

Guarding the Hidden Wounds of War:

The Lived Experience of Chronic Combat-Related PTSD in Vietnam and Korean

War Veterans

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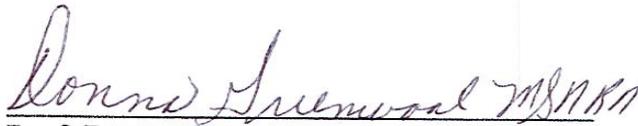
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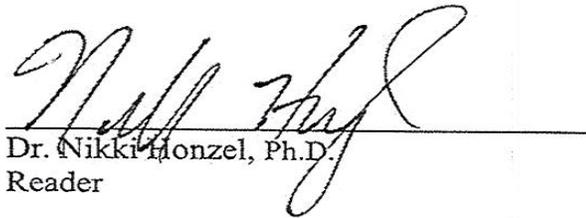
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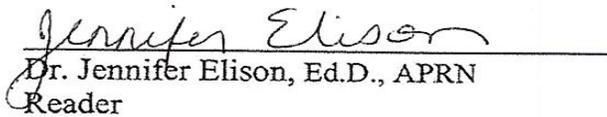
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To my family and closest loved ones – you know who you are – thank you for supporting me from afar. You mean the world to me.

Dedication

I would like to dedicate this project to the veterans who have so boldly shared their stories with me and – equally importantly – to the brave young brothers and sisters whom they lost but will never forget. Thank you for your service and your valor.

Abstract

Combat-related Posttraumatic Stress Disorder (PTSD) is a debilitating condition that affects between 18.7% and 30.9% of Vietnam veterans at some point in their lives (Dohrenwend et al., 2006). Current literature highlights the clinical relevance of PTSD, supporting the fact that it is a chronic, fluctuating condition (Chopra et al., 2014, p. 95) with detrimental effects on not only mental but also physical health (Goldberg et al., 2014, p.1589). PTSD correlates with impaired cognition, concentration, problem solving, and reasoning (Mota et al., 2016, p. 351) along with increased likelihood of chronic illness, disability, unhealthy weight (Goldberg et al., 2014, p. 1585) and pain (Pagotto et al., 2015). Clinical recognition of these types of symptoms in veterans over the age of 65 is imperative as they make up approximately 40.5% of the military demographic (Pless Kaiser et al., 2016, p. 391). Unfortunately, factors like stigma and skepticism about evidence-based treatments for PTSD deter many patients from talking about their symptoms; this complicates the process of diagnosing and treating the disorder (Hundt et al., 2015, p. 542). Considering the prevalence of PTSD in Vietnam and Korean War veterans and the difficult nature of its diagnosis, improved methods of assessment and identification need to be adopted in the healthcare setting. Recurrent PTSD in aging veterans is a problem that needs to be addressed, not just by healthcare professionals in general, but by nurses in particular. Nurses spend extensive time at the point of care building rapport and trust with patients; thus, nurses are often the best-suited caregivers to catch symptoms of PTSD and should be equipped with the knowledge and training to do so. This study is designed to support this end and to add to the limited body of research addressing the nursing care of patients with PTSD. The aim of this study is to

explore the lived experience of chronic PTSD in aging veterans for the purpose of providing nursing-focused recommendations for establishing rapport, assessing symptoms and coping skills, and providing trauma-aware care for aging Vietnam and Korean War veterans struggling with combat-related PTSD.

Chapter I

Background

No matter what the title – posttraumatic stress, combat stress reaction, battle fatigue, soldier’s heart, or shell shock – the effects of experiencing trauma in combat are powerful and lasting. These effects predate modern war tactics, technology, and medicine. Eighteenth century Austrian physician Josef Auenbrugger wrote about his military patients who often became, “sad, taciturn, listless, solitary, musing, full of sighs and moans . . . [their] disease is called nostalgia” (Anders, 2012). Lady Percy in William Shakespeare’s *Henry V* implored her war-fatigued partner to take heart, saying, “tell me, sweet lord, what is’t that takes from thee / thy stomach, pleasure, and thy golden sleep? / why dost thou . . . start so often when thou sit’st alone?” (Anders, 2012). Young Nez Perce warriors reminisced on their elders’ warnings about the consequences of seeing battle, saying, “they said I would be changed in my body . . . I would react to sounds, movement and touch in a crazy way, as though I was back in the war . . . I would forget how to trust and would think that others were trying to harm me . . . my dreams and visions would be dark and frightening . . . I would be unable to find the connections between myself and the rest of creation. I would look forward to an early death. And I would need healing in all these things” (Karlin, 2013, p. 150). Combat and trauma-related stress have been unseemly realities for centuries or longer, but they haven’t always been validated or given the care they warrant. It was not until 1980 – five years following the end of the particularly stressful and traumatic Vietnam War – that symptoms like those identified by Dr. Auenbrugger, Lady Percy and the Nez Perce elders were labeled and confirmed as a valid, treatable, researchable condition called PTSD (Spector, 2016;

Friedman, 2016). Due to the multi-faceted and still largely unknown nature of the disorder, further research is needed to guide the care of those who have seen combat and who carry the wounds of war.

Introduction

Even now, over 42 years post-Vietnam War, PTSD is a relevant issue for a great deal of Vietnam-era veterans (Dohrenwend et al., 2006). This is a highly treatable issue: clinical practices and guidelines have drastically improved since most Vietnam veterans with PTSD experienced the initial trauma that triggered and continues to trigger their stress-related symptoms. In order to provide a background for addressing this issue and rationale for its importance, this chapter will explain what PTSD is, who is at risk, and why nurses are the perfect candidates for assessing and identifying symptoms of PTSD.

Description of PTSD

PTSD is a trauma-related condition that has both a psychological and a biological component (Post Traumatic Stress Disorder, 2007). It is defined in the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V) by the following diagnostic parameters: exposure to trauma, intrusive symptoms, avoidance of trauma-related stimuli, negative changes in mood or cognition, and hyperarousal. The following conceptual definitions clarify these terms: the term “trauma exposure” implies that the traumatic event happened directly to the patient or a close relative or friend, that the patient directly witnessed the trauma happening to another person, or that the patient had repeated exposure to evidence of death or trauma. “Avoidance of stimuli” is a term that means the patient actively steers clear of memories or reminders of the trauma. “Negative changes in mood/cognition” are present when the patient experiences dissociative or amnesia-like symptoms regarding the event; displays ongoing negative beliefs about self; has a general mistrust for others; has an unmovable, distorted understanding of the causes of the traumatic event; is stuck in a persistently negative emotional state; is unable to feel

positive emotions; or shows decreased interest in formerly enjoyable activities. When a patient is in a state of “hyperarousal,” he or she either has unpredictable, angry outbursts often; is reckless or destructive; shows an exaggerated startle response; cannot concentrate; is hypervigilant; or has consistent difficulty sleeping (DSM-V, 2013, pp. 271-272). Symptoms must persist for longer than one month and must impair the patient’s social or occupational functioning in order for them to warrant a full diagnosis of PTSD. Before assigning a diagnosis, the health professional must rule out substance abuse and other psychological conditions that could be responsible for symptoms (DSM-V, 2013, p. 272). Presence of some of these criteria does not necessarily mean that the individual will develop PTSD (Post Traumatic Stress Disorder, 2007). In other words, some patients experience acute stress and may exhibit some of these symptoms, but many have the resilience to recover from the stress without developing PTSD.

Etiology and Risk Factors

The primary etiological factor linked to the development of PTSD as it pertains to veterans is extensive combat exposure. Among the veterans involved in the Congressionally-mandated National Vietnam Veterans Readjustment Study (NVVRS) in 1988, 35.8% of males and 17.5% of females with “high levels of war-zone exposure,” suffered from chronic PTSD symptoms 13 years after the war’s end (Price, 2016). These rates are jarringly high when compared to the 15.2% and 8.5% of all other male and female Veterans, respectively, who participated in the NVVRS who met full criteria for PTSD at that time (Price, 2016). Male veterans as a unit have markedly higher levels of exposure to war-zone trauma than female veterans (King et al., 1995, p. 193).

In addition to veterans with extensive combat-related trauma exposure, all persons who have experienced or witnessed past life threatening, prewar or childhood trauma are at a heightened risk for developing PTSD (Xue et al., 2015, p.1; Management of PTSD Working Group, 2010, p. 17). This is likely due to the negative effects early trauma can have on resilience. The forms of prewar trauma with the highest correlation to PTSD development for women are family instability and trauma during early childhood. For men, the most impactful forms of prewar trauma are family instability, antisocial behavior during childhood and history of trauma early in life (Price, 2016). Females, Hispanic male Veterans and those who hold an ethnic minority status also represent people at risk (Price, 2016; Xue et al., 2015, p. 1).

Other risk factors for developing combat-related PTSD include inadequate social support and young age during and after deployment; combat-related injury; and concurrent psychological disorders, especially depression (Steenkamp et al., 2015, p. 490; Price, 2016). One meta-analysis of 32 clinical trials investigating risk factors for PTSD in Veterans confirmed these predisposing factors and included additional significant predictors of PTSD. They include: combat specialization; army service; non-officer rank; higher number and longer cumulative length of deployments; witnessing someone being wounded or killed; and discharging a weapon. Finally, inadequate social support during the post-deployment, post-trauma period has negative effects on resilience and is recognized as one of the major risk factors contributing to PTSD (Xue et al., 2015, p.1; Management of PTSD Working Group, 2010, p. 17). Lack of social support is especially important to consider for Vietnam veterans in light of the overall poor civilian appraisal of the war.

Inversely, the effects of combat and trauma exposure may be mitigated by military preparedness and unit cohesion (Goldmann et al., 2012). To the best of the principal investigator's knowledge, these are the only protective factors identified for combat-related PTSD.

Clinical Importance Specific to the Nursing Profession

Adequate psychosocial care – particularly as it relates to PTSD – for Vietnam and Korean War veterans is a problem that becomes increasingly important for healthcare providers to address as these patients, the “baby boomers,” age and more frequently encounter the healthcare system seeking care for chronic and acute health conditions. Unfortunately, increased contact with healthcare systems does not necessarily mean more accurate identification of chronic PTSD. The VA system recommends but does not require regular screening for PTSD in patients who are as far removed from active duty as Vietnam veterans. VA care providers are encouraged to screen all new patients for PTSD during their first visit and then annually after that, along with all patients who exhibit signs of trauma-related stress. Screening tools are also supplied to primary care providers because this is a setting in which symptoms of PTSD are often identified (Management of PTSD Working Group, 2010). There is no evidence of standardization of these screening practices for aging patients, however. Though some civilian hospitals are changing their policies, many veteran patients at these hospitals receive care without ever being asked about their military service.

The physiological and emotional aspects of PTSD are clinically relevant because they put profound strain on the patient and the patient's support system. The disorder negatively affects occupational and interpersonal functioning (DSM-V, 2013, p. 272).

Many individuals with decreased functioning secondary to PTSD also suffer from at least one comorbid psychiatric disorder. The most common of these correlated disorders are depression, anxiety and substance misuse or abuse (Brady et al., n.d.; Steenkamp et al., 2015, p. 490). Repercussions of these comorbid disorders may include, but are not limited to: suicidal ideation, self-harm, overdose, impaired relationships, loss of interest in pleasurable activities, avoidant behaviors, hopelessness, uncontrollable worry, fatigue, irritability, appetite and weight changes, and sleep disorders (Venes, 2016).

Understanding the possible impacts of these and other chronic effects of PTSD becomes more important as patients age and become increasingly vulnerable, both physically and mentally. Because nurses spend so much time interacting with patients in primary and acute settings at the point of care, they are the perfect spokespeople for these patients. They have the power to identify warning signs and to advocate for the patient by transmitting these to the physician. Nurses also have the knowledge and training to assess coping skills and to educate patients about further coping strategies in order to enhance resilience and quality of life.

Recurrent, chronic PTSD in aging Vietnam veterans is a problem that needs to be addressed not just by healthcare professionals in general, but by nurses in particular, for various reasons: first, because nurses spend so much time interacting and building rapport with patients; second, because most practitioners do not routinely screen for the disorder; third, because as veterans with PTSD age they become increasingly vulnerable and may lose the ability to practice lifelong coping strategies; fourth, because PTSD and correlated disorders are isolating in an already isolating time of life marked by decreased independence; and finally, because PTSD is a disorder that still affects the lives of an

estimated 9.1% of Vietnam veterans (Dohrenwend et al., 2006). Nurses have the power to identify PTSD symptoms in undiagnosed patients and to help aging patients find creative coping strategies in order to make peace with the past and live a meaningful, satisfying, healthy life.

Purpose Statement

The aim of this phenomenological study is to explore the lived experience of chronic PTSD in aging veterans for the purpose of providing nursing-focused recommendations for establishing rapport, assessing symptoms and coping skills, and providing trauma-aware care for aging Vietnam and Korean War veterans struggling with combat-related PTSD.

Chapter II

Review of Literature

Current literature supports the fact that PTSD is a chronic, fluctuating condition that has detrimental effects on the physical and mental health functioning in members of the veteran population (Chopra et al., 2014, p. 94; Goldberg et al., 2013, p. 1589). Ample research about the nature of PTSD supports these findings and addresses the issue as it pertains to veterans. However, very little literature specifically relates these concerns to nursing practice. Further research is needed to explain the nurse's role in providing much-needed, treatment-enhancing support for veterans suffering from PTSD. The following review of literature examines twenty-three recent, well-designed clinical studies and three articles from nursing journals that add to the body of knowledge about PTSD in veterans; these findings can be applied to nursing practice in order to guide care and future research.

Impact of PTSD

Physical effects. PTSD is a debilitating disorder, negatively affecting physical quality of life in veterans (Goldberg et al., 2013, p. 1589). One well-designed, well-distributed, controlled cross-sectional study involving 5,574 Vietnam veterans with a mean age of 61 found evidence to support the idea that veterans with a diagnosis of PTSD consistently scored in the top (worst) decile for disability and had diminished physical functioning according to the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 (Goldberg et al., 2013, p. 1587-89). Pagotto et al. (2015) also supported the notion that PTSD impairs concentration, vitality, and physical functioning and correlates with physical pain proportionally to the severity of the stress symptoms

(Pagotto et al., 2015). Veterans with PTSD weigh more on average and have a greater burden of chronic illness than veterans without PTSD (Goldberg et al., 2013, p. 1585).

One nursing-focused article by Conard et al. (2013) explains these physical consequences and their pathophysiology. The pathological process of PTSD begins with an event or events – the initial trauma exposure – that can start the chemically adaptive process of sympathetic nervous system (SNS) overinvolvement. This adaptive process is a naturally protective mechanism designed to maintain alertness and energy reserves during periods of extreme stress when survival is imperative. However, when the SNS is activated on a chronic basis, the thyroid gland becomes hyperactive and the digestive system hypoactive; the adrenal glands perpetually release cortisol; endorphin stores are depleted; gluconeogenesis increases, elevating blood sugar and impacting pancreatic enzyme activity; and extra cholesterol is produced and released into the bloodstream. The consequences of these chronic physiological changes can include hyperarousal; insomnia; indigestion, dry mouth and abdominal discomfort; decreased libido; increased heart rate for long periods of time; and plaque formation in the arteries and veins (Conard et al., 2013, p. 112). Often, these physical symptoms – for good reason – become the primary focus of medical care in the hospital. However, this can complicate and delay the identification of psychological symptoms.

Mental, emotional and social effects. Intrusive psychosocial symptoms of PTSD such as flashbacks, nightmares, invasive memories, blame, fear, guilt, shame, alienation, inability to feel positive emotions, uncontrollable anger, and self-destructive behavior can impair mental, emotional, and social functioning (Pagotto et al., 2015; Post Traumatic Stress Disorder, 2007). These symptoms often lead to social withdrawal, anger and

aggression (Xue et al., 2015, p.2). In fact, of all the domains impacted by PTSD, social functioning is the most severely affected (Pagotto et al., 2015; Xue et al., 2015, p. 1). This relationship is directly proportional; across ages and socioeconomic statuses, evidence of social defeat decreases and increases as PTSD symptoms decrease or increase, respectively (Troop, 2013, p. 365). As a result, veterans with PTSD are more likely to be divorced, unmarried, and unemployed and are more likely to have co-occurring psychiatric disorders than veterans without PTSD (Goldberg et al., 2013, p. 1585). Goldberg et al. (2013, p. 1579) used the Veterans RAND 36-Item Health Survey and a Mental Composite Summary to quantify mental health-related data and found that those with PTSD had overall decreased mental health functioning compared to veterans without PTSD.

The implications of the physical and psychosocial consequences of PTSD as presented by Goldberg et al. (2013) are not only credible but also highly relevant to the nursing practice. Nurses will often encounter Vietnam veterans with PTSD who experience decreased physical and mental health quality of life and increased physical and/or mental medical needs. In order to anticipate these needs, nurses working with Veterans should integrate rigorous, thoughtful psychosocial assessment into all routine physical assessments. Specifically, based on the above evidence concerning struggles of Veterans with PTSD, nurses should integrate questions about symptoms of stress, quality of sleep, adequacy of financial resources and employment, and satisfaction with social support and relationships.

Community effects. PTSD does not affect the individual exclusively; it also creates concerns and challenges from a public health standpoint (Stenkamp et. al., 2015,

p. 490). Close loved ones and family members of patients with PTSD suffer from the effects of the disorder. As one participant involved in this study put it, “the whole family gets PTSD” (Interview with DT, 2017). Indeed, these effects can be devastating for families and support systems since PTSD cannot be isolated to impact only one sector of life. Veterans with PTSD are more likely to be divorced and unemployed than Veterans without the disorder (Goldberg et al., 2014, p. 1585). PTSD influences veteran employees’ ability to function and to be productive in the workplace (Yehuda et al., 2014, p. 1) and veterans with PTSD are more likely to have a lower annual income than those without PTSD (Goldberg et al., 2014, p. 1585). These interpersonal and economic effects of PTSD ripple from the individual to the support system to the community, and have the potential to create significant interpersonal and economic strain.

Vulnerable Populations

Aging Veterans are prone to re-experiencing PTSD symptoms. PTSD does not discriminate; it makes people with diverse backgrounds and temperaments vulnerable. However, evidence supports that there is at least one group of people who are particularly susceptible to the effects of chronic stress: aging veterans. One well-controlled longitudinal study conducted by Mota et al. (2016, p. 348) found that of 1,441 veterans over the age of 55 who had a past diagnosis of PTSD, 9.9% also had subsequent clinically significant exacerbations of the disorder. The average length of time that elapsed between the initial worst trauma and an acute exacerbation of PTSD was three decades (Mota et al., 2016, p. 348). Mota et al. (2016, p. 351) identified that several cognitive factors, including impaired cognition, concentration, problem solving, and reasoning correlated with subsequent PTSD diagnosis in an aging veteran population.

Mota et al. (2016, p. 352) recognized that these age-related cognitive declines – along with the decreased modulation of hypervigilance and startle response that comes with age – contributed to the noteworthy rates of PTSD exacerbation in aging veterans.

Because of the large sample size and the minimum age of veterans included, findings from Mota et al. (2016) can be applied and generalized to the population of Vietnam veterans. Probability-based sampling techniques used in the study contributed to a participant distribution that was representative of the general population of veterans, further increasing the study's applicability (Mota et al., 2016, p. 349). Rigorous assessment and validation of PTSD diagnoses enhanced the study's reliability: DSM-IV criteria were used to standardize the assessment of lifetime PTSD symptoms during wave one and DSM-V criteria were used to re-assess all participants for acute PTSD symptoms during wave two, ten years later (Mota et al., 2016, p. 350).

Nurses caring for aging veterans can benefit from the results of this well-designed, age-specific study of PTSD. Based on study findings, roughly one in ten aging veterans with a diagnosis of PTSD in remission will suffer from an exacerbation at some point in their lives (Mota et al., 2016, p. 348). Because nurses spend a great deal of time interacting with patients at the point of care, they are in the perfect position to anticipate and identify these exacerbations. In order to advocate for patients by recognizing stress symptoms, nurses should adopt ongoing psychosocial assessment habits. In addition, as champions of patient-centered care, nurses ought to promote the standardization of assessment for age-related exacerbations of traumatic stress by mental health professionals. Fortunately, it is possible to manage symptoms if exacerbations are appropriately assessed, correctly identified, and quickly treated.

Symptom Characteristics

PTSD symptoms are chronic and fluctuating. In their randomized, controlled, longitudinal clinical trial, Chopra et al. (2014, p. 86) collected evidence supporting the claim that the above quality of life and functioning deficits affect veterans with PTSD on a chronic, fluctuating basis. This study, which involved 1,185 participants with a mean age of 73.5, selected participants from seven primary care centers across the country and looked at PTSD symptom trajectories over a six-month period. Full initial and follow-up PTSD symptom assessments were given at the baseline, three-month, and six-month post-randomization marks using DSM-IV criteria (Chopra et al., 2014, p. 88). After the initial assessment, participants were divided into four groups: no trauma, trauma only, partial PTSD and full PTSD. After examining the changes in these four groups over time, investigators found that 30% of patients initially diagnosed with PTSD exhibited full symptoms over a six month time period; the remaining 70% of patients initially diagnosed with PTSD either transitioned to experiencing partial PTSD symptoms or they experienced phases of full remission (Chopra et al., 2014, p. 94). When investigators compared these numbers with established mental health data for participants, they found that those initially diagnosed with PTSD had the highest incidence of comorbid depressive and anxiety disorders, as well as lower overall social support and lower Mental Health Quality of Life (MHQoL) scores (Chopra et al., 2014, p. 89). These comorbid disorders did not fluctuate over time the same way PTSD symptoms did (Chopra et al., 2014, p. 93). Though PTSD is experienced on a chronic basis and is correlated with comorbid mental health disorders in many veterans, the majority of

veterans with PTSD experience full or partial remission at some point in the disease process.

The large sample size, geographic heterogeneity of participants, and randomized nature of this clinical trial contribute to its rigor. However, in order to make full conclusions about the long-term trajectory of PTSD, longer-term longitudinal research is needed to support these findings. As a pilot study, this trial provides reasonable evidence that PTSD is not static in nature but that it fluctuates independently of other comorbid mental disorders (Chopra et al., 2014, p. 95).

An understanding of the dynamic nature of PTSD can enhance nursing practice. Health professionals must anticipate the changing process of the disorder by assessing stress symptoms and social support needs over time. Nurses should ask patients with current or past PTSD specific questions about how their current stress level compares to their normal stress level, what sorts of coping mechanisms are most helpful when they experience stress, and whether they feel their social support is adequate. This last question is especially important because, as the following study explains, significant stressors can trigger recurrent symptoms of trauma-related PTSD at any point in time after exposure to the initial trauma.

Life stressors reactivate symptoms of PTSD. Data presented by Sachs-Ericsson et al. (2016, p. 84) gives a longitudinal picture of PTSD over a ten-year period of time. This study involved 727 veteran participants over the age of 50, making findings generalizable to the population of Vietnam and Korean War veterans (Sachs-Ericsson, 2016, p. 85). According to Sachs-Ericsson et al. (2016, p. 82), after PTSD symptoms subside, they can recur at any point in time, especially if the patient in question has been

exposed to traumatic experiences in combat in the past. This is likely because combat exposure “sensitizes” veterans to stressors. Combat-related trauma is especially predictive of PTSD exacerbation when multiple significant stressors are introduced into the patient’s life after the initial trauma; these life stressors trigger recurrent symptoms of PTSD. This has significant implications for the aging population of veterans because of the unique stressors that come with the aging process and because of age-related neurodegeneration that can reduce resilience (Sachs-Ericsson et al., 2016, p. 87). Consistent with the findings of the previous study by Chopra et al., this study found that PTSD symptoms may subside or stay dormant until the patient experiences a significant new stressor, such as a hospitalization or the death of a loved one, which decreases the patient’s coping capabilities (Sachs-Ericsson et al., 2016, p. 87).

Significant stressors are implicit in the hospitalization experience. In light of this, nurses who work in the hospital setting need to look for subtle signs of stress and hypervigilance in veterans with a current or past diagnosis of PTSD. Whether these veterans actively complain of symptoms or not, the nurse should, “integrate . . . assessment of trauma and PTSD . . . into the routine examinations of aging combat veterans,” and proactively advocate for the patient by spending time at the bedside first establishing rapport and then assessing levels of stress and anxiety (Sachs-Ericsson et al., 2016, p. 88).

Evidence-Based Treatments for PTSD

Trauma-focused psychotherapy. Trauma-focused psychotherapies – specifically Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PET), and Eye Movement Desensitization and Reprocessing (EMDR) Therapy – are the most

extensively researched forms of treatment for PTSD and are more likely than pharmacotherapy to be prescribed as first-line treatment for the disorder (Steenkamp et al., 2015, p. 489-490). One meta-analysis of 36 randomized controlled trials found that – although pharmaceutical and psychotherapies are effective – trauma-focused therapies are more effective in treating symptoms than pharmacotherapy alone (Haller et al., 2016, 342). CBT typically takes place over 10-12 visits and focuses on restructuring the client's maladaptive thoughts and beliefs about the initial trauma (Steenkamp et al., 2015, p. 490). This type of treatment requires significant dedication and willingness to change. PET involves four stages or components: psychoeducation, in vivo exposure, imaginal exposure and emotional processing (Rauch, 2012, p. 680). Each of these components requires the patient to repeatedly recount traumatic memories in a supportive setting for the purpose of reducing the patient's emotional response to the trauma. The four phases each take place over the span of several appointments, which can create significant emotional and financial burden. EMDR borrows elements from the previous two types of psychotherapies: clients are challenged to restructure beliefs and recount trauma in a safe environment; the difference is that these two components take place while the client is asked to also focus on an external stimulus (Steenkamp et al., 2015, p. 490).

One systematic meta-analytical review conducted by Cusack et al. (2015, p. 128) supported the use of these three types of trauma-focused psychotherapies by comparing the efficacy of eight other psychotherapies with trauma-focused PET, CPT and EMDR. This study included data from 64 clinical trials. Large effect sizes supported the efficacy of PET, CBT, CPT and EMDR in reducing symptoms of PTSD (Cusack et al., 2015, p. 139). Nurses can increase enrollment in evidence-based psychotherapies by educating

patients about these treatment options, their efficacy, and the varying levels of commitment involved.

Complementary therapies. Though trauma-focused psychotherapies are evidence-based and proven effective, they require dedication. The act of recounting trauma and confronting triggers is a significant deterrent, making these kinds of treatment undesirable to some patients. In these instances, some alternative therapies exist. Most alternative therapies focus on supporting patients' coping skills rather than facing trauma head-on. Alternative therapies complement evidence-based therapies well but are not recommended as primary treatments for PTSD. For the purposes of examining a wide array of treatments available for PTSD, thirteen alternative therapies will be briefly discussed.

The clinical trial conducted by Steenkamp et al. (2015, p. 490) found evidence to support Stress Inoculation Training (SIT) as a non-trauma focused alternative therapy. This type of therapy, instead of focusing on past trauma, deals with the effects of the trauma and teaches the client to manage the stress response and adopt positive coping skills. However, investigators reported that results of the use of SIT in the veteran population are infrequently documented and little is known about the success of this type of therapy when it comes to combat-related trauma and stress (Steenkamp et al., 2015, p. 490).

One meta-analysis of 18 randomized controlled trials focusing on psychotherapeutic interventions for PTSD symptoms found that several "nonspecific" psychological interventions, though not as effective as evidence-based trauma-focused psychotherapy, proved beneficial. Nonspecific interventions (i.e. those focused on

fostering “hope for the future” or other subjective goals as opposed to trauma-specific goals such as normalizing exposure to triggers) do not focus on the trauma itself, but on the resilience of the client (Gerger et al., 2013, p. 601). Present centered therapy, forgiveness therapy, applied muscle relaxation, imagery based relaxation and supportive counseling were among the nonspecific interventions studied (Gerger et al., 2013, p. 605-606). Results of this study showed a smaller relative superior effectiveness of trauma-focused over nonspecific therapies for clients with “complex” trauma such as veterans with combat exposure (Gerger et al., 2013, p. 610). This indicates that nonspecific interventions may be a safe and effective way of providing relief for veterans who prefer interventions that do not focus directly on the trauma.

An article by Bowsfield & Samra (2015, p. 26) explains additional best practices for alternative therapies in a nursing context. These best practice guidelines are laid out by the International Society for Traumatic Stress Studies (ISTSS) in their 2005 Treatment Guidelines, the most recent version of the guidelines at that point in time (Bowsfield & Samra, 2015, p. 27). The ISTSS support trauma-focused psychotherapies such as CPT, PET and EMDR along with pharmacotherapy for the treatment of PTSD; in addition, the ISTSS suggests that several supportive therapies may provide additional benefits. The guidelines support a single-session psychological debriefing shortly after the traumatic event; group therapy; psychodynamic treatment; psychosocial rehabilitation; hypnosis; couple and family therapy; and creative therapies (Gerger et al., 2015, p. 27-30).

Psychological debriefing encourages the expression of feelings after the traumatic event (Gerger et al., 2015, p. 27). Group therapy focuses on group processing and expression of feelings about a shared event or condition; one strength of this approach is its implicit

inclusion of social support as part of the treatment. Psychodynamic treatment focuses on bringing unconscious thoughts and feelings about an event or a trigger into conscious reality. Psychosocial rehabilitation focuses on improving the interpersonal functioning and life skills of the patient (Gerger et al., 2015, p. 29). Hypnosis is not often used on its own but is integrated with other treatments (Cusack et al., 2015, p. 132). Couple and family therapy directly addresses how the family or supportive unit is affected by the disorder. Finally, creative therapies focus on representing the trauma and related feelings through a creative art medium of choice (Gerger et al., 2015, p. 30). As of February 2017, the ISTSS still included all these supportive therapies in their guidelines for PTSD treatment.

From a nursing perspective, these alternative therapies provide an important holistic component to the treatment of PTSD. These treatments have important psychosocial focuses such as family functioning and social support. As identified by the ISTSS (2015, p. 30), further research would be helpful in confirming or denying the relative effectiveness of these treatments, but their diversity allows the PTSD and its effects to be addressed from multiple angles.

Pharmacotherapy. No one drug is able to treat the vast array of PTSD symptoms. Individual medications must be used to treat individual symptoms and because of this, medication regimens can become complex and hard to follow and the additive costs of medications can be overwhelming. The most common and effective medications used to treat symptoms include Selective Serotonin Reuptake Inhibitors (SSRIs) and Prazosin (Haller et al., 2016, p. 342). Other medications that are also

sometimes used include other antidepressants like tricyclic antidepressants and MAOI inhibitors, along with mood stabilizers and atypical antipsychotics (Jeffreys, 2016).

The aforementioned trauma-focused psychotherapy, alternative therapy and pharmacotherapy options available for patients with PTSD are important for nurses to understand in depth. As patient educators, nurses play a central role in informing patients with PTSD about treatment options and effectiveness. Nurses should present all three forms of therapy in an objective, informed, nonbiased manner that empowers patients to make their own informed decisions about care.

Deterrents to Treatment Seeking Behaviors

Clinician documentation of barriers. Though trauma-focused psychotherapies for PTSD are evidence-based and clinically effective first-line treatments for PTSD, they are often not utilized (Lu et al., 2013, p. 71). Veterans' reservations about initiating treatment are difficult to quantify; however, one qualitative study conducted by Lu et al. (2013, p. 72) provided tangible evidence of treatment-related barriers. Investigators performed qualitative content analysis on clinician documentation in the medical records of 63 veterans who had been diagnosed with PTSD and who were given the option of receiving Trauma-Focused Evidence-Based Psychotherapies (TF-EBPs) like PET and CPT. Two to three years' worth of chart data were analyzed for each patient. This data revealed that 87% (n = 55) opted not to receive TF-EBP treatment (Lu et al., 2013, p. 74). However, Vietnam-era veterans had a higher rate of TF-EBP initiation than younger veterans involved in the study (Lu et al., 2013, p. 84-85). Researchers investigated the reason for this low rate of TF-EBP use and identified eight major barriers to care. These included: referral to other nontrauma-focused PTSD treatments like symptom

management skills or acceptance and commitment therapy; more urgent clinical priorities or other psychiatric-related crises; logistical barriers like conflicting obligations, geographic distance, competing personal commitments, or legal issues; difficulty establishing trust with the clinician; receipt of care in other settings; intense anxiety and discomfort related to being in the VA setting and risking exposure to combat-related triggers; fear of disclosing classified information related to trauma; and stigma, negative self-judgment, or negative judgments from others (Lu et al., 2013, p. 72). For most of these patients, more than one of these barriers to care applied (Lu et al., 2013, p. 76). Another study by Hundt et al. (2015, p. 541) found that veterans additionally faced barriers such as anxiety, avoidance, skepticism about the effectiveness of TF-EBPs, and lack of knowledge about available treatments.

Strengths of the study by Lu et al. include large sample size and constant peer debriefing throughout the coding and data analysis process. Data saturation was reached after 30 charts were coded, but investigators continued gathering data to enhance the rigor and dependability of findings (Lu et al., 2013, p. 74). However, transferability of the study data to veterans seeking care in civilian hospitals was limited because the study only included veterans seeking care at one VA hospital in Portland (Lu et al., 2013, p. 84). Further research is needed to examine barriers to PTSD treatment for veterans who seek care at civilian hospitals.

Stigma. As the previous study briefly mentioned, mental health-related stigma carries profound psychosocial impact in the military sphere, especially as it relates to treatment-seeking behaviors. The same drive for independence and strength that keeps soldiers alive on the battlefield often deters them from seeking help for mental illness.

Stigma and mental barriers against seeking healthcare are multi-faceted: one Military Times article explained that many veterans, “don’t want to be seen as the weak link”; they are worried a diagnosis will keep them from being deployed or receiving a promotion; or they are deterred by the side effects of medicating the disorder (Kime, 2015). Psychosocial impacts of seeking help and receiving care for PTSD are often the reason veterans’ symptoms go untreated.

In one grounded theory qualitative study conducted by Mittal et al. (2013, p. 87), 16 veterans with combat-related PTSD discussed open-ended questions about stigma in small focus group settings. Veterans reported that the strongest sources of perceived stigma were the public, families, and other veterans. Stigma caused many veterans to initially avoid treatment for PTSD and instead rely on their own resilience or on substance use to cope (Mittal et al., 2013, p. 90). In addition to deterring veterans from seeking treatment, stigma made veterans feel “dangerous/violent,” “crazy,” “weird,” “unreliable,” “cold hearted,” or “weak.” Stigma-related guilt made many veterans feel “blamed” by society for “getting” PTSD (Mittal et al., 2013, p. 88).

Results of the above study represent the specific opinions of OEF/OIF veterans; however, results can be applied to the population of Vietnam and Korean War veterans because they address current perceived societal views of veterans with combat-related PTSD. The rigor of the study was demonstrated by data saturation, meticulous manuscript coding and several rounds of peer debriefing which were used to promote consistency in data interpretation (Mittal et al., 2013, p. 87-88).

Another study conducted by Quartana et al. (2014, p. 1671) adds to the evidence supported by Lu et al. (2013) and Mittal et al. (2013) because it specifically explains

stigma's effects on mental healthcare utilization trends in the military population. This study used a multi-sample approach to compile data from two independent data sources focusing on mental healthcare utilization and stigma. The population size for this study totaled 12,853 veterans. Investigators enhanced study credibility and rigor by adjusting for non-response bias effects and selecting a sample that was demographically representative of the Army population as a whole (Quartana et al., 2014, p. 1671). A validated 17-Item PTSD Checklist was used to confirm participant diagnoses; a Likert-scale survey was used to assess veterans' perceptions of stigma; and the same criteria for quantifying healthcare utilization was used across the two sample sets (Quartana et al., 2014, p. 1672-73).

Longitudinal findings from data collection between 2003 and 2011 showed a 94% increase in mental health services utilization over this eight-year span (7.6% utilization in 2003 vs. 14.8% utilization in 2011). In contrast, perceived stigma reported by study participants decreased across the same time span: 51.1% of veterans reported a perception of stigma that would affect their readiness to seek mental health care in 2003, while 43.6% reported the same type of perception in 2011 (Quartana et al., 2014, p. 1675). These findings suggest encouraging trends in the sphere of mental healthcare for the military population: as time goes by, perceived stigma decreases while veterans' mental healthcare utilization increases. Still, even after accounting for positive changes in utilization of mental healthcare rates, investigators found that at the end of the study, almost 60% of veterans with a diagnosis of PTSD or Major Depressive Disorder (MDD) or both still did not utilize resources for mental healthcare (Quartana et al., 2014, p. 1678).

Study investigators increased credibility by recruiting an expansive pool of participants and by giving a thorough, transparent account of limitations (Quartana et al., 2014, 1677-78). Quartana et al. (2014, p. 1677) posited that the increasing numbers of mental healthcare utilization by veterans may be attributed to an increase in the numbers of veterans with mental health problems during this time period; however, this threat to validity is unlikely because utilization increased similarly in subgroups of participants who had debilitating psychiatric diagnoses like PTSD or MDD as well as those who had no psychiatric diagnoses.

Data from the above three studies about stigma and barriers to treatment utilization hold powerful implications for nursing practice and explain the intricacies and difficulties of treatment initiation. Participants' reasons for declining treatment can help to guide nursing assessment for patients who are seeking relief from symptoms. Helpful nursing assessment topics include: perception of stigma, comfort level in the healthcare setting, and comfort level with the healthcare provider. By empowering patients to express their feelings and concerns about treatment and by using motivational interviewing to address ambivalence, nurses can help patients overcome their reservations about receiving treatment.

Methods for Promoting Engagement in Evidence-Based Psychotherapy

Though helping patients overcome their doubts about receiving care for PTSD is a difficult task, there are several effective methods for doing so. Evidence supporting these methods is detailed below.

Motivational interventions. When it comes to encouraging patients to consider psychotherapy or other treatment methods for PTSD, Lu et al. (2013, p. 83) postulate

that, in light of the barriers to care identified in their study, motivational interviewing and shared decision-making will increase utilization of TF-EBPs. An initial assessment of readiness for receiving treatment should be conducted; after this assessment, healthcare providers should use motivational interviewing to address ambivalence related to psychotherapy. Giving patients several choices of evidence-based psychotherapies may enhance feelings of autonomy and increase adherence to care plans. Lu et al. (2013, p. 83) are transparent about the fact that these are informed hypotheses, not researched recommendations. Further research must be conducted to confirm their effectiveness.

Peer support helps veterans cope with stigma. Participants in the study by Mittal et al. (2013, p. 89) reported that a sense of camaraderie and social support from fellow veterans made them feel understood in the face of debilitating stigma. In addition to peer support from other veterans, military members involved in a grounded theory study by Hundt et al. (2015, p. 539) reported that the following factors were most helpful in helping them overcome barriers to receiving PTSD treatment: feeling a need to talk about the trauma, feeling prepared to deal with the rigors of evidence based psychotherapy (EBP), prior knowledge of the therapist, encouragement from providers, and desperation for relief from symptoms.

Stratified, purposive sampling techniques contributed to the heterogeneity of the 23-member pool of participants in this qualitative study. Investigators protected data authenticity by audio-recording all interviews, transcribing them verbatim, and saving them on a HIPAA-compliant, password-protected server (Hundt et al., 2015, p. 540). Two coders interpreted each transcript using grounded theory analysis techniques. Coding discrepancies were resolved through peer debriefing sessions and final coded

categories provided a comprehensive, meaningful representation of findings (Hundt et al., 2015, p. 541).

The above information provided by Mittal et al. and Hundt et al. is relevant to the nursing profession in particular because it clues nurses in on effective strategies for promoting evidence-based therapy initiation in veterans. Two particularly powerful tools for helping veterans overcome treatment-seeking barriers include peer support and encouragement from trusted healthcare providers. Though the first tool is outside the sphere of control for nurses, the second tool is a powerful asset to nursing practice. The power and importance of taking time to establish trust and rapport with patients cannot be overemphasized. Once nurses establish a working relationship with the patient, group therapy should be presented to veterans as a helpful avenue for sharing war-related stories and receiving support from peers.

Relief and Remission

Though exacerbations are common and the barriers to receiving treatment are extensive, many PTSD patients have had significant relief from symptoms. One qualitative study conducted by Adjukovic et al. (2013, p. 1-2) examined self-identified protective factors for PTSD management from 43 patients who were directly involved in the recent war in Yugoslavia. Participants with a diagnosis of PTSD who were experiencing remission attributed eight factors to their recovery: social attachment and support, coping strategies, personality hardiness, mental health treatment, material support, normalization of everyday life, psychological safety, and community involvement (Ajdukovic et al., 2013, p. 3). Of these, the most frequently mentioned protective factor was social support (Ajdukovic et al., 2013, p. 4). Participants who had

recovered from PTSD reported that the support and attachment in their close relationships was reciprocal (Ajdukovic et al., 2013, p. 11); participants who were still suffering from PTSD showed common themes of feeling dependent on family members, feeling worthless, and feeling passive in their role as part of a family (Ajdukovic et al., 2013, p. 4). Recovered patients expected their supportive relationships to continue in the future; unrecovered patients were worried about being burdensome to their supporters and driving close friends away (Ajdukovic et al., 2013, p. 7). Personality hardiness, another protective factor frequently mentioned by recovered participants, included a propensity for hope and optimism, a self-efficacious attitude, and a future-oriented outlook. Conversely, unrecovered patients reported having low expectations for mental health improvements. Unrecovered patients also tended to accept their condition as it was (Ajdukovic et al. 2013, p. 9). Recovered and unrecovered participants both reported that they found therapy and psychoeducation helpful for symptom management (Ajdukovic et al., 2013, p. 9).

The above study compared qualitative interview responses from one group of participants who previously had suffered from PTSD and were experiencing remission, and a second group who still suffered from symptoms of PTSD (Ajdukovic et al., 2013, p. 2). Methodological strengths of this study included: large sample size; use of in-depth, face-to-face interviews; re-assessment of participants one and two years after the initial interview; a set group of investigators conducting interviews throughout the entire study; open-ended interview questions designed to assess personal experiences; a heterogeneous sample of participants from six countries with shared experiences of trauma from the same war in Yugoslavia; use of the purposeful heterogeneity model for random

participant selection; standardization of trauma and PTSD assessment using the Life Stressor Checklist-Revised and DSM-IV criteria; inter-rater reliability during coding which yielded consistent results; and achievement of data saturation (Ajdukovic et al., 2013, p. 2-3).

This study provides integral insight on patient perspectives that can be applied to nursing practice. Findings emphasize the importance of assessing social support and relationship satisfaction. Results can also guide assessment questions: nurses should ask about feelings of reciprocity in relationships and adequacy of community involvement. This study also demonstrates the importance of assessing the self-concept of the patient. Since key aspects of a healthy self-concept such as hope for the future and belief in one's own abilities were identified as protective factors against PTSD symptoms (Ajdukovic et al., 2013, p. 9), nurses should not overlook this key piece of the psychosocial assessment. Finally, because veterans find psychotherapy helpful for symptom management, nursing practice should support education about evidence-based therapies through referral and open conversation.

Resilience and Posttraumatic Growth

Data about resilience and posttraumatic growth (PTG) compliments data about remission. Angel (2016, p. 57) defines resilience as, "the stable trajectory of healthy functioning across time following a traumatic event." Eighty three percent of patients involved in Angel's study showed an initial period of decline and then some level of resilience following a traumatic event. The study identified several factors that resilient individuals exhibited: these included living by meaningful principles, maintaining an optimistic outlook, developing a network of social support, facing fears, and having

resilient role models (Angel, 2016, p. 58). PTG is a positive change that occurs in about 75% of patients diagnosed with PTSD when they begin to successfully cope, in some capacity, with the trauma that caused the PTSD (Angel, 2016, p. 57). Several factors can be used to quantify PTG: these include increased intimacy in personal relationships; enhanced appreciation for life; and the discovery of new life possibilities and personal strength. Other factors such as spirituality, optimism, and life purpose also correlate with PTG (Angel, 2016, p. 58). Resilience and PTG both require the individual to shift from feeling devastated and controlled by the trauma to choosing to look for opportunity and personal strength.

In order to promote this difficult change in momentum, Angel (2016, p. 58-59) recommends that nurses utilize resources and skills such as the newly developed PTSD Toolkit app and the 10-item Posttraumatic Growth Assessment Short Form, both of which are within the nursing scope of practice to use. For healthcare providers serving veterans in civilian settings, Angel (2016), in solidarity with the Joining Forces Campaign, recommends that nurses ask all patients upon admission if they have ever served in the military. Finally, nurses should use motivational interviewing skills along with questions like, ‘how has being involved in the military added meaning to your life?’ to encourage veterans to explore personal strength and capacity for growth (Angel, 2016, p. 59). Though these insights provided by Angel (2016) are helpful and relevant to the nursing practice, the study is limited by the fact that it does not provide adequate demographic or methodological details to judge the credibility of the sample size or the methods for data analysis. Thus, these findings must be taken as subjective opinions and need to be supported by further research.

Tsai et al. (2015, p. 165) provide much needed evidence that supports Angel's (2016) theories about PTG. Investigators collected data from a nationally representative sample of 3,157 US veterans involved in the National Health and Resilience in Veterans Study (Tsai et al., 2015, p. 165). The study was aimed at examining the prevalence of PTG in veterans, explaining which traumas and psychosocial factors correlate with PTG, and suggesting several supportive nursing interventions that will enhance PTG despite the presence of PTSD (Tsai et al., 2015, p. 166). Tsai et al. (2015, p. 165) used the Posttraumatic Growth Inventory-Short Form recommended by Angel (2016) and found that 72% of veterans who had been diagnosed with PTSD experienced some level of PTG after the most traumatic event in their lives. Factors such as social connectedness, religiosity, optimism, extraversion and life purpose strongly and independently correlated with PTG (Tsai et al., 2015, p. 165-166). On the other hand, depression, social constraint and disruptions in social activities correlated negatively with PTG (Tsai et al., 2015, p. 166). Investigators suggested that nurses do several things to promote PTG: help veterans process the symptoms of PTSD when they re-experience them; support veterans' endeavors to increase social connectedness; and help veterans connect with intrinsic religiosity (Tsai et al., 2015, p. 165).

Strengths of this study included a large, nationally representative sample of veterans; probability-based sampling; weighted post-stratification demographic distributions which enhanced generalizability of findings across gender, race, ethnicity, etc.; and full informed consent and IRB approval (Tsai et al., 2015, p. 166-167). Despite the strong methodological approach, study findings showed small to moderate effect sizes (Tsai et al., 2015, p. 175). Though the sample was nationally representative of veterans,

most participants were Caucasian males; further research is needed to enhance the generalizability of findings to minority populations.

As investigators already identified, findings from this study are highly applicable to the nursing profession. Nurses can capitalize on whatever resilience-building personality traits or coping skills the patient has, such as positivity, spirituality, seeking out support, etc. If the patient is not able to identify positive personality traits or coping skills, the nurse can use motivational interviewing skills to help the patient identify small ways to see the trauma in a different light.

Culturally Competent Nursing Care

Research directly relating cultural competence to nursing care is limited. For the purpose of presenting the most helpful data to date, scholarly articles will be discussed in this section where full clinical studies are inadequate or nonexistent.

Military cultural competence. Westphal and Convoy (2015) provide invaluable insight for nurses seeking to cater to the specific cultural needs of the military population. Their article, published in the *Online Journal of Issues in Nursing*, (2015, p. 10) provides recommendations for giving care to veterans who are suffering from traumatic stress injury. Dealing with trauma tactfully in the context of military culture is an issue of patient-centeredness: when a sensitive topic like trauma and emotional/mental fragility is dealt with in a way that gives voice to the patient's suffering but does not compromise autonomy or dignity, this communicates to the patient that his or her vitality and emotional well-being is the number one focus of care. This consideration is just as important in civilian settings as in military settings, as 59% of veterans who qualify for VA services opt to seek medical care elsewhere (Westphal & Convoy, 2015, p. 10). From

this context, it is clear that nurses in all settings should be equipped with the tools to assess for early signs of psychological trauma injury and to incorporate these into care planning (Westphal & Convoy, 2015, p. 11). Education for recognition of subtle symptoms is especially important, as Westphal & Convoy (2015, p. 11) point out, because of the “military ethos” and the “rhetoric of heroism” which instill selflessness, courage and stoicism as primary values. Nurses ought to be equipped with practical tools for addressing stress injury in matter-of-fact ways that do not compromise these values or jeopardize patient dignity and autonomy.

Conard et al. (2015, p. 111) added to these findings by stressing the fact that nurses need to be informed in three specific areas before caring for members of the military. Specifically, nurses should: understand how to apply broad, open-ended screening questions to identify military members (e.g. “Have you ever served?” is a good starting point); familiarize themselves with the idiosyncrasies of the military culture as a way of establishing rapport; and contribute to the development of inter-professional teams designed to provide holistic care for the physical and psychosocial needs of veterans. As more and more veterans are seeking care in civilian facilities (Conard et al., 2015, p. 111), nurses serving in civilian hospitals should be informed about these three points just as much as VA nurses. These considerations about thorough, insightful assessment and rapport building are imperative for nurses to focus on when dealing with veterans suffering from PTSD, since signs are easy to miss and this specific population of hurting patients can be easily misunderstood.

Conclusion

The studies presented in this review of literature provide a convincing case for the importance of clinical awareness of PTSD in veterans. Though the literature provides several subjective but helpful suggestions for nurses caring for this unique population, the objective evidence directly relating nursing skills to the assessment and care of PTSD is meager. Further research is needed to explain how nurses can practically go about tackling the serious psychosocial concerns of PTSD in the process of care planning. The burning clinical question that remains is this: how can nurses establish rapport with veterans suffering from chronic PTSD, how can they identify exacerbations, and how can they go about incorporating their concerns into effective treatment plans?

Chapter III

Methodology

Approval to conduct research dealing with human participants was granted by the Carroll College Institutional Review Board. Informed consent to carry out and record interviews was obtained from each participant. The following sections explain the phenomenological design for this study, as well as the study's sample, confidentiality measures, method of data collection and process of data analysis. Bracketing and study limitations are also discussed in this section.

Design

This study's design was based on the phenomenological model of research, in which individual experiences of a phenomenon are examined through in-depth interviews (Schmidt & Brown, 2015, p. 241). Participants were individually invited to participate in hour-long, in-person interviews in a private room on the Carroll College campus in Helena, Montana. Interviews were scheduled during times that were convenient to participants. In keeping with the phenomenological approach, interviews were transcribed verbatim (Schmidt & Brown, 2015, p. 240-241). No interventions were implemented and no deception was used. Investigators did not ask participants to recount trauma. The primary investigator informed each participant before each interview that he or she had the right to stop the interview or refuse to answer any question at any point in time. The primary investigator obtained permission to contact participants within four months of the initial interview to clarify statements, themes and ideas (See Appendix B).

Sample

Three Vietnam veterans – three men and one woman – and one Korean War veteran living in Helena, Montana were recruited using a snowball sampling technique. The primary investigator shared information about the study with pertinent contacts; these contacts then passed the study information along to their Vietnam and Korean War veteran connections who were given the primary investigator’s contact information. Veterans who expressed an interest in participating were initially screened through a short phone interview, during which the primary investigator confirmed that each individual veteran had served on an active duty basis in the United States Military during the Vietnam or Korean War and that he or she had a past or present diagnosis of PTSD. The primary investigator also asked participants questions to rule out the presence of co-occurring mental illnesses such as schizophrenia, bipolar disorder, panic disorder, dementia and traumatic brain injury. These criteria were assessed based on patient testimony rather than medical chart data or diagnostic screenings.

Data Collection

Each in-depth, detailed interview was conducted in person, recorded, and transcribed verbatim. Participants were asked to provide information about how PTSD affects their lives; what it was like to go through a significant exacerbation of PTSD; whether anyone was there to help during that exacerbation and what that person did to be helpful; how nurses can support veterans who are on edge because of trauma-related stress; how to recognize hidden signs of PTSD; and what insight they’ve gained about living with PTSD that they would like the rest of the world to know (see Appendix A, Interview Script). In addition to these set interview questions, the primary investigator

asked each participant relevant follow-up questions and offered clarifying statements to ensure an accurate understanding of the participants' ideas and experiences.

Confidentiality

Participants' identifying information collected for the purposes of this study was kept confidential in accordance with the regulations specified by the Carroll College IRB committee. Interview transcripts and audio recordings of interviews were stripped of patient identifiers and stored on a locked device in a locked room when not in use. In all study contexts, participants were referred to using sets of initials or pseudonyms. All contact information for participants was stored on a locked device in a locked room when not in use. Participant consent forms were stored in a locked box and shredded, along with all other hard-copy data containing patient identifiers, at the end of the data collection process. All in-person interviews were conducted in a private room to protect participant confidentiality.

Qualitative Data Analysis

To effectively analyze the data presented by participants, the primary investigator and one reader collaborated to "break down, examine, compare, conceptualize, and categorize data" (Schmidt & Brown, 2015, p. 391). Colaizzi's method of phenomenological nursing inquiry was utilized to analyze the data. This strategy involves reading the transcripts several times to gain a general feeling and to extract important statements; formulating meanings for each important statement; organizing these meaningful statements into clusters of themes; integrating these themes into an exhaustive description; and asking participants to validate the findings (Abalos et al., 2016, p. 21). In keeping with Colaizzi's model, the two investigators responsible for data

coding in this study read through transcripts several times and individually coded transcripts line-by-line, color coding key words and making margin notes to label trends in responses. Data reduction was assumed by omission: phrases and stories that were not highlighted or underlined were omitted from the final data. Each investigator used open coding to group data into seven or eight categories of logical, important themes (Schmidt & Brown, 2015, p. 393). The two investigators then met to reconcile their individual themes and used peer debriefing to ensure that the truth emerged from the data (Schmidt & Brown, 2015, p. 407). Together, these two investigators came up with a final set of two broad categories and ten sub-themes, which are discussed in Chapter IV.

Bracketing

According to Schmidt & Brown, (2015, p. 235) bracketing is, “a strategy used by researchers to set aside their personal interpretations to avoid bias.” Because the primary investigator had no personal experience with military service and has no close friends or family members in the military, this individual was able to approach the study with bias-free inquisitiveness.

Study Limitations

The small sample size ($n = 4$) was a significant limitation of this study. The difficulty of the participant recruitment process speaks to the isolating, hidden nature of PTSD. The primary investigator began recruiting by posting fliers and contacting physicians at the Ft. Harrison VA in Helena, Montana. A psychologist and a physician at the Ft. Harrison agreed to share information with patients about the study. No participants reached out to the primary investigator despite these efforts, so snowball sampling was used. Despite the use of this more personal form of recruitment, participants who were

willing to talk about PTSD were hard to find. The difficult process of finding veterans who were willing to talk serves as a testament to the idea that military stigma about mental illness and the need to appear strong complicate the identification and care of PTSD.

The second major limitation of the study was the lack of confirmed diagnoses. Because the primary investigator did not have access to patient medical records and because completing a diagnostic screening for PTSD was not in the primary investigator's nursing student scope of practice, the primary investigator had to rely on patients' testimonies that they had served in the military and had an ongoing diagnosis of PTSD. Further research involving a greater sample of veterans with clinically confirmed diagnoses of PTSD would be useful for building on this study's findings.

Finally, all study participants were similar in that they were all officers and all had loving spouses and strong support systems. This does not wholly discredit the study findings; if anything, it goes to show that even the most fortunate veterans are deeply affected by the wounds of war. However, the fact that all participants represented a specific demographic limits the generalizability of findings. In order to correct this, it would be useful to conduct a follow-up study including a larger sample with members who represent many races and social statuses included in the population of Vietnam and Korean War veterans.

Chapter IV

Results

The purpose of this study was to investigate the lived experience of chronic combat-related PTSD through first-hand accounts from veterans living with the disorder and serving during the Vietnam and Korean War eras; additionally, this thesis was designed to explore and explain how nurses can build rapport and provide support for veterans during stressful times of PTSD exacerbation. The following section explains the data that emerged from in-person interviews with four veterans suffering from PTSD. From these veterans' responses, two broad categories and ten subthemes emerged. These included: 1) Living with PTSD: The Past Is Always Present, a) Living "off the edge," b) Closer to death than to life, c) Avoiding the triggers, d) Masking the signs, e) Unrelenting unrest, f) Responsibility and remorse, g) Finding comfort in camaraderie, and 2) Nursing: Honoring the Unspoken Needs, a) Establish rapport, speak with veracity, b) Validating the trauma and c) Active intuition. These broad categories and subthemes will be discussed in detail in the following pages and supported using quotes from the study participants themselves. Themes will be included only if they represent the opinions of at least half of the study participants. Positive results supporting each theme as well as negative results will be discussed. For confidentiality purposes, each participant will be referred to using a pseudonym.

Broad Category 1--Living with PTSD: The Past is Always Present

The first cluster of themes relays how veterans serving in the US armed forces during the Vietnam and Korean Wars perceive living with chronic PTSD. The common thread in the following seven subthemes is this: when it comes to these phenomena, the

past is never the past. Combat trauma and the stress that accompanies it become a part of the veteran's identity and affect all stages of life. Despite veterans' efforts to leave the past in the past, it is always tangible. It is always relevant. It is always present.

Living “off the edge.” Living “off the edge” means being controlled to some extent by angry or emotional outbursts that are reactions to war-related triggers. All four participants experienced some form of living “off the edge.” Participant Kevin summarized this idea when he told the primary investigator to, “be on your guard. [Veterans with PTSD] are, most of them, somewhat dangerous in public . . . [with] the road rage thing, they have no idea what they're dealing with . . . we [veterans with PTSD] are a little off the edge.” All participants described that when they were dealing with PTSD or a trigger of PTSD, they would struggle with some form of anger or agitation. “We got angry,” Duane said, “we were in the streets, some of us threw our metals back, some of us went into the yak and never came back again, some rode motorcycles, many had terrible relationships and had abusive relationships, and nobody ever thought about it in relation to the trauma.” No matter what form it took, living with PTSD meant living with anger.

Like Kevin, Mark dealt with overt anger when he was especially triggered. “I lost my first two wives,” he said. “They divorced me. The one, I damn near choked her to death and the other I almost bit her ear off.” These incidences happened during war flashbacks. “These things would occur,” Mark went on, “nobody could tell me why, but things that had nothing to do with military service would come up and there'd be a flashback.” Mark's strength showed when he explained that over time, he became better

at anticipating his triggers and resisting their control over him. Now, the triggers have to “sneak up” on him to cause anger and agitation.

Susan and Duane described a more covert type of anger. “You’re just walking on eggshells your whole life,” Susan explained. For her, anger and agitation caused by triggers were mostly directed internally. When one VA healthcare provider denied Susan coverage in her quest to seek care for PTSD, she explained that what set her off, “was my anger. I was so angry that they were denying my experience that one night I just – I got this explosion of mental clarity and I sat down and I wrote a statement to them.” At first, Susan discredited her anger because it did not manifest like many veterans she knew:

I get agitated if there’s somebody behind my back. And I can’t be startled.

I overreact. [But] I never hit my kids ever, didn’t even spank them . . .

And I didn’t drink alcohol and I didn’t do drugs. I didn’t self medicate. I

was outside of the norm . . . [but] my vet counselor said, ‘Susan, you are

so angry.’ And I said, ‘I am not. I don’t hit my kids. I don’t kick the dog.

I’m not angry.’ And he said, ‘anger turned inward is depression.’ I never

thought of that.

Duane, too, explained that he dealt with anger that was, “not with any human that I was with . . . If you talk to people who have worked with me my whole life,” he explained, “I was seen as unflappable, calm under pressure, all that. But I have this sadness . . . It’s like an incredible sadness that never goes away.” Though, like Susan, the effects of war on Duane’s psyche were not consistent with the outward signs of many veterans they knew, grief and loss affected this participant emotionally in a deep and lasting way.

Closer to death than to life. On another opinion, all participants agreed: they have carried death very close to them in the form of memories of lost battle buddies and contemplations of suicide. “Death is so close to combat veterans,” Susan explained. “They are so used to death and dying that it’s closer to them than life.” For many veterans with PTSD, death is the “easy way out.” Susan illustrated this idea poignantly:

I never would have believed that I would drive myself to the ER and check myself in. But that was better than going to the bridge. And for me, I knew the bridge . . . some people use drugs and they overdose, some go in the car and use carbon monoxide, some use a gun. Those things weren’t for me. I was just gonna jump off the bridge ‘cause it was water and I always loved the water. It was very soothing; it was very comforting. For me it was going to be water. So I knew where to go. And Vietnam veterans with serious PTSD know where their escape route is. And they will go there.

Susan also carried the memories of her lost companions with her. During her interview, she reminisced about a close friend and fellow veteran who called her late at night just before he committed suicide. She didn’t realize until the next day that this had been his final interaction with another human. “I can still feel my hair stand on end,” Susan said as she told the story.

Though Duane did not actively plan his “escape route” like Susan had, he explained that his wife’s tireless ability to hear his stories of loss and trauma, “probably saved my life.” Mark expressed similar sentiments, explaining that if it weren’t for “old grunts” who watched out for him, he most likely would have taken his own life.

For Keith, death was especially close. He “tried to end the pain” and would have succeeded if it weren’t for a nurse who came and sat with him and talked him down from the proverbial edge. “I was standing in an isolated area with the window in front of me with the wrong kind of thoughts . . . it was crazy, like [I was] not even in [my] body,” he explained. Keith, too, told a story about a friend who was discharged from the army for failing to attend monthly trainings, only to end his own life days later. In a striking and powerful way, all four participants explained that these near misses were the aftermath of the emotional scars of combat.

Avoiding the triggers. As a coping mechanism for avoiding the types of reactions described above, all four participants utilized some form of avoidance. “[One thing] I have come to realize is very therapeutic for me is avoiding things. Like I cannot watch the news, I cannot watch trauma,” Susan explained. Kevin made a very similar statement: “I was able to avoid triggers. I didn’t read any books on Vietnam . . . nor did I watch any movies. It just didn’t work.” Duane independently mentioned that he had a hard time watching war movies. Mark mentioned that he avoided triggering noises: “I couldn’t go to a Fourth of July celebration – I’d plug my ears. The fireworks [were] fine, but the cannon—I couldn’t handle that.” Susan independently mentioned avoiding the fireworks on the Fourth of July like the plague. She also explained that, “if a gaggle of helicopters flies over, my autonomic nervous system just kicks in. I start to—anxiety. I’m kind of reliving those choppers coming in because that meant mass casualties.” Mark described another auditory trigger: “if a car backfired . . . most of the time I’d be layin’ on the ground with my hands over my head. The repercussion of what actually happened

in combat, it's never totally left me." Mark gave an additional example of a typical trigger that was not sensory, but emotional and mental:

Let me give you an example: the guys were told when they enlisted that their old jobs would be waiting for them when they came home. And lots of times that [didn't] happen. They'd go to a place like Boeing: 'well, we're sorry, we don't need you right now.' Ok. That will trigger PTSD right now. Immediately. The guy's saying, 'you're screwing me over.' And then they have a flashback to something that screwed 'em over in combat.

Susan also described an "unusual" emotional trigger that happened in 2015, explaining that, "I know that I have to be careful because if something triggers [me], I'm not gonna be fine." In this instance,

We were having a dinner party at our house. Nice people. Good friends. The subject came up and we were talking about Vietnam. I was sharing this story, and my husband interrupted me . . . people were listening to my story, which is pretty rare because I don't usually talk much about Vietnam . . . I said, 'honey, you interrupted me. Would you let me finish?' And the person sitting to the right of me . . . he took his napkin . . . and he threw it at me. I mean, it was just a cloth napkin. He threw his napkin at me and said, 'I wanna hear what [your husband] has to say.' It was like having things thrown at us when we came home from Vietnam. People threw things at us. They would not listen to us. They cut us off. They

didn't want to hear what we had to say . . . so the trigger was: this is Vietnam all over again.

When a trigger like this would happen, Susan usually dealt with it by getting away. She used to, "just go hide. Go for a long drive and get lost and run out of gas because I just [kept] driving." Instead of running away, Susan has since learned to deal with her triggers by seeking help.

Kevin, Duane, Susan, and Mark each independently described avoiding triggers by working. Kevin avoided by, "continually doing things." Duane began tending bar as soon as he got out of the Marine Corps because it was a socially acceptable way to keep himself busy when he had trouble sleeping. He began to have "increasingly more responsible jobs" working with legislative counsel and serving as city manager for several cities. "That led me to a lifetime of work," he explained, "instead of worrying about sleeping I just worked—my kids and my wife would say I was a workaholic." Susan independently called herself a, "workaholic," devoting her life to advocacy work as a way to "give back." Mark also used work to escape reality after war:

That's one of the things about being on the racetrack. I was the kind of rider that was always there. And you got up in the morning at five o'clock, you exercised horses till they shut the track down . . . and then after it was all over you went out and partied till two o'clock in the morning. So I gradually—the stress and strain of what happened in Korea—I didn't have to confront it any more.

Regardless of the form of the trigger or memory – tangible or intangible, auditory or emotional – all veterans involved in this study, in the words of Duane, “found ways to cope” with the trauma, “by avoiding coping with it.”

Masking the signs. Veterans don’t want other people to know when they’re struggling to cope. This is a sentiment that was echoed by all four participants. “Masked is a good word to use,” explained Kevin,

Because most of us in public are masked . . . Most veterans don’t come back in the house [when the car door slams] and say, ‘I was in my car and I slammed the door and I just got so jittered up that I couldn’t do this so I’m back in the house. . . they don’t want to get into that.

Duane explained that “masking the signs” is a practice that, for men at least, is engrained in military culture: “I think men don’t talk . . . some people talk too much and people say, ‘real people who have been in combat don’t talk.’ So they put you down if you try to tell somebody. . . we never told anybody that we served.” Duane expressed that he was shocked when the Veterans’ War Memorial was built in Washington, D.C. because it sparked his first ever conversations with coworkers about the war; in fact, he had worked with some of these coworkers for ten years without knowing they served in Vietnam or were even veterans.

In addition to suppressing verbal cues, veterans try to mask the signs that they are struggling by hanging back and hiding physical cues. Kevin explained that veterans often try to mask their inability to cope with stress by, “not keeping or making eye contact . . . not sitting in a group, standing back.” Susan also mentioned lack of eye contact as a telltale sign that a veteran is struggling. Mark pointed out that, while soldiers are often

comfortable telling stories about the war, they avoid talking about its effects on them because they don't want to seem weak: "so the guys say, 'oh yeah, I was in this unit . . . and they sent us to Cambodia . . . and we ate chipmunks' . . . but what actually is the problem they don't want to admit. Because . . . soldiers don't want to cry." Susan also mentioned that she refused to cry during and since the war. Mark and Duane both picked jobs that required long hours through the night (bar tending and jockeying) so that their inability to sleep and to cope with emotional strain would not seem out of place. The unanimous agreement voiced by participants about "masking the signs" shows that military culture discourages the display of emotional wounds and weakness; the four veterans' willingness to talk about it anyway shows their strength.

Unrelenting unrest. All four participants experienced disordered sleep as an indirect manifestation of dealing with the trauma. One experience expressed by Duane sums up this struggle:

I have troubles sleeping. I can't get to sleep. And then if I get to sleep I'll wake up . . . it's not like a casual thing, it's like I *can't* sleep . . . I've been away from Vietnam since 1969, and I [still] sleep in my poncho liner on the couch, you know, because I'm going to interrupt my wife's sleep.

The other three participants reported having nightmares related to trauma that impaired their sleep. Kevin described, "sleep disorders [and] wakin' up sweats." For all participants, the memories of war were just as present and tangible subconsciously as they were consciously.

Responsibility and remorse. All four veterans involved in this study carry a heavy weight of responsibility and remorse. They feel a sense of responsibility for the

friends they lost and a sense of remorse about leaving their wounded behind or not being able to say goodbye. Kevin explained that he has had to remind himself, “whoah! You didn’t start the Vietnam War.” “You wish you could go back and pick up the spent rounds and the grass and the country,” Duane said. Here is a description of responsibility and remorse in Duane’s own words:

Lots of people were killed and I remember . . . you’d leave your dead men behind . . . I watched almost the whole platoon of Bravo Company get wiped out and then lay there, you know, yelling and moaning. It was terrible. ‘Cause I was right there, but I couldn’t – they were so f***** up I couldn’t help them. So I’ve been frustrated about that . . . we lost one of the nicest guys I know. So those are things that I carry.

It is hard for Duane to let go of this weight because, as he puts it, “I’m responsible for them . . . I’ve been in my mind reliving all these experiences as if I’m 23 and they’re 18.” Mark describes a similar sense of accountability for lost brothers:

I got a pretty substantial decoration for being involved in an incident . . . [but] I didn’t want the decoration . . . When I’d concluded my participation in it, I simply took my pot off – my iron hat – and sat on it and cried like a baby . . . four guys covered for me to do this and they’re all dead now.

When MH made up his mind that he wasn’t going to let the PTSD beat him, it was this sense of responsibility that drove him. He thought, “I owe it to the guys that didn’t come home from my school. And I owe it to the guys that tried so hard to make it

alright for me when it was never gonna be alright for them.” For Susan, her responsibility and remorse centered around the lack of recognition her fellow Army nurses received:

I can easily fall into guilt . . . I’ve always had a monkey on my back . . .

But I gave back in my own way. I gave back because, you know, I did all that work on . . . [advocacy] . . . but I never took a paycheck. I was never paid for what I did. And I gave thousands of hours of work . . . And this is how I work through my therapy. My anger. I could take that anger and let it destroy me, or I could take the anger and do something constructive with it and continue my nursing by healing . . . this is healing the wounds of war. And healing is part of nursing.

Because of their inability to save all of their brothers and sisters on the battlefield, all four of these veterans carry a sense of duty and regret, even to this day.

Finding comfort in camaraderie. Therapeutic relationships are the positive aspect of sharing combat experiences with other veterans. Three of the four participants agreed that sharing the company of other veterans gives them a sense of validation, camaraderie and understanding that they don’t get anywhere else. Duane mentioned that while he did not actively seek out the supportive company of vets, he knew other veterans understood him better than most people and suggested that veterans with PTSD talk to other combat veterans. Susan summed up the idea of camaraderie idea perfectly:

You go to the American Legion or the VFW and you’re with other vets and it just feels comfortable. You don’t have to, you know, prove yourself. You’re accepted completely . . . I love being with other vets. In particular combat vets ‘cause they’re the ones that really understand. It’s

comfortable and it's reaffirming and there's camaraderie and a bond that when you leave the military, you miss. You miss the camaraderie. You miss that bonding. There's something missing in your life. And then when you find it again, you realize that it's really kind of nurturing.

Duane agreed with this idea by advising that nurses should ask veterans, "have you ever talked with other people, like people you served with or other veterans?" 'Cause I think that [dealing with PTSD] is something people do in isolation." For Mark, it was the understanding of fellow veterans in a psychiatric hospital that saved his life when he was dealing with acute PTSD after his time in combat:

They straightened me out pretty fast. And I will never be able to thank the guys enough because they didn't take any crap. They said, 'look, you little SOB. We went through a lot more than you did. And you're gonna make it. And you better get your act in gear and we're tired of hearing you whine and cry . . . none of us is ever going to leave here alive. [But] by God, you will' . . . they tried. They tried so hard. And they were determined that I was gonna go home.

Though it sounds gruff, Mark explained that it was this straightforward understanding from fellow soldiers that helped him overcome his acute symptoms. It was their shared experience that pushed him to put his faith and trust in the "old grunts" that helped him: "one minute you're talking to the guys at the cannon next to you and the next minute they're in pieces. You can't explain that to a civilian. You can't explain it to somebody that's never been in combat." For Duane, the understanding of other veterans was identified as a therapeutic tool for veterans with PTSD; for Mark and Susan, finding

comfort and understanding in the company of other veterans was an important part of their recovery from the acute symptoms of PTSD.

Broad Category 2--Nursing: Honoring the Unspoken Needs

Military culture discourages talking about trauma and expressing its effects. This fact was well supported in the Review of Literature and by the veterans involved in this study who talked about the inherent loneliness that accompanies living with PTSD. As a way of avoiding unearthing the trauma, many veterans spent years not talking at all about their service; some still avoid this. This creates an obstacle for nurses who care about identifying and supporting the psychosocial needs of veterans with PTSD. Veterans' psychological and emotional needs often go unexpressed. They do, however, often manifest themselves in different ways: somatic symptoms, triggers that cause reactions that are disproportionate to the stimulus, anxiety, depression, etc. Because these needs will often be unexpressed or even actively hidden, it is up to nurses to intuitively perceive and validate these needs without being asked to do so. As the following sections will demonstrate, veterans feel there are ways to support veterans' needs related to PTSD while honoring their desire for privacy and respect related to mental health. In other cases, direct conversations about PTSD are important to veterans; however, the participants in this study suggest that strong rapport should be established before this takes place. In the following sections, veterans explain how nurses can anticipate and validate the needs of veterans with PTSD in a way that promotes dignity, autonomy and respect. For nurses who hope to be effective in supporting the needs of veterans with PTSD, it is essential to establish rapport, to be truthful and direct, to validate the effects

of trauma, and to use active intuition. These terms and concepts are defined and explained in further detail in the following sections.

Establish rapport, speak with veracity. Veracity is, “habitual truthfulness,” “accuracy,” or “devotion to the truth” (Veracity, n.d.) and it is an important tool to use when talking to veterans about PTSD. 50% (n = 2) of the veterans involved in this study mentioned truthfulness and directness as essential tools to use when talking with veterans. “Don’t lie to a veteran,” Kevin warned,

It’s not going to work. It’s better to say, ‘I have no idea how to deal with this. I’m going to go back to my notes . . . to see how screwed up you are.’ That sounds a little rough, direct, but that would work. Keep it simple. Be direct. Kind of like with an old neighbor that’s grouchy. Be direct. Help him. Smile. Shovel his walk. You didn’t have to, he didn’t expect it and he may be contrary to you doing it, but keep doing it.

For Mark, veracity was also a value. Mark’s older mentors were direct and truthful with him when they told him bluntly that they weren’t going to let him get stuck in the ‘monkey ward.’ He trusted them because he knew they were not tip toeing around the issue. This is what saved him from taking his own life and gave him the inspiration to combat his symptoms.

Mark and Kevin agreed that while veracity is of paramount importance, it should never precede rapport. Along with Susan, both of these veterans suggested that when it comes to talking about mental health struggles, trust is earned, not assumed. Mark expressed uneasiness about talking to providers about PTSD before trust was established. “What do you think you would use as an introductory avenue to bring up the issue of

PTSD? You wouldn't have it in the thing [admission interview] like, 'did you ever have measles, did you ever have your appendix out, did you ever have PTSD—'" Mark asked the principal investigator as he gave her a wary look and shifted uncomfortably in his seat, "you wouldn't have it in the chart like that." Mark feared that directness right off the bat could seem like flippancy and could create a barrier between the veteran and the provider.

Though Susan did not mention the importance of directness in her interview, she did warn that trust ought to be established before the subject of PTSD is overtly discussed because, "veterans will not talk to you if they don't trust you." Kevin voiced similar sentiments when he shared a story about a psychiatrist who pushed his veteran son, who struggles with PTSD, to talk before any trust or rapport was established:

They had him in a very small room . . . and [the chief of psychiatry] came out [of the room] all big eyed. And stayed out. Because she had tried to mother my son. You know, 'I care about you,' all this nice talk. 'I really need you to tell me what you're thinking. You're safe here . . . She pushed a couple, three times, and he finally looked her right straight in the eye and said, 'I want to rip your head off.' Whoah! So there's an example where she pushed with good intentions but pushing somebody that's got issues and you can see them tightening up... back off. You're not safe. It's not helping.

Though, as Kevin explained, directness is important, it should be used with caution and should never be used before trust is established.

Validating the trauma. Invalidation from clinicians breaks trust and negatively impacts veterans; conversely, validation can be used as a powerful tool for establishing rapport and showing support to veterans. For the purposes of this study, invalidation is defined as any speech or action that conveys disinterest and undermines the validity of a veteran's war experiences and their impact on him or her. Validation, on the other hand, is any speech or action that conveys an interest in the veteran's war experiences or an understanding that those experiences were significant to and impactful for the individual veteran.

Susan's story about the friend who interrupted her and threw a napkin at her while she was sharing a sensitive experience is a strong testament to the power of invalidation. The friend's invalidating actions wielded so much power over her emotions that she ended up triggered, "off the edge," and in the emergency room. The effect of this invalidation was that it broke her trust: "we're still friends," Susan said about the friend who interrupted her, "but friends to a point because I will never bring up Vietnam in front of these people again. So there's a wall there." It is important for clinicians not to brush off veterans' experiences because of the lifelong impact they have on these individuals.

Duane independently told a story of a clinician who failed to validate trauma's impact on his life. He warns nurses not to dismiss a veteran's experiences: "if a veteran comes to you as a provider and says, 'I think I have PTSD, I can't sleep, and is there anything you can do?' you should at least do more than just say, 'I'll see what I can do.'" Because Duane went out on a limb to ask for help and the clinician failed to act or show any concern, Duane is, to this day, wary of bringing up the issue again to a provider.

Fortunately, validation is a powerful tool in the opposite direction. Veterans notice when an individual respects and appreciates their service and sacrifice. Showing this respect is a way to build rapport and show support. Susan shared a story of a clinician friend who gave her the validation she, at first, was not able to give herself. This friend persistently supported her and believed in the validity of her experiences, even when she brushed him off. This is what catalyzed the beginning of her process of accepting help for PTSD:

He said, ‘Susan, do you know you have PTSD?’ I said, ‘I do not. I don’t have PTSD; I’m fine’ . . . and he said, ‘well, I’ll send you the form. Fill it out. And it’ll get your foot in the door and they’re there for you [the VA services] if you need them’ . . . the form came and I started filling it out and I got so angry I threw it in the garbage . . . a few weeks later, he called and he said, ‘Susan, I didn’t get your forms.’ And I said, ‘I’m not filling them out. They’re telling me I have to beg to prove I have PTSD’ . . . He said, ‘how about I fill it out for you?’ I said, ‘fine.’

If it weren’t for this friend’s help and support, as well as the support of her family who wrote letters to the VA to testify that she would, indeed, benefit from services for PTSD, Susan may have resisted treatment for the rest of her life. Susan went on to explain another instance in which validation from an outside source might have saved her nursing career, which she gave up because of a trigger at work:

I’d been thrown into a flashback. In my mind what happened was, ‘I am now an incompetent nurse and I can’t be trusted.’ And that was so devastating to me. I couldn’t deal with it . . . So I basically gave up my

nursing career because of that. And if I had known what it was about, if I had had some good therapy, if I had been validated . . . [I would have been] allowed to find help and therapy.

Susan still looks back on this incident with remorse and a sense of loss. She later explained that if someone had been there to explain to her what flashbacks are and to encourage her to seek help, she most likely would have been empowered to continue in the career she loved.

The nurse who saved Kevin's life validated his trauma by believing him when the memories of war were driving him to contemplate suicide. She put him on speed dial, and she came and found him immediately when he reached out to her for help. "She didn't hesitate," Kevin said, "She came to me. She found me."

Duane explained that nurses can validate veterans and show an interest in their service by using simple questions: "are you a veteran? . . . Have you experience trauma? Are you interested in talking about it? Or do you not want to talk?" Even if that veteran prefers not to talk, at least he or she knows the clinician considers his or her experiences impactful and valid. By employing the tool of validation, clinicians can begin to establish a sense of therapeutic trust and safety that veterans need in order to comfortably discuss stress-related symptoms.

Active intuition. The use of active intuition is a practice that veterans notice and appreciate. The power of active intuition or the detrimental effects of not using active intuition were two abstract concepts mentioned by every participant in this study. It is easiest to define this concept by first defining its opposite: the opposite of active intuition is when an individual takes a veteran's chief complaint and does not further investigate

the physical, emotional or mental need that drives it or serves as the root cause. Active intuition is, conversely, a skill that is employed when an individual listens to the veteran's complaints and actively employs intuition and critical thinking in order to identify the unvoiced need that drives the complaint. Active intuition is being, "tuned in to where a person is at emotionally," to borrow Susan's phrase, not just where the person says he or she is at. Active intuition means employing many senses and skills – listening, seeing, discerning, reading body language, picking up on subtle verbal cues, critically thinking, communicating therapeutically – to try to truly understand the patient and meet the patient where he or she is at. Susan puts this skill into simpler terms by explaining that a nurse who uses active intuition, "walk[s] into the room and see[s] everything." Susan also illustrates this concept beautifully when she describes visiting a provider about some frustrating skin problems:

I mentioned that I'd always wondered if it had anything to do with dioxin. She perked up and said, 'dioxin! Where have you been?' And I said, 'well, Vietnam.' And she was instantly on top of that. And unless they ask, we usually don't talk about things like that. But she said, 'oh, my dad was in Vietnam' . . . and then she started asking me all these questions about my service in Vietnam. And just that one thing that I said, she was on top of it and asked all these questions and I just felt like, 'this doctor really cares. She's trying to get to the bottom of things.'

Dioxin is one tiny word that could have been easily brushed off or missed by this care provider. Because the doctor was tuned in to Susan at that moment, she picked up on

Susan's unvoiced need and made her feel validated and human and appreciated all at once.

Duane described an experience where the healthcare providers he met lacked active intuition. In other words, they took his somatic symptom at face value and did not try to "get to the bottom" of it. This had an impression on Duane:

I went to the sleep unit and I couldn't sleep and then the nurses there yelled at me, 'why didn't you bring your Ambien?' I said, 'well, I'm coming here because I can't sleep!' They say, 'oh, we don't know how to do that.' You know what I mean? So there was no empathy . . . never in all of my gatherings did anybody ever ask me, 'well, are you a veteran? Have you been in war?'

The nurses and care providers at the VA where Duane sought help for his insomnia took his problems at face value. They assumed the root of his sleep problems was sleep apnea. All he wanted was for someone to pick up on his inner struggle, to really listen to his complaints and explore the root cause of his unrest. Cues like this are easy to miss. In order to pick up on the unvoiced needs of veterans, nurses have to actively and intuitively read between the lines. Kevin gives another poignant example of a scenario where active intuition was not employed. In this case, the care providers took their patients at face value, assuming that the veteran who struggled most overtly was the most acute. Kevin warns against this temptation and explains that nurses must use intuition to see a person's struggle no matter how masked it is:

I went on a veteran sponsored fly-fishing trip on the Smith River. I remember watching the people involved in that program and they were

focused primarily on the fishing . . . but it was obvious to me they thought one of these guys was more way out there than the rest of ‘em. And that’s who they expected and who they watched the most, when the person that didn’t show the signs was – he tried to commit suicide after the trip . . . be careful that you not minimize someone that doesn’t look or act according to the symptoms of a crisis of combat posttraumatic stress because that can be devastating to the individual.

In this instance, like in the instance at the sleep clinic, the trip leaders took each patient at face value. Active intuition means not taking patients at face value but looking deeper. Mark echoed this idea that veterans’ symptoms or lack thereof cannot be taken at face value but must be intuitively appraised because, like many other veterans, he, “can relate the incidents of combat that happened to me, no problem. But the wherewithal’s, the innuendos, what created the response I had then and what response I have now? That’s kind of hard to put into words.” If the issue at hand is related to PTSD or the effects of war, many veterans have a difficult time encapsulating their struggle in words. Relying on direct patient testimony often fails in creating a comprehensive picture of the problem; unfortunately, so does relying on signature signs of PTSD. Mark explained that this is because the effects of war are different for each veteran: “the tragedy is, because a guy’s been in a combat situation, his reaction to what he has seen or what happened or what he did might be completely the opposite of the guy next to him, though they were both in the same situation and saw the same hell brought to earth.” In order to create a comprehensive picture of the struggle of the veteran with PTSD, active intuition must be employed along with patient testimony.

Summary of Qualitative Findings

PTSD is a complex disorder that is difficult to explain and difficult to treat. Four veterans shed some light on the topic by explaining their experiences with PTSD and their opinions about how nurses can help. From their responses, two broad categories and ten sub-themes emerged that focused on the lived experience of PTSD and the supportive strategies nurses can employ to validate and understand veterans suffering from the disorder.

Chapter V

Discussion

As participant Susan pointed out, “nothing can prepare you for war but war itself.” Because the transformation that occurs as a result of combat exposure is different for every soldier, the effects of war experiences are complex and difficult to typify. Despite the difficulty, the participants in this study provided nearly unanimous insight about what it is like to live with PTSD and what they need from the people around them when they are struggling. Their insight led to the development of a set of themes. Specifically, living with PTSD means living “off the edge,” feeling closer to death than to life, habitually avoiding triggers, masking the signs, living with unrelenting unrest, dealing with a profound sense of responsibility and remorse and finding comfort in camaraderie that cannot be matched anywhere else. When veterans are struggling with PTSD, they need caregivers and those around them to speak truthfully and directly, to validate their trauma, and to use active intuition. The following paragraphs are dedicated to discussing each of these themes.

Living “Off the Edge”

Participants unanimously agreed that “living off the edge,” or living with anger and frustration, is inherent to the life of a veteran with PTSD. Anger can be directed outwardly, as Kevin and Mark demonstrated with their stories of road rage and intimate partner conflict. Anger and frustration can also be directed inwardly, as Susan and Duane demonstrated when they described their “anger turned inward” which manifested as a profound sense of unrelenting sadness. Living off the edge is precarious. Some days are peaceful; some days the triggers cannot be controlled. But the threat of being pushed “off

the edge,” past the brink of anger and frustration is always looming. Susan explained that this precariousness leads to a feeling of lost control; she added that the anger response is a way veterans try to regain control.

This finding is hugely important for nurses to understand because it promotes empathy: nurses need to be able to imagine and understand how exhausting it would be to live with an uncontrollable sense of frustration or sadness that strikes at the most unexpected times. When a veteran reacts to a trigger and is pushed “off the edge,” it is important for nurses to understand that this response is not always voluntary or chosen; it results from a feeling of lost control. For nurses working with veterans, it is important to anticipate these reactions and stay safe. It is important for nurses not to let themselves be controlled by the veteran’s anger or to respond in kind; this will only increase the chaos. Instead, when nurses understand that living with PTSD means living “off the edge,” they are empowered to provide a sense of safety and stability for veterans by responding to frustration with firm, kind, calm reassurance and understanding.

This finding is consistent with current evidence, which explains that veterans with PTSD have increased rates of depression and social/relational difficulties. Though these results provide a starting point for understanding veterans’ anger, frustration and sadness, they are not comprehensive. This finding is limited in that it does not provide insight about how to respond to veterans who are pushed “off the edge.” Further research could explore clinicians’ tips for staying safe and veterans’ needs when they are triggered and angry.

Closer to Death Than to Life

The feeling of being “closer to death than to life” was two-fold: veterans felt close to death themselves because of their extensive exposure to it in combat; this led to the feeling that death was the “easy way out.” Veterans also felt close to death in the sense that the memories of their brothers and sisters who died never left them. The legacies of their close friends who passed followed them closely, even decades after the war.

This theme makes it clear that from a clinical perspective, providers should take thoughts of suicide seriously and respond with deep empathy when a veteran expresses a memory of a lost friend. It is difficult to pick up on cues about thoughts of death and dying. Clinicians have to be present with their patients and listen closely to pick up on these cues.

Existing literature, presented previously in the Review of Literature section, speaks to the increased rates of suicide for the veteran population and supports this finding. This theme is limited in its scope of impact in that it provides the reader with important information about the prevalence of suicidal thoughts in veterans with PTSD, but it does not address recognizing the signs of suicidal ideation in veterans, which is often subtle and masked.

Avoiding the Triggers

Avoidance was a primary coping strategy identified by every single one of the participants. For many, this is a necessary coping strategy for maintaining control over emotions. This is relevant because some veterans may not want to talk to clinicians about war memories, much less trauma or stress responses. It is important for the clinician to respect this need and to then look to nonverbal cues to gauge whether or not the veteran

is stressed. The clinician may also want to indirectly gauge the veteran's level of comfortability with war memories by asking him or her whether he/she watches any movies or reads any books about the war.

Masking the Signs

Signs of PTSD are difficult to pick up on because veterans actively mask them; this is consistent with the study findings presented in the Review of Literature about military cultural competence and mental health-related stigma in the military. Signs of posttraumatic stress will often be covert and veterans may not want to talk about them. In order to protect rapport, it is important that nurses respect this aspect of the military culture. For some individuals, strong rapport may need to be developed before the subject of PTSD is broached openly and overtly.

This finding underscores the importance of understanding that veterans with PTSD will most likely hide the signs; however, it does not explain how nurses can effectively identify signs that are not obvious. In fact, it is difficult for many veterans with PTSD to describe how to tell when they are struggling. This was an issue that was addressed through an interview question: the primary investigator asked each participant, "do you have any insight that might help nurses recognize when veterans are struggling with PTSD symptoms, even though the signs are often hard to pick up on?" Despite the directness of this question, not a single participant was able to give a clear-cut answer. It is difficult to convey the preliminary, covert signs of posttraumatic stress. Further research is certainly needed in order to more comprehensively explain the hidden signs of PTSD and how clinicians can recognize them.

Unrelenting Unrest

Sleep problems and sleep disturbances were major health complaints this study's participants unanimously voiced. It is probable that poor sleep quality makes it harder to cope with the other symptoms of PTSD. The relationship between sleep quality and adequacy and the severity of other PTSD symptoms was not a topic that was addressed by this study; it is a relevant topic for further research.

Responsibility and Remorse

Unlike participants' more tangible, measurable complaints such as poor sleep, anger and avoidance, responsibility and remorse are abstract effects of PTSD that do not fit into the obvious criteria for PTSD. Because responsibility and remorse are abstract concepts, they are hard to prove. Because they are hard to prove, they are often not addressed in discussions of PTSD symptoms and are not validated often enough. This theme is notable because no existing research covering the topic was found in the review of literature. To the best of the primary investigator's knowledge, this is a fresh finding.

Finding Comfort in Camaraderie

On this all participants agreed: no one understands a veteran like another veteran. It is important for clinicians to remember that they will never be able to meet all of the veteran's needs for support and understanding. However, the vignette provided by Susan about a civilian gynecologist is of note because it shows one way civilian providers can make connections with veterans despite the lack of shared combat experiences. In this scenario (see page 66), this gynecologist sparked a connection with Susan by eagerly sharing that she had a loved one, her father, who served in Vietnam. This gave Susan the sense that this provider had some understanding of and interest in what Susan had been

through. Susan walked into the office hoping not to address the fact that she had been in Vietnam; once this provider began to establish rapport by showing interest and understanding, Susan felt comfortable sharing part of her story.

This finding is notable for clinicians: while civilian nurses do not benefit from the instant trust that comes with being a veteran working with veterans, they can build bonds by showing a personal connection to Vietnam through a friend or shared experience. This finding also applies to other themes shared in this thesis, as this practice may be used to establish rapport and validate a veteran's experiences.

Establish Rapport, Speak with Veracity

Veracity and directness are important to veterans, but they are also tricky issues. If the subject of PTSD is broached too early with a veteran before rapport is established, it can actually turn the patient off and act as a barrier to communication. This finding was new in the sense that its replicate was not located anywhere in the review of existing research. While it is important to understand that veracity and rapport must go hand in hand, further research is needed. Research should focus on methods for establishing rapport. Verbal and nonverbal ways to signal honesty, which could be used in conjunction with veracity, would also be helpful topics of research.

Validating the Trauma

This theme, to the best of the primary investigator's knowledge, is a new finding and is unique to this study. Validation is another way of establishing rapport and communicating therapeutically with veterans. Validation opens doors and builds trust while invalidation does just the opposite. This finding is a powerful tool that takes no time at all to implement and that is within the scope of nursing practice. The problem

with validation is that it is not an inherent tool all nurses possess; because of this, validation as a tool should be supported by further research so it can be included in evidence based education for nurses learning to work with veterans.

Active Intuition

Active intuition is an abstract concept that, as it relates to veterans with PTSD, is unique to this study. It is the hardest of all the themes to articulate. It is a skill that cannot be explained or defined in a clear-cut way because, by nature, it changes depending on the situation and veteran's needs. No veteran can be taken at face value, since oftentimes the least symptomatic veterans with PTSD are the most acute. Active intuition requires looking at each new patient situation with fresh eyes.

Conclusion

The purpose of this study, which focused on the phenomenological exploration of four veterans' experiences with PTSD, was to enhance nursing knowledge of the disorder and present recommendations for establishing rapport and providing support for veterans. Participants' reports of their difficulties with PTSD, even decades after the war, support the fact that the disorder is a complex subject to broach with veterans and that it has profound and lasting effects on the individual. The four participants involved in this study identified seven specific examples of these effects on the individual: living with PTSD means dealing with periods of agitation, avoiding triggers, masking the signs of inner struggle, feeling close to death, having difficulty with rest, carrying a deep sense of responsibility, and finding comfort in camaraderie. In response to these impacts of PTSD, nurses can help veterans by establishing rapport and speaking with veracity, by finding ways to validate the impact of the combat experience on the veteran, and by using active intuition to uncover and attend to the needs created by PTSD that the veteran may not be able to express.

Appendix A: Interview Script*Interview Script*

The Lived Experience of Chronic Posttraumatic Stress Disorder in Vietnam Veterans:
Implications for Nursing Practice

Amy Mohr

- Can you give me a brief description of what you're like when you're at your best?
- Now, for comparison's sake, can you tell me what you're like when you realize you're starting to struggle with PTSD symptoms?
- How does PTSD affect your life?
- Can you think of a time when you've felt the worst you've felt? What was that like, and was there anyone there to help you? What did he/she do that was so helpful?
- If you could give nurses some tips about helping veterans who are experiencing symptoms of PTSD, what would those tips be?
- Do you have any insight that might help nurses recognize when you are struggling with PTSD symptoms?
- If you could make others understand one thing about living with PTSD, what would it be?

Appendix B: Consent Form

Carroll College Subject Consent Form for Participation in Human Research

Title of Study: The Lived Experience of Chronic Posttraumatic Stress Disorder in Vietnam Veterans: Implications for Nursing Practice

You are being asked to participate in a research study about chronic posttraumatic stress disorder (PTSD). From this study, the investigator(s) hope to learn how nurses can better advocate and care for persons suffering from this disorder.

You have been selected to participate in this study because we believe you might have valuable insight on what it is like to live with PTSD. If you agree to participate, you will be asked to attend one hour-long interview, which will involve five questions about what it is like to live with PTSD and how you think nurses could do a better job of caring for Veterans. The study is expected to involve four participants. If you choose to participate in the initial interview, you may also be contacted over the phone within ten months of the interview and asked to clarify the meaning of your interview statements.

Participation in this study may involve certain risks, including the discomfort involved when talking about symptoms and past experiences with PTSD. If interview topics trigger psychological or emotional distress, investigators will terminate the interview process and advocate for you by notifying a clinician at the VA. As a participant, you will have the right to refuse to answer a particular interview question or to end the interview at any point in time. The study is of no direct benefit to you, but is intended to help nurses understand how to better care for other Veterans with PTSD.

If you choose to participate, the cost to you will be the time it takes to participate in one in-person interview.

Your privacy is important to us. Confidentiality of records identifying you will be maintained by removing all identifiers from the data you provide. Investigators may choose to audio-record your interview so they can review data you provide at a later date. If you agree to allow investigators to audio-record your interview, please check the box below. This audio-recorded data, along with any written data, will be stored on a password-protected device in a locked room when not in use. Your contact information will be stored in a locked cabinet in a locked room when not in use. Only primary investigators will have access to study data, including data that identifies you as a participant.

By checking this box, I agree to allow investigators to audio-record my interview and I understand that this audio-recorded information will be kept confidential.

Further information about this research study may be obtained by calling Amy Mohr at 724-992-0994. Additional questions about the rights of human subjects can be answered by the Chair of the Institutional Review Board, Dr. Alan Hansen 406-447-5401 or ahansen@carroll.edu.

I, _____ (*name of subject*), agree to participate in this research. The investigator has thoroughly explained the nature and process of this research to me. I have read the above and understand the discomforts, inconvenience and risk of this study. I understand that I have the right to refuse to participate in this study and that refusal to participate will involve no penalty or loss of benefits to which I am otherwise entitled. I also understand that I may withdraw from the study at any time without penalty or loss of benefits to which I am otherwise entitled. To the best of my knowledge I have no physical or mental condition that would be adversely affected by my participation. I have received a copy of this consent form for my own records.

Signature of Participant

Date

Printed Name of Participant

Signature of Witness

Date

Printed Name of Witness

Appendix C

Script to Guide Interview

To start off interview:

- Sign consent form and explain
 - *Get consent to record interview
- Can stop the interview at any point in time
- Confirm PTSD, served in Vietnam
- Confirm no diagnosis of TBI, schizophrenia, dementia or panic disorder

At the end:

- Give crisis hotline sheet
- Go through ending script again explaining the project
 - The scars and effects of war are powerful and lasting. We see that and want to honor the service of Veterans by helping nurses better care for Veterans who experience war-related stress. Findings from these interviews will be used to enhance research and to guide nursing care of Veterans.
- Ask if I can call him back within ten months to clarify any of his interview statements because I want to make sure I've gotten the full meaning

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