited to veterans of World War II, The Viet Nam War, the Gulf War, and United Nations peacekeeping operations.. The National Vietnam Veterans Readjustmaent Study estimated lifetime prevalence of PTSD among American Vietnam theater veterans is 30.9% for men and 26.9% for women. Although we do not have comparable rigorous scientific data on PTSD prevalence among veterans from other eras, it is clear that PTSD is an occupational hazard of military duty and prevalence of this disorder is not inconsequential.

VA currently pays approximately 1.3 billion dollars per year to veterans disabled by PTSD due to military-related trauma. Compensation for PTSD can be paid by VA's Veterans Benefits Administration (VBA) to veterans any time after their military service if 3 conditions are satisfied:

- a traumatic event occurred during military service
- they meet the diagnostic criteria for PTSD
- a credible link between the disorder and the traumatic event is established

A recent review of 143 initial C&P claims for PTSD revealed that there were sometimes significant deficiencies in documentation of an accurate and detailed trauma history. Another common problem was that the examiner did not adequately describe how DSM-IV diagnostic criteria were met Other problems identified were that the examiner utilized DSM-III rather than DSM-IV criteria, and that the examiner sometimes failed to discuss whether other mental disorders that were diagnosed were related or unrelated to PTSD.

In order to improve the quality and timeliness of PTSD C&P exams, the National Center initiated a process to develop a standardized approach to assessment of PTSD for disability purposes. Led by the National Center's Patricia Watson, we assembled a task force that included Caroll McBrine VBA, Larry Lehmann of VA's Mental Health Strategic Health Care Group, Miles McFall of the Seattle Northwest Mental Illness Research Education & Clinical Center (MIRECC), and Terry Keane, Paula Schnurr, and myself from the National Center. Together, we have developed a manual which provides recommendations on "best practice" procedures for conducting C&P exams for veterans seeking compensation for PTSD Included in this manual are state-of-the-art guidelines for assessing PTSD as well as disability examination worksheets The manual includes standardized instruments for assessing trauma exposure, DSM-IV Diagnostic Criteria for PTSD, and PTSD symptom severity. The manual also has an important section on how to use the Global Assessment of Functioning scale, which has become a very important component in VA's C&P procedure.

continued on page 32

NEW DIRECTIONS, **continued from page 31**

We hope that this manual will raise the quality and standards of PTSD C&P examinations. We believe that an investment of more time and professional resources for the initial disability evaluation will reap the dividend of major improvements in the procedure for processing all PTSD disability claims. As a result, we anticipate that there will be substantial savings down the road because claims will have been processed more appropriately and efficiently. Given that the diagnostic and disability assessments will have been substantially improved, we expect that more veterans will be satisfied with their initial C&P evaluation. Greater satisfaction means that many fewer veterans will launch appeals of VBA's decision regarding their disability, thereby reducing the additional time and expense of the appeals process. Most important, however, is that our veterans deserve no less than the most accurate and efficient procedure for adjudication of their PTSD disability claims.

We recognize that production of a manual alone will not be enough. In order to change the behavior of psychiatric examiners and VBA adjudicators to improve the PTSD C&P procedure, we launched a major nationwide educational program about PTSD disability evaluations in general, and about our new PTSD C&P manual in particular. On February 7, 2001 we presented a Satellite Broadcast to enhance caregivers' skills for conducting C & P examinations for PTSD, using these best practice guidelines. The broadcast was produced by VA's Employee Education System (EES). Along with members of the C&P task force mentioned previously, we were joined by Al Batres,Chief of Readjustment Counseling Service, Dudley Blake from the Seattle, Northwest MIRECC, and Jeff Knight from the National Center. We are currently working with EES to plan a follow-up satellite broadcast that will be augmented by, VISN-wide trainings, and web-based instructions.

Also planned for the future are research efforts to assess the quality of reports generated by practitioners using these guidelines, in comparison to current practices (eg business as usual).. Finally, the National Center for PTSD is continuing to with VBA to study other possible improvements in the C&P process, such as establishing firm documentation of exposure to military trauma prior to the formal C&P diagnistic evaluation.

We are very enthusiatic about these collaborative initiatives with VBA and hope that these efforts will lead to significant improvements for veterans seeking compensation for military-related PTSD.

EARLY INTERVENTION: A CLINICAL FORUM

Josef I. Ruzek, Ph.D.
Education & Clinical Laboratory, NC-PTSD

Can early intervention with trauma survivors prevent development of PTSD and other post-trauma problems? Evidence regarding the effectiveness of the most widely used early intervention, psychological debriefing (1), remains inconclusive at present. Debriefing has not performed well in randomized controlled trials; three studies suggest a possible harmful impact of the procedure. However, the controlled studies that have been conducted have a variety of limitations; for example, debriefing as tested in this research has differed significantly from mainstream application of the method (e.g., it has been applied one-to-one rather than in a group). Nonetheless, practice guidelines generated on behalf of the International Society for Traumatic Stress Studies (2) include, at present, the following judgments/recommendations:

* Debriefing has not been shown to prevent psychopathology;
* Debriefing is well-received by most participants;
* It may be useful for screening, educating, and referring survivors;
* Participation should not be mandatory; potential participants should be clinically assessed;
* Debriefing should be accompanied by clear and objective evaluation procedures.

The guidelines also state that "more complex interventions for those individuals at highest risk may be the best way to prevent the development of PTSD following trauma" (p. 54). One emerging approach to such complexity is seen in the cognitive-behavioral treatment for Acute Stress Disorder (ASD) developed and tested by Richard Bryant and his colleagues (3,4). Their package, delivered in 4-5 individual sessions, includes education about trauma reactions, progressive muscle relaxation training, imaginal exposure to trauma memories, cognitive restructuring, and graded "real life" exposure to avoided situations. For victims with ASD due to accidents or violence, it appears to significantly reduce PTSD symptoms six months post-trauma, and to significantly outperform 4-5 sessions of general supportive counseling.

Current research and theories suggest that the next generation of early intervention services is likely to focus on several specific kinds of goals:

Reduction of physiological arousal – High arousal in the first days following trauma exposure has predicted development of PTSD in some studies. It is possible that successful reduction of arousal during the initial hours, days, or weeks following traumatization may inhibit a variety of processes that lead to chronicity of reactions.

Restructuring of negative trauma-related beliefs – It is possible that how survivors appraise their experience and its effects on their lives may prolong their distress. Identification and successful change of beliefs like "I deserve what happened" or "I can't protect myself from harm" or "I'm going crazy" or "my marriage will be wrecked" may aid in the recovery process.

Reduction of maladaptive coping – Responding to trauma-related distress via some types of coping – excessive avoidance, alcohol or drug use, "workaholism" - is likely to be associated with worse outcomes. Whether these coping methods interfere with natural healing processes, or whether they create additional problems that exacerbate distress, it is possible that their replacement by other coping tools might improve post-trauma recovery.

Prevention of "loss of resources" – Trauma survivors are at risk for the loss of important possessions, conditions of living (e.g., a good marriage, a job), personal characteristics (e.g., self-esteem), and tools to acquire other resources (e.g., money, credit, insurance), and loss of such things may be expected to affect responses following trauma. Future helping approaches will likely do more to prevent loss of resources, especially deterioration of social support, in the aftermath of trauma. They may also more explicitly focus on assisting survivors in returning to key life roles (e.g., parent, employee, student).

Facilitation of "emotion processing" – Treatments for acute trauma reactions might, like treatments for chronic PTSD, be based on the idea that survivors will benefit from systematic exploration of their trauma-related memories, thoughts, and feelings, to extinguish conditioned emotional responses, incorporate new information into the trauma memory, or reorganize that largely fragmented memory.

Major questions are "When and for whom should such processing be advocated?" and "Can it be harmful to some survivors?" and "Are there situations when avoidance of trauma memories is helpful for the survivor?"

Although the above principles are included in existing early intervention activities like debriefing and psychoeducation, it is likely that evolving models of care will more explicitly and systematically target these goals.

References

1. Raphael, B. & Wilson, J.P. (2000). Psychological debriefing: Theory, practice and evidence. Cambridge, UK: Cambridge University.

2. Bisson, J.I., McFarlane, A.C., & Rose, S. (2000). Psychological debriefing. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies (pp. 39-59). New York: Guilford.

3. Bryant, R.A., Harvey, A.G., Dang, S.T., Sackville, T., & Basten, C. (1998). Treatment of acute stress disorder: A comparison of cognitive-behavioral therapy and supportive counseling. Journal of Consulting and Clinical Psychology, 66, 862-866.

4. Bryant, R.A., Sackville, T., Dang, S.T., Moulds, M., & Guthrie, R. (1999). Treating acute stress disorder: An evaluation of cognitive behavior therapy and supportive counseling techniques. American Journal of Psychiatry, 156, 1780-1786.

NATIONAL CENTER FOR PTSD CLINICAL TRAINING PROGRAM

The Education and Clinical Laboratory Division for the National Center for Post Traumatic Stress Disorder at the Palo Alto CA VAMC, in collaboration with the VA Employee Education System, offers a Clinical Training Program (CTP). The training program is approved for 30 Category 1 CEUs for physicians, psychologists, social workers, and nurses.

Each year we welcome many mental health professionals from across the United States and from around the world. Most clinicians who enroll in the program have a working knowledge about treating the effects of trauma and PTSD and are looking to upgrade their clinical skills. The CTP offers a broad range of educational activities, including:

* **Lectures**
* **Clinical consultation**
* **Clinical observation of group treatment**
* **Group discussions facilitated by staff**

Specific training topics include warzone trauma group treatment, treatment of women veterans, treatment of sexual assault related PTSD, relapse prevention, cross cultural treatment issues, assessment and treatment of families, disaster mental health services, cognition and PTSD, assessment of PTSD, and psychiatric assessment.

Training programs are scheduled for a minimum of one week, though longer programs are available if the applicant can justify an extended stay. Programs are scheduled nine times per year, on the second or third week of the month.

Funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or VA Employee Education System.

For more information, or to request an application, please email:
Josef.Ruzek@med.va.gov
or telephone FTS 700-463-2673; commercial number 650-493-5000, ext. 22673.

NATIONAL CENTER FOR PTSD EDUCATION, TRAINING, & SUPPORT SERVICES

PTSD Assessment Library

Available upon request are selected instruments from our library of assessment and program evaluation tools (with accompanying articles), together with templates describing over 100 trauma-related measures courtesy of Beth Stamm, Ph.D., and Sidran Press. Telephone (650) 493-5000 ext. 22477.

PTSD Article Library

A helpful set of key articles on aspects of PTSD is available to VA or Vet Center clinicians free of charge. Telephone (650) 493-5000 ext. 22673.

PTSD Video Library

The Menlo Park Education Team maintains a small videotape lending library exploring topics related to PTSD diagnosis, evaluation, and treatment. Videotapes may be borrowed free of charge. Telephone (650) 493-5000 ext. 22673.

PTSD Program Liaison and Consultation

The Menlo Park Education Team can help VA health care professionals locate needed resources. Services may include assistance in locating relevant articles, locating resource persons, or problem-solving. Staff are available to consult in the areas of PTSD Diagnosis and Treatment, Program Development and Design, Women and Trauma, Relapse Prevention, and with other PTSD-related concerns. Telephone (650) 493-5000 ext. 22977.

National Center for PTSD Web Page

The NC-PTSD Home Page provides a description of activities of the National Center for PTSD and other trauma related information. The world wide web address is: *http://www.ncptsd.org*

PILOTS Database

PILOTS, the only electronic index focused exclusively on the world's literature on PTSD and other mental health consequences of exposure to traumatic events, provides clinicians and researchers with the ability to conduct literature searches on all topics relevant to PTSD. *http://www.ncptsd.org/PILOTS.html*

NC-PTSD Research Quarterly

The *Research Quarterly* reviews recent scientific PTSD literature. Telephone (802) 296-5132 for subscription information.

Disaster Mental Health Training and Consultation

Education staff provide training in disaster mental health services, including team development, interfacing with other agencies, on-site and off-site interventions, debriefing, and psychoeducational and treatment interventions with disaster survivors and workers. Telephone (650) 493-5000 ext. 22494 or email: *ncptsd@bruceyoung.net*

Conferences and Training Events

The Menlo Park Education Team provides consultative support for the development of training in PTSD. Services include assistance in finding faculty and designing program content. Telephone (650) 493-5000 ext. 22673.