Post-traumatic Stress Disorder at the End of Life

JOY A. LARAMIE, MSN, CANP, BC-PC

More than 600,000 veterans die each year. In 2001, 25% of Americans who died were veterans. However, most veterans do not die in a Veterans’ Affairs medical center. Therefore, it is important for healthcare providers in all settings to be familiar with the often unique needs of the veteran population, especially with regard to chronic terminal illness at the end of life.

What Is Post-traumatic Stress Disorder?

Post-traumatic stress disorder (PTSD) is an anxiety disorder that can occur after a person has experienced or witnessed life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults such as rape (National Center for Post-Traumatic Stress Disorder Web Site, 2006). It has been demonstrated that witnessing death or serious injury to others is sufficiently stressful to cause PTSD (Carson et al., 2000). In addition, individuals who have been in the position of harming or killing others (e.g., in a motor vehicle accident or in combat) can face significant traumatic stress after the experience. Findings show that soldiers who have killed in combat, or believe that they have, experience higher rates of PTSD (Baum, 2004). Any trauma, especially when prolonged or repeated, may convert the ordinary adaptive response of “fight or flight” into a pathologic reaction (Allen, 1995).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000) defines trauma as any event that a person experiences, witnesses, or is confronted with that threatens death or serious injury or is a threat to the physical integrity of oneself or others. Most survivors of trauma, especially those with adequate coping mechanisms, can adjust to the incident and have no lingering effects. However, some persons have stress reactions that do not abate and may worsen over time. These reactions can develop into PTSD, which may be severe enough to have a significant impact on their daily life, as well as that of their spouses, family, and significant others.

Tick (2005) describes PTSD in the following passage:

War devastates not only our physical being but our very soul—for the entire culture as well as for the individual. In war, chaos overwhelms compassion, violence replaces cooperation, and instinct replaces rationality. When drenched in these conditions, the soul is disfigured and can become lost for life. What is called “soul loss” is an extreme psychospiritual condition beyond what psychologists commonly call dissociation. It is far more than psychic numbing or separation of mind from body. It is a removal of the center of experience from the living body without completely snapping the connection. In the presence of overwhelming life-threatening violence, the soul—the true self—flees. The center of experience shifts; the body takes the impact of the trauma but does not register it as deeply as before. With body and soul separated, a person is trapped in a limbo where past and present intermingle without differentiation of continuity. Nothing feels right until body and soul rejoin.

Symptoms

Acute stress disorder encompasses symptoms that appear within 1 month of the traumatic event and are present for a minimum of 48 hours, but no more than 4 weeks. After 1 month, the presence of symptoms indicates the onset of PTSD. The diagnosis of acute PTSD is made if symptoms last less than 3 months. Chronic PTSD is defined as the presence of these conditions, the soul is disfigured and can become lost for life. What is called “soul loss” is an extreme psychospiritual condition beyond what psychologists commonly call dissociation. It is far more than psychic numbing or separation of mind from body. It is a removal of the center of experience from the living body without completely snapping the connection. In the presence of overwhelming life-threatening violence, the soul—the true self—flees. The center of experience shifts; the body takes the impact of the trauma but does not register it as deeply as before. With body and soul separated, a person is trapped in a limbo where past and present intermingle without differentiation of continuity. Nothing feels right until body and soul rejoin.
symptoms for 3 or more months, and delayed-onset PTSD refers to the onset of symptoms for the first time at least 6 months after the onset of the traumatic incident (Flannery, 1999).

Feldman & Periyakoil (2006) describe PTSD as comprising three clusters of symptom types: repetitive, avoidance, and hyperarousal. Repetitive or “reexperienced” symptoms often include disturbing memories, nightmares, and hallucination-like flashbacks. Avoidance symptoms consist of attempts to avert reminders of the trauma (e.g., objects, places, and people). Avoidance of these reminders can lead to significant functional impairment. In addition, attempts to suppress repetitive trauma-related memories and emotions sometimes lead to amnesia for aspects of the trauma or a sense of emotional numbness (Feldman & Periyakoil, 2006). Hyperarousal symptoms include hypervigilance, difficulty concentrating, mood swings, irritability or outbursts of anger, exaggerated startle response, and insomnia.

The chronic nature of PTSD renders trauma victims vulnerable for life, and midlife is a time of particularly high risk for either delayed onset or reactivated PTSD. Midlife generally entails some reduction in activity, with a shift from planning to reminiscence, and from occupation with current events to a review of one’s life experiences. Alterations in perspective may trigger a reemergence of the suppressed traumatic memories.

In addition, aging often is characterized by many losses and exit events, from retirement to disease (Solomon & Mikulincer, 2006). The deaths of loved ones, the loss of a job, and diminished health are events that may rekindle wartime memories, survivor guilt, and unresolved grief. These events also can erode important long-standing coping mechanisms (Kaiman, 2003).

If PTSD is suspected on the basis of behavior or history, the most effective screening method is to ask patients about their current symptoms and past experiences. A variety of screening tools exist, but asking questions such as “Have you had nightmares about it or thought about it when you did not want to?” and “Did you feel you were on guard, watchful, or easily startled after the experience?” can help in ascertaining symptoms of PTSD (Friedman, 2006).

The Experience of Veterans

Having reviewed some basics of PTSD, it is important to discuss the experience of combat veterans and how their exposure to uncertainty and violence on the battlefield may make them particularly vulnerable to this disorder.

Findings show that PTSD has been recognized (in retrospect) after all wars: as “soldier’s heart” in the Civil War, as “shell shock” in World War I, and as “combat fatigue” in World War II. However, the concept of PTSD was formalized in the diagnostic nomenclature in 1980 after extensive experience in treating Vietnam veterans. Although the majority of veterans successfully adjust to postcombat life, more than one fourth have PTSD at some time in their life, and for many, the disorder becomes chronic. Often, PTSD is associated with additional problems including depression, anxiety and other psychiatric disorders, adjustment problems, substance abuse, distrust in authority, survivor guilt, adverse consequences for family members, and extensive need for extended psychiatric services (Allen, 1995; Feldman & Periyakoil, 2006).

It is estimated that 7.8% of Americans will experience PTSD at some point in their lives, with women (10.4%) twice as likely as men (5%) to experience PTSD. The estimated lifetime prevalence of PTSD among American Vietnam veterans is 30.9% for men and 26.9% for women. As many as 15% of all male Vietnam veterans and 8.1% of all female Vietnam veterans carried a diagnosis of PTSD in one study (National Center for Post-Traumatic Stress Disorder Web Site, 2006).

Why Was Vietnam Different?

The Vietnam War was fought and viewed differently than previous wars, which contributed to the difficult readjustment experienced by many of its veterans. The average age of the soldiers was 19 years, as opposed to 25 years in World War II (Sevy, 1989). These young soldiers lacked the maturity and preparation that might have helped them cope with traumatic experiences. There was no fixed goal for winning this war upon which the soldiers could focus (Sevy, 1989). A village or town might be secured, often with many civilian Vietnamese casualties, only to be abandoned days later. It was not uncommon for “innocents”—women, children, and even entire villages—to be killed by American soldiers in the course
of combat. The Vietnam War often involved guerrilla warfare, with no front line behind which one could be reasonably safe, leaving all soldiers at risk, regardless of their jobs or positions.

The decision that soldiers would serve 1-year terms created a lack of cohesiveness and an environment of mistrust. There was a constant influx of new soldiers, who were “untested” and uncertain. Then there were those just waiting to finish their final weeks so they could return home, and who consequently were attempting to minimize their exposure to risks. The soldiers who were fortunate enough to complete their terms and leave Vietnam were faced with both joy at going home and a conflicting “survival guilt” as buddies were left behind (Sevy, 1989).

Alcohol and drugs including marijuana, heroin, and opium joints (“OJs”) were widely used in Vietnam among soldiers in combat. Many came home addicted, further complicating their ability to adjust to the responsibilities of the lives to which they were expected to return.

Unlike previous wars, daily television coverage of the Vietnam War brought the brutal reality of combat into America’s living rooms, not just selected stories of heroism and “proof” of the righteousness of the country’s actions. Most of the United States population did not support the war and viewed those who fought not as heroes, but as villains. Those returning were not received with parades. They were not welcomed home and never were “thanked” for their service. Indifference, hostility, and denial allowed no catharsis for the veteran (Sevy, 1989). Returning Vietnam soldiers often did not even receive support from older veterans. The United States did not “win” this war. Even veterans of previous wars would preach to returning Vietnam soldiers of the wars they had won (Sevy, 1989).

With the current involvement of the United States in military actions, the number of veterans (both men and women) of conflicts such as those in Afghanistan and Iraq can be expected to rise. In each era, soldiers have faced a variety of stressors during combat. In the current Iraq War, soldiers are killing with small arms on battlefields the length of a city block. There are concerns that the high rate of “close-up” killing in Iraq has the potential to traumatize a new generation of veterans (Baum, 2004).

Today’s soldiers also face terrorist tactics such as suicide bombings, risk of torture or execution if captured, and difficulty discerning apparent civilians from enemy combatants. In addition, those in military occupations that were relatively safe in past wars (e.g., truck drivers, mechanics, medical personnel) now face serious threats just as frontline soldiers do (Reeves, Parker, & Konkle-Parker, 2005). Still, findings show that even some of the most grievously wounded Iraq war veterans seem more disturbed by the killing they did than by their own injuries (Baum, 2004). A study has shown that approximately 16% of Iraq veterans suffer from depression or PTSD, but that fewer than 40% have sought professional help (Hoge et al., 2004).

End of Life

Psychiatric symptoms are highly prevalent in patients near the end of life (Feldman & Periyakoil, 2006). It can be challenging to make an accurate diagnosis and develop a treatment plan, especially when there may be multiple comorbid issues such as depression, substance abuse, personality disorder, delirium, and even chronic pain (Otis, Keane, & Kerns, 2003).

Long-forgotten traumatic memories can be triggered to resurface by escalating stress and reminders of trauma. With sufficient “priming” (i.e., the diagnosis of a terminal illness),
memories break into consciousness in the form of intrusive remembrance and flashbacks. This gradual priming process, which has been termed “kindling,” may explain the often delayed onset of PTSD (Allen, 1995). When symptoms of PTSD emerge at the time of death, the patient may need significant medical, psychosocial, and spiritual support for healing. This experience may also frighten families (Grassman, 2006).

The onset of PTSD can complicate the dying process in several ways. First, the threat to life inherent in terminal illness may mimic the original trauma, exacerbating previously mild PTSD symptoms and leading to significant distress. Second, when key memories are trauma related, the normal process of life review can lead to intense anxiety, sadness, guilt, or anger. Third, because avoidance symptoms are central to the diagnosis, individuals with PTSD tend to cope by avoiding or ignoring problems. This avoidance can lead to poor medical adherence and render problem-focused provider-patient communication difficult.

Fourth, distrust of authority can lead patients to excessive questioning of providers’ actions and even refusal to accept care. Finally, patients with PTSD may lack caregivers due to a history of social isolation and avoidance (Feldman & Periyakoil, 2006). Family and other involved caregivers may not be aware of the details of the veteran’s combat experience because the veteran may have never discussed those experiences with them.

**Treatment**

The most successful interventions for PTSD are cognitive restructuring, behavioral modification, and psychotropic medications. Psychotherapy oriented specifically to the effects of combat trauma can be helpful even years after the combat experience (Hendin, 1983). In a group therapy setting, veterans with PTSD may discuss traumatic memories and experiences with others who have had similar experiences, although the focus of such therapy is not to relive the war but to acknowledge its effect on the veteran’s life. Exposure therapy involves having the patient repeatedly relive the frightening experience under controlled conditions to help him or her work through the trauma (National Center for Post-Traumatic Stress Disorder Web Site, 2006).

When PTSD is exhibited in veterans at the end of life, treatment options are determined by the symptoms and the length of expected survival. Many of the standard treatments are not practically applied in the last few weeks of life, but there still are important considerations and interventions that can help significantly. In the event of long-standing PTSD, the veteran and family can provide valuable assistance to the medical team regarding specific approaches that have been helpful for them over the years.

In general, it is important to allow the patient as much control in the development of the treatment plan as possible. Approach the patient calmly and slowly, remaining in his or her field of vision (Kaiman, 2003). Provide clear explanations of all interventions and ensure the veteran’s understanding and consent (if possible). Do not use bed alarms or physical restraints for veterans, especially those who are former prisoners of war. Do not allow the patient to be positioned in such a way that he feels trapped or “boxed into” a room. Avoid startling, loud noises, and movies or television shows exhibiting war and violence. The sounds of helicopters or jets can prompt memories of combat. It is important to be sensitive to the fact that healthcare providers of Asian ancestry may trigger symptoms in veterans of the Vietnam and Korean Wars, as can those of German descent in veterans of World War II.
It is important to be willing to listen to these veterans’ stories, no matter how difficult they may be to hear. Veterans talk in both direct and symbolic ways about how an innocent went to war, what beliefs he held, what goals and dreams he had, what politics and values he upheld, what role models he followed, and how he imagined his future (Tick, 2005). You may hear a veteran say, “I left my soul in Vietnam” or Korea, or Iraq, or other sites of combat. Validate their experience and express your appreciation for their service to our country. Provide symbols of appreciation for their service in the form of certificates, pins, or cards. Support or provide ceremonies of recognition for Memorial Day, July 4th, and Veterans’ Day (Grassman, 2006).

Veterans also may share with you “confessions” of actions taken during wartime that they have not discussed with anyone before, not even their closest friends and family. They need assistance with the often difficult and prolonged process of forgiving themselves for these actions. A chaplain or member of their church or place of worship can be very helpful in this process.

Communication regarding combat experiences often is full of slang terminology and references to specific locales and battles, the significance of which may be lost on those with limited knowledge of the specific wars. Box 1 provides a limited list of common lingo of the Vietnam War. Far more extensive references are available on the Internet. Box 2 lists some sites of particularly brutal battles in the Vietnam War. Recognition of these references will help to facilitate understanding of the veteran’s experience in combat.

For patients with at least 1 month of life expectancy, antidepressants can be very effective in managing symptoms. However, it is important to remember that these types of medications have a delayed onset of effect. Two major classes of drugs effective in palliating PTSD for terminally ill patients are selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs).

Thought to alleviate the avoidance and numbing symptoms of PTSD, SSRIs are effective in relieving anxiety and panic symptoms, whereas TCAs are thought to alleviate intrusive symptoms as well as anxious and depressed affect. If TCAs are used, imipramine or desipramine are generally preferred because of their lesser anticholinergic effects (Feldman & Periyakoil, 2006).

For patients expected to live only days to weeks, the focus of care should be on rapid alleviation of distress and enhancement of comfort using medications with a rapid onset of action. For relief of PTSD symptoms such as agitation, hyperarousal, and hostility, short-acting benzodiazepines or neuroleptics can be used (Feldman & Periyakoil, 2006). Promethazine also has been effective for treating PTSD symptoms of dying veterans (Grassman, 2006).

Other classes of drugs that have been used to treat PTSD (although not approved by the Food and Drug Administration for this purpose) include clonidine, lithium, anticonvulsants for intrusive symptoms, low-dose risperidone for impulsive aggression and psychosis, and atypical antipsychotics such as olanzapine for psychotic episodes (Feldman & Periyakoil, 2006).

Summary
Nurses and other healthcare providers in almost all settings can expect to encounter military veterans. Awareness of the types of veteran experiences helps providers understand and effectively treat veterans’ physical, emotional, and spiritual health. These issues may become more pronounced in the face of terminal illness and the end of life, an already difficult period for patients and families. Recognition of the presence of PTSD is critical to providing appropriate, compassionate, and comprehensive care for the dying veteran and his or her family. Box 3 lists additional resources for the education of patients, family members, and providers.

Box 2. Sites of Brutal Vietnam Battles

- Khe Sanh: Operation Niagara
- My Lai
- La Drang Valley
- Dien Bien Phu
- Tet Offensive
- Hamburger Hill
- Operation Attleboro
- Hamlet of Ap Bac
- First Battle of Saigon
- Eastertide Offensive
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Joy A. Laramie, MSN, CANP, BC-PC, is a Nurse Practitioner at the Veterans’ Affairs Medical Center in Washington, DC, working in Hospice and Palliative Care and Long-Term Care. She received her BSN from Boston College in 1987 and her MSN from George Mason University in 1992. She is board certified as an adult nurse practitioner and in advanced practice palliative care.

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Address for correspondence: Joy A. Laramie, MSN, CANP, BC-PC, 4812 North 20th Place, Arlington, VA 22207 (e-mail: joylaramie@aol.com or joy.laramie@med.va.gov).

REFERENCES

Box 3. Additional Resources


Anxiety Disorders of America (Phone: 240-485-1001)
American Psychological Association (Phone: 800-964-2000)
National Alliance of the Mentally Ill (NAMI) (Phone: 800-950-6264)
VA Health Benefits Service Center (Phone: 877-222-VETS)