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Serving Our Older Veterans: Current Issues
and Best Practices



Introduction to the Research Articles in the Special Issue on Older Veterans

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Service in the military continues to be counted among those life experiences that run the risk of not being broached in exchanges between clients and helping professionals even though we know all too well it can influence in significant ways, and over a life time, an individual's physical and emotional well-being.

More than nine million strong, older veterans, for a multitude of reasons, may not take the initiative to tell elder care professionals about their past military service. Reasons for not raising the subject include an older adult's failure to tie an experience which occurred many years ago with their present day needs and concerns. Still others will avoid confronting their military past because of the emotional (and physical) pain that such memories can engender including the full gamut of unpredictable feelings, flashbacks, headaches, and even nausea. In addition, in part due to the complexity and changing nature of the system of veterans' entitlements, both older veterans and the professionals that serve them are likely not going to be aware of the vast array of resources and services that are available at the federal, regional, state, and local levels for those having served in the military. The result, in all too many cases, is that the older veteran and his or her spouse fail to benefit from a well-established and supportive infrastructure that has the capacity to dramatically improve their health and quality of life.

In this special issue of the New Journal of Geriatric Care Management, we devote ourselves to advancing a better understanding and appreciation for the enormous impact that military service to our nation can have on physical and emotional health and well-being in later life. At the same time, we want to emphasize how important it is that geriatric care managers make a concerted effort to address any and all issues surrounding the consequences of military service if that experience is perceived to be a potentially meaningful factor impacting on the aging experience of clients.

Kenneth Shay begins by setting the historical context of the U.S. Department of Veterans Affairs (VA). To be sure, Ken has an impressive understanding of this extremely complex and constantly evolving enterprise. The story he tells underscores how the VA has increasingly taking a lead in developing innovative strategies and caring approaches to serving veterans who now find themselves surviving into extreme old age.

Cliff Singer provides us with both an authoritative and succinct review of what we currently know about dementia risk factors in military veterans as compared to civilian populations. He addresses a range of topics including traumatic brain injury, post-traumatic stress disorder, depression, health-related risk factors, and preferred treatment strategies. He has assembled a comprehensive set of professional clinical sources to turn to for those who want to explore these topics further.

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Janis Petzel, a geriatric psychiatrist with extensive experience treating patients in VA facilities, provides us with a thought provoking article aimed at both encouraging discussion and informing your clinician–patient relationships. She draws liberally from literary works that depict the harsh realities of war as she shares with the reader what have been some of the most impactful experiences over the years for her personally.

While care management practice can be taxing regardless of the individuals and families you work with, Jennifer Middleton reminds us that working with older veterans can present practitioners with particularly stressful and traumatic situations. To be of maximum benefit to our clients we need to be mindful of and skillful at addressing secondary trauma and compassion fatigue in ourselves through self–care and promoting resilience.

Finally, Jennifer Crittenden provides an extremely helpful and timely summary of the latest resources and benefits available to older veterans and their spouses and where geriatric care managers can turn for help. Her efforts will, no doubt, be a great benefit to those on the front lines working with individuals who served their country in the military. You will also find practical tips on how to effectively serve this population.

I hope you find this collection of articles helpful in your professional practices.

Topics: Editor's and Guest Editor's Message, Veterans

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Journal

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Aging Veterans and the Department of Veterans Affairs

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Introduction

The US Department of Veterans Affairs (VA) is the current American embodiment of an ancient social pact, one that has existed in many forms since antiquity, between a society and those who go to war on its behalf. The pact is that in return for the soldier risking his (or her) life, society will care for an injured soldier, and sometimes his dependent family members, until death. In the era of Greek city-states and even the Plymouth Colony, average life expectancy for humans was four decades or less, and the number of individuals affected numbered at most in the hundreds. Now, as expectancy is more than eight decades and military service engages millions of individuals whose ages cover the full adult lifespan, the promise of lifetime care for former warriors has become an enormous, costly, complex, and largely elderly-focused health and support services enterprise. This article will describe the factors bearing on the evolution of VA's role in caring for aging individuals, the number and needs of the individuals affected, the challenges of planning for the needed services, and the processes at work to optimize the approaches available for addressing those needs.

Several terms require clarification for what follows. Because age 65 still marks eligibility for Medicare (the national health care insurance plan for "the elderly") and is a common trigger for discussions of retirement, the terms "elderly", "aged", and "aging" will variously refer to individuals of and beyond that age. "Geriatric" is a term derived from Greek roots for "old man" and "healer," and will be used to refer to health care for individuals, largely but not exclusively elderly, whose care needs stem from the interplay of a lifetime of acquired disabilities, one or more chronic diseases typically experienced in advanced age, and psychosocial factors. The "not exclusively elderly" is an important qualifier, for two reasons. First, many young veterans sustain sufficiently severe physical and brain injuries, which leaves them with daily care needs more typically encountered by non-veterans of very advanced age. Second, as a group, the care needs of a given age group of veterans is comparable to that of non-veterans who are 10-20 years older (Selim et al., 2004), which means geriatric care in VA is often needed by veterans less than age 65. As has already been noted, "VA" refers to the Department of Veteran Affairs. Its predecessor agency was the Veterans Administration but that name ceased to exist with the elevation of the program to its present Cabinet status in 1989.

Within VA are three sub-agencies: the Veterans Health Administration (VHA), Veterans Benefits Administration, and National Cemetery Administration. Signage and informal use, both by VA and non-VA entities, still often make reference to "the Veterans Administration" but that is technically a misnomer unless in an historical context. Finally, nearly every state in the US operates one or more "state veterans' homes", each with its own admission criteria (e.g., some admit spouses of veterans; some limit their services to veterans with war time service), and all receive substantial VA support for both new construction and operating costs. State veterans'

homes are not part of VA but are often confused with it by members of the public, who variously may refer to these state-operated facilities as “Veterans’ Homes,” “Veterans’ Hospitals”, or even “Veterans’ Centers”.

On a final introductory note, it is important to stress that VA is huge. Its over 330,000 employees make it the federal government’s second largest employer. Its budget in 2014 exceeded \$153.8B, of which more than a third (\$57.3B) was for VHA alone (VA Office of Budget, 2014). VHA’s infrastructure includes 150 medical centers, over 900 community-based outpatient clinics, 133 nursing homes, 46 Residential Rehabilitation Treatment centers and 232 Veteran’s Readjustment Centers. There are presently 21.6 million living veterans (individuals who have been honorably discharged from the Army, Navy [including Marines], Air Force, and Coast Guard), of whom 8.8 million are enrolled for benefits with VHA. More than 6 million of these annually seek care from VHA. Veterans range in age from 19 to over 100 years, with 42% of them currently age 65 and over and nearly 1.2 million aged 85 and above. Forty-seven percent of enrolled veterans are over age 65 and over 53% of VA patients are in that age group. Currently 8.6% of all veterans and 7.5% of enrollees are female. The region over which VA provides its services includes all of the continental United States (including Alaska), Puerto Rico and the US Virgin Islands; Hawaii, Midway, American Samoa and Guam; and an outpatient clinic in the Philippines (Veterans Health Administration Department of Policy and Planning, 2014).

The Making of Today’s VA

In 1864, President Abraham Lincoln took the first step in the development of a national system for care of veterans when he designated three sites to host facilities with that purpose, one each in Wood (now Milwaukee) Wisconsin; Togus, Maine (near Augusta); and Dayton, Ohio. He reiterated his intent the following year in his second inaugural address to the Congress on the eve of the Civil War’s end, in which he urged his countrymen “to bind up the nation’s wounds, to care for him who shall have borne the battle and for his widow and his orphan.” Prior to this time, fulfillment of the pledge to care for veterans had been a state responsibility and most states supported “veteran’s homes” or “old soldiers’ homes” for that purpose. Between 1865 and 1930 federal involvement in carrying for injured veterans from the Civil and Spanish–American Wars was first a responsibility of the U.S. Merchant Marine and then the U.S. Public Health Service (Committee on Veterans Affairs, 1967). Other federal agencies were charged with administering veterans’ pensions and providing housing for homeless veterans. These three missions were combined in 1930 into a consolidated, independent “Veteran’s Administration” that included a Department of Medicine and Surgery charged with operating its own health care facilities on behalf of veterans. Featuring spacious grounds and large wards, VA hospitals treated residents with substantial health and functional needs who might spend months or even years in care. Some wards—sometimes whole facilities—were devoted to caring for those with tuberculosis. VA patients whose infirmities left them unable or unwilling to resume care for themselves once their acute needs were addressed, were under little to no pressure to leave. When the influx of newly injured soldiers dwindled to a trickle, VA hospitals devolved into combinations of chronic care facilities (“nursing homes”) and residential supervised-living settings (“domiciliaries”) with only limited acute inpatient and little to no outpatient service.

After World War II, the sudden influx of millions of newly–returning and in many cases severely injured soldiers from Pacific and European theaters –a sizable, challenging subset of the over 16 million Americans who had served—quickly overwhelmed VA both in sheer numbers of patients and in their needs for extensive, complex medical services. Under the leadership of General Omar Bradley, Congressional support for veterans, which had already expanded before the end of the war to include the GI Bill to facilitate higher education for veterans and reduced-rate home mortgages to assist them securing housing for their young families, included authority to design and build up to 90 new VA hospitals. Although fewer than half that number were actually built, Congressional representatives (then and to this day) jockeyed for facilities on behalf of their constituencies, to “bring home” much-needed economic benefits in the form of multimillion dollar building contracts and sustaining employment opportunities.

Adequate numbers of appropriately-trained VA physicians, however, remained in critically short supply. In another far-reaching move of the post-war era, VA established the means for schools of medicine to affiliate with its hospitals, thereby supporting medical school class expansion through federal salary support of physician-educators. Veterans Affairs medical staff swelled as greater numbers of medical trainees could be overseen by new medical school faculty, themselves enticed into academic medicine through access to a large new pool of VA medical research funds. This arrangement was prescient, pervasive, and effective; by 1948, sixty schools of medicine participated in these affiliations and the figure in 2014 was 107. Presently nearly 60% of the physicians trained in the U.S. have spent at least some of their time doing so in VA settings.

As had happened after the initially high demand for VA medical and surgical services from World War I faded in the 1920s, the agency by the 1960s predominantly served those who had no other source of health care. Veterans Affairs began to be invisible to the public and its clinicians were looked down upon by the medical establishment. Injured returning soldiers from Vietnam found themselves in crowded and outdated facilities, cared for by indifferent staff insulated from personnel actions by the entrenched Civil Service bureaucracy. Medical trainees regarded the veterans as little more than objects on which to practice nascent medical skills. Fellow patients might just as likely be indigent and homeless veterans from World War II and Korea, as comrades-in-arms from Southeast Asia. Public ambivalence and even hostility toward the war effort stifled Congressional interest in addressing VA shortcomings portrayed unfavorably in the media.

Yet despite its shortcomings at points of care, VA survived and even prospered as a large government program through the 1970s and '80s. Non-profit Veteran Services Organizations (VSOs, e.g., American Legion, Veterans of Foreign Wars, etc.) and interest groups championing medical education allied to preserve annual VA support. Congressional representatives, mostly veterans themselves, could always be counted on to support (or at least not to publicly oppose) budgets for VA nationally that in turn maintained local facilities employing hundreds or thousands of voters. A candidate shaking the hands of veterans in wheelchairs or in parades always made for compelling photo coverage at election time. This support by interest groups, independent of what patients experienced, led in 1989 to the Veterans Administration becoming a new Executive Branch agency, the Department of Veterans Affairs (Light, 1991).

Cabinet status elevated visibility and as the Clinton administration (1992–2000) sought to reign in the federal deficit, all of government including VA health care experienced strong pressure to exercise fiscal accountability. Hospital stays that lasted weeks and months in VA were shamed by private sector care measured in days, and interest groups found it difficult to deny that billions might be saved if veterans' care was handled by the private sector. The Veterans Health Administration was thrust into a decade of careful tracking of workload, expenses, and quality that permitted fiscal modeling, budgeting, and appropriation requests based less on prior allocation and more on patient distribution, need, and services. Mindful that its survival depended on veteran preference for VA care over all alternatives, VA transformed from a health system dominated by inpatient service into one focused on ambulatory care; from one characterized by indifference to one committed to patient satisfaction and customer service. By the dawn of the new millennium, VHA was outperforming the private sector on most metrics of health care value (Longman, 2007) and, with the onset of extensive military activity in the Middle East in 2003, was soon experiencing all-time highs in reputation and veteran enrollment.

Elderly Veterans and the VA

In the early 1970s, leadership of the VA Department of Medicine and Surgery began to plan for the challenges they would face as the 13 million living World War II veterans aged into their seventies. "Geriatric medicine" or care of the elderly was a recognized medical specialty in the UK, but had little to no presence in the US. The VA health system, built on addressing severe acute injuries and serving as a social support system for chronically needy veterans, would soon be responsible for an unprecedented number of elderly veterans. In decades prior

the “age wave” that was similarly, but more slowly, looming for all developed nations as birthrates and infant mortality declined. The following section will describe unique aspects of clinical care for the elderly and some approaches VA employed, evaluated, and shared to identify and then address these differences through its systematic approach to geriatric assessment and focus on patient-defined outcomes (Shay and Yoshikawa, 2010).

In part due to VA medical research, one challenge of the aging veterans of World War II was that growing numbers of them were entering old age having survived diseases that would have been fatal for members of earlier generations. Those surviving heart attacks and strokes could count on living longer, although with congestive heart failure and paralysis. Some of these and others were aging with diabetes and hypertension and their various renal, cerebral and ophthalmic consequences. Many could be counted on to develop severe lung disease attributable to asbestos from ship-building and cigarettes issued by the military, contracting forms of cancer only seen in the elderly. Veterans of all ages were increasingly arthritic to varying degrees in part due to privations suffered in long marches, winter warfare and prisoner-of-war camps; and growing numbers were dealing with depression in addition to combat-related anxiety and other mental disorders.

Most alarming was that increasing numbers of longer-living individuals were experiencing unaccountable, irreversible deterioration of their mental faculties. This “senility” rendered many of the elderly increasingly dependent on others for basic functions, particularly the administration of medicine, eating properly, and attending to personal hygiene. Medical specialties with expertise in addressing individual disease states and treating particular organ systems had evolved through the twentieth century, but medicine had less familiarity in treating patients afflicted with combinations of disease, and little to no experience with the confusion, frailty, and general “dwindling” of advancing age attributable to no single disease or organ.

Veterans Affairs leaders undertook a bold preemptory move in 1975, when six VA sites with ongoing “geriatric and gerontology” research programs–collaborations with their affiliated medical schools focusing on aging and its health challenges –were designated as Geriatric Research Education and Clinical Centers (GRECCs). To their existing investigations they were given the added charge (and resources) to put their findings to use in developing new approaches for caring for those affected by those diseases; to teach the existing VA clinical workforce about those approaches; and to develop a new cadre of doctors, nurses, and other health professionals to become leaders in geriatric care. Congress endorsed this plan in 1980, authorizing up to fifteen such centers; in 1986 they expanded the authorization to 25. Since 1999 and presently VA has supported twenty GRECCs. Although the earliest U.S. training programs in geriatric medicine were started independent of VA, by the late 1970s, almost all American geriatric medicine fellowships were VA-supported, and mostly affiliated with GRECCs. As a result, more than half of the physicians with geriatric training in the US have received at least some of their training in GRECCs. It is reasonable to assert that an enormous proportion of geriatrics research, clinical training, and models of care in the US derive directly or indirectly from GRECCs.

Detailing the many contributions of GRECCs is beyond the scope of this paper, although interested readers may want to review Supiano et al., 2013 to learn more. But the aggregate of years of GRECC developments had begun to make clear by the mid-1980s that care for elderly persons (including veterans) needs to differ from other medical specialties in that its goal is not to cure but rather to optimize and preserve function and quality of life in the face of age and concurrent illness. To attain that goal requires more than the physician alone can provide. It requires a multidisciplinary geriatric team because the assessment and plan for care must extend beyond strictly medical considerations to include factors of patient preference, self-care, living status, nutrition, medications, family involvement, mental health, and function. This approach evolved from early work of Dr. Marjory Warren in British long term care hospitals in the 1940s (Warren, 1946). Warren noted that many of her elderly patients were unable to return home because even brief hospital stays quickly rendered them bedridden due to inactivity, disorientation and sleep deprivation in the unfamiliar setting, along with depression, and bouts of infectious disease. Warren found that, if she focused her efforts on maintaining or

restoring function even while addressing illness, many more patients were able to return to the community rather than becoming consigned to living the remainder of their lives cared for by nurses in an institutional setting. Warren's approach had not originally been subjected to systematic study but the creation of GRECCs and the new training programs in geriatrics provided the right settings and personnel to do so—and the challenge presented by millions of aging veterans was the right incentive.

Several GRECC-based randomized controlled trials (e.g., Rubenstein et al., 1984; Cohen et al., 2002) established the worth of comprehensive geriatric assessment (CGE), Warren's systematic, multidisciplinary identification and management of the factors—medical but also social and environmental—responsible for each older patient's diseases and disabilities. Prior to GRECCs, VA nursing homes—and actually most nursing homes in the US—were populated by thousands of elders who initially hospitalized for discrete medical conditions, became deconditioned due to inactivity in the hospital and delirious from dehydration, infection, bedsores, and overmedication, making discharge home inadvisable or impossible. Adoption of CGE VA-wide to instill the practice of CGE in specialized “Geriatric Evaluation and Management (GEM) programs” seemed a wonderful approach for coping with the “tidal wave” of World War II veterans.

In the 1980s, the VA's Office of Geriatrics and Extended Care overcame resistance from more traditional, specialty-based medical interests and implemented GEM programs VA-wide. “Interdisciplinary Team Training in Geriatrics” (ITTG) programs provided onsite instruction and skills-building in team-based CGE. But when heightened focus on VA fiscal accountability arose in the early 1990s as described previously, positions associated with GEM and ITTG, still not fully embraced by many physician leaders, were easy targets for cost-cutting. By 2003, GEM was available in less than one in three VA medical centers. Yet the lessons of GEM had definitely impacted not only VA but U.S. nursing home practice as well. Veterans Affairs facilities possessed staff experience and infrastructure for assessing and then establishing plans of care for nursing home admissions, focusing rehabilitative and restorative efforts on veterans who then were more likely to return to less restrictive settings. In the private sector, Medicaid reimbursement increasingly grew to be contingent on periodic detailed assessments of nursing home residents (e.g., the Minimum Data Set, developed partially in GRECCs) to establish, implement, and track restorative plans of care and hasten discharge to settings of less restriction and greater independence.

Reduced permanent nursing home placement created a need for programs both in and outside VA for assisting frail elders and their caregivers in the community. A variety of non-institutional approaches to extended care had been demonstrated in GRECC and other settings to be safe, effective, preferred by patients and families, and more cost-effective than nursing homes. But since established VA nursing homes still had to be staffed and maintained, VA leaders' will to offer one or more alternative long term care programs was initially mixed. Then in 1999, the Veterans Millennium Healthcare and Benefits Act (Congress's “Mill Bill:” U.S. Congress, 1999) directed all VHA settings to offer a menu of VA-developed and proven alternatives to nursing home care services (including GEM, Home-Based Primary Care, Respite Care, Adult Day Health Care, Purchased Skilled Nursing and Purchased Homemaker/Home Health Aide care) to all enrolled veterans who stood to benefit from them.

The legislation was in direct response to a report commissioned by the VHA under Secretary of Health to compare VA's long term care practices to those supported by Medicaid (Federal Advisory Committee on the Future of VA Long-Term Care, 1998). The panel noted that about 4% of VA's long term care (LTC) budget was devoted to non-institutional forms of care, whereas Medicaid spent about 12% of its LTC budget nationally on the more cost-effective, less restrictive non-institutional models. The Mill Bill was intended to address this discrepancy, and as of 2014, VA was devoting about 12% of its LTC budget for that purpose. Yet by that time Medicaid's expenditures for the less restrictive services had grown to more than 40% of its LTC budget. Veterans Affairs is currently developing and implementing a range of new programs, incentives, and tracking mechanisms to bring VA into parity with Medicaid, although a constant challenge for VA is annually anticipating

its budgetary needs: only about 43% of veterans are enrolled with VA; only about two-thirds of those will use VA healthcare in a given year, and over 70% of veterans using VA services also seek and obtain some or much of their health care from other sources (Gardner and Hendricks, 2004).

At the beginning of the 21st century the geriatrics-derived focus on function and patient preferences rather than providers' drive to cure disease at all cost led to the growth of "palliative medicine"—care directed to optimizing patient well-being and comfort. Palliative care initially gained the greatest acceptance for patients facing death, whose final days and weeks had routinely come to be spent in intensive care units, undergoing escalating combinations of procedures that only postponed the inevitable yet subjected patients to discomfort and health systems to enormous costs. Veterans Affairs was a leader in the growth of palliative care (Shreve, 2010), both as a set of clinical programs and through retraining opportunities for clinicians from many disciplines. End of life care for veterans is now widely offered in VA settings as well as through a large and growing network of community hospice partnerships motivated to honor veterans' service by easing closure for them and their loved ones.

Despite VA's historic focus on extended care options for elderly veterans, most VA care for patients of advanced age is actually delivered through primary care, termed "Patient-Aligned Care Teams" (PACT) in VA. PACTs are charged with coordinating regular "wellness" visits and specialty services, and usually consist of a team of an MD or nurse practitioner, a registered nurse, a health technician, and clerical staff. PACT was introduced into VHA in 2010 and reflects the same attention to health education, the role of the home and family, and prevention of future problems that is a hallmark of geriatrics. Because training focused on geriatrics is not a customary part of most doctor's education, veterans with particularly significant geriatric needs, like interacting complex diseases, dementia, or complicated pharmacy regimens, are increasingly treated by a special "Geriatric PACT" staffed by clinicians who do have advanced expertise in addressing the particular concerns more likely to arise in such a patient population (Shay and Schectman, 2010).

Ger iPACT, or the equivalently-focused services it comprises, has actually been offered at VHAs longer than PACT, but it is still not available everywhere in VA, for the simple reason that there simply are not enough personnel in VA with that expertise. Geriatric practice as a specialty in the US is in most cases dependent almost wholly on Medicare payments, and the reimbursement to doctors for the sort of care coordination and education that are central to geriatric practice make it extremely challenging for doctors who exclusively treat the elderly to earn a living wage.

As a result, the number of geriatricians in the US has been slowly shrinking, despite the increasing proportion of the population that is aging and could best benefit from geriatric care (Committee on the Future of Health Care Workforce for Older Americans, Institute of Medicine of the National Academies, 2008). Physician salaries in VA don't rely on Medicare collections, but they are indexed to what doctors make in the private sector, so there is little incentive to pursue geriatrics as a specialty even if one intends to work for VA. The result of this is that geriatric specialists in VA are generally called on to educate colleagues about the particular needs of their oldest and most complex patients, in addition to following their own panels of very old veterans.

Concluding Remarks

It should be apparent from the preceding comments that VA is a very large, complex, and constantly evolving enterprise. Veterans Affairs' commitment to serve those who were willing to put their lives at risk for their countrymen has never wavered, but the challenges of an enormous governmental organization that has to be responsive to changing demography, shifting societal priorities, political forces, and technological improvements are numerous, complex, elusive and daunting. Nevertheless, VA has made an enormous, positive mark on the health and health care of all older Americans through its decades of effort on behalf of aging veterans, and undoubtedly will continue to do so for decades to come.

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Topics: Dementia, Veterans

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Dementia Risk Factors in Veterans

Clifford M. Singer, M.D

There is a dramatic increase in the prevalence of dementia among veterans. Because of the aging of the veteran population and a high prevalence of dementia risk factors among veterans, it is estimated that there will be 423,000 new cases of Alzheimer's disease and other dementias among military veterans in the decade ending in 2020 (Veitch et al., 2013). Over 25% of these new cases of dementia will be associated with specific military factors, especially traumatic brain (TBI) and post-traumatic stress disorder (PTSD). This paper reviews what is currently known about dementia risk factors in military veterans as compared to civilian populations.

Traumatic Brain Injury

Estimated prevalence of TBI

As a result of the high frequency of blast injuries and improved acute medical and surgical care in the field, veterans of recent wars have survived serious head injuries in greater numbers than ever before. In a survey of Operation Iraqi Freedom veterans from two brigades (Hoge et al. 2008), 15% had sustained a traumatic brain injury (TBI) either with loss of consciousness (LOS) or change in mental status. Using direct clinical evaluation of U.S. veterans of Iraq, Terrio et al. found 22.8% had suffered TBI, although most were mild (Terrio et al., 2009).

Persistence of Symptoms after Mild or Repetitive TBI

There are few data to inform us of how frequent persistent cognitive problems are after mild TBI (Chapman, et al., 2014). Data from a large Swedish data base of both military personnel and civilians of people sustaining TBI confirm that most head injuries are mild, but many people sustain multiple mild TBI over time, which may be far worse in terms of long term outcomes than single injuries (Nordstrom, et al., 2014). There is naturally less objective evidence of injury in mild TBI; no or only brief loss of consciousness, no edema or bleeding visible on neuroimaging, vague symptoms and varying levels of mood and cognitive symptoms. Yet, Lange et al. found that 20–48% of people with mild TBI experienced neuropsychiatric symptoms at least three months after the injury (Lange, et al., 2012). The symptoms included headache, dizziness, fatigue, irritability, insomnia, decreased concentration, memory impairment, and depressed mood.

Mechanism of Injury in TBI

Direct forces may cause tissue laceration, hemorrhage, and contusion. The opposite pole of the brain may also be damaged through impact with the bony skull as the brain moves within the cranium. Indirect damage occurs through acceleration and de-acceleration. G-forces may also injure the brain diffusely through shearing forces that stretch neurons and fragile blood vessels. Improvements in military and emergency medicine in the field saved the lives of thousands of soldiers who would have likely died in previous wars, leaving them to live with the persistent sequelae of severe head injuries. Tragically, these immediate effects of TBI are only the beginning for many individuals. There can be secondary effects of the initial injury that initiate processes of inflammation and cascading processes that lead to progressive neurodegeneration and dementia.

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Progressive Dementia after TBI

Chronic Traumatic Encephalopathy (CTE) is the term often applied to the condition of progressive cognitive decline (dementia) seen in some individuals after both single and repetitive head injury. Three stages of CTE symptoms were initially described in boxers: Stage 1 with mood and perception disturbances; Stage 2 with more pronounced emotional lability, impulsivity, poor judgment, memory impairment, slowed thinking, and early neuromuscular symptoms (Parkinsonism); and Stage 3, with cognitive impairment severe enough to be called dementia, along with more pronounced Parkinsonism (tremor, muscle rigidity and slowing of gait and movement) (Corsellis et al., 1973).

In more recent work, investigators have described four stages with more detailed neuropathological findings: Stage 1 with initial disruption of delicate blood vessel networks in frontal cortex and early white matter (myelin) abnormalities in deep brain (subcortical) regions. Stage 1 damage may be accompanied by vague symptoms of headache and disturbances in attention and focus. Stage 2 shows more pronounced abnormalities in neuronal axons in temporal lobes, accompanied by more pronounced psychological changes. In Stage 3, there are “macroscopic” changes visible with normal neuroimaging studies (brain CT or MRI), such as global cortical atrophy and more obvious white matter disruption. Increasing and measurable neuropsychological deficits in memory, executive function, and visuospatial function are present along with increasing impulsivity and emotional lability. Finally, in Stage 4, progressive atrophy is seen on brain imaging along with more extreme cognitive and psychiatric disorders (McKee, et al., 2013). Not all the psychiatric symptoms are due to structural brain damage; PTSD is likely an important factor in the mood and anxiety symptoms of CTE (Chapman & Diaz-Arrastia, 2014). TBI may also increase risk for stroke later in life, yet another risk factor for dementia (Burke, et al., 2013). Finally, TBI increases risk for depression, PTSD and brain deposition of beta-amyloid protein, all three of which are associated with increased risk of dementia, including dementia from Alzheimer’s disease (Byers & Yaffe, 2014).

Post-Traumatic Stress Disorder (PTSD)

PTSD and Dementia Risk

Post Traumatic Stress Disorder is a chronic and severe anxiety disorder that can occur in people exposed to serious injury, violence, or threat of death or violence (DSM 5, 2013). It is diagnosable in 22% of Iraq and Afghanistan veterans entering the VA health care system (Seal, et al., 2009). It is known that PTSD increases vascular risk factors, such as hypertension, hyperlipidemia, and diabetes in veterans (Cohen, et al., 2009). Dysregulated stress response with chronically activated sympathetic nervous system tone also increases cardiovascular risk, especially of hypertension, and therefore may accelerate cognitive aging (Levine, et al., 2014). Having been a prisoner of war (POW) appears to increase risk of developing dementia, but also increases risk of developing PTSD. Veterans with PTSD who were POWs may have an especially high risk of dementia in late life (Meziab et al., 2014).

Like depression, PTSD is associated with smaller volumes of the hippocampus, a brain structure that is key to processing memory and emotions. Also like depression, PTSD increases production of cortisol, a stress hormone that impairs normal repair and regeneration of the hippocampus. That may be the reason combat veterans with PTSD have smaller hippocampal volumes and memory deficits compared to age-matched controls (Bremner, et al., 1995). However, in a classic cause versus effect debate, it is not yet clear whether people with PTSD, on average had smaller hippocampal volumes to begin with. That is, reduced hippocampal size occurring as part of normal childhood brain development may predispose one to PTSD, rather than the smaller hippocampal volumes being the result of damage and atrophy from chronic stress (Weiner, et al., 2013). There are also genetic risk factors for PTSD that also increase risk for dementia (Weiner, et al., 2013). Thus, although we know that PTSD is associated with increased risk factors for dementia, we don’t yet know for certain that PTSD increases risk for late life dementia, or whether PTSD and dementia just share common risk factors.

Current research is aimed at answering these and other questions regarding the degree to which PTSD accelerates cognitive aging and specifically, whether it increases risk of developing AD (Weiner, et al., 2013).

Depression

Depression and Dementia

There is considerable evidence showing that depression increases the risk of dementia in older adults (Byers & Yaffe, 2014). An increased risk of dementia in old age from both minor and major depression has been shown to be true for veterans, as well (Byers, et al., 2012). The relationship between depression and dementia is complex and understanding associated risks can be challenging, since depression can cause cognitive problems and dementia can cause depression (Byers & Yaffe, 2014). Depression is common in people with dementia, occurring in about 20% of persons with Alzheimer's disease and 50% of people with vascular dementia (Byers & Yaffe, 2014). However, depression itself increases risk for dementia. Major depression and Alzheimer's disease have several underlying mechanisms in common. Depression, for example, increases risk for cardiovascular disease. Vascular disease, such as atherosclerosis and small strokes can cause cognitive impairment and dementia. Vascular disease can also affect mood, motivation, and behavior to create a syndrome of "vascular depression" that is one form of mood disorder in older adults. Older veterans tend to have high rates of vascular disease and likely have higher rates of vascular depression. Depression itself increases risk for stroke and hence, dementia (Liebetrau, et al., 2008). Impaired blood flow to the frontal lobes and their connections to deeper (subcortical) brain regions are thought to contribute to some of the symptoms depression and dementia have in common: impaired executive function, cognitive slowing, motor slowing, and resistance to antidepressant treatment (Alexopoulos, 2006).

The Syndrome of "Pseudodementia"

The term "pseudodementia" has been used to refer to the syndrome of depression-caused cognitive impairment. The term is commonly used by clinicians when cognitive impairment is attributed to depression but appears much like the dementia of Alzheimer's disease (AD). Some may argue that there is nothing at all "pseudo" about the cognitive impairment of depression, since it can be as debilitating as neurodegenerative dementia and may better be referred to as "dementia of depression". In fact, dementia of depression may represent an early phase of a degenerative process such as AD, even though the cognitive impairment does improve as the depression lifts. But while depressed, older adults may experience many of the same symptoms seen in persons with AD, vascular dementia and other old age dementias: impaired attention, working memory, processing speed, and dysfunction in activities of daily living. (Steffens DC and Potter GG 2008) Whether or not the depression simply "unmasks" the incipient dementia or accelerates its development through shared mechanisms is uncertain. (Byers AM et al. 2012)

Potential Mechanisms Linking Depression and Dementia in Veterans

Depression increases the output of the stress-related hormone, cortisol, which impairs the regenerative capacity of the hippocampus. This is thought to be one factor in the hippocampal atrophy seen in people with histories of severe depression. (O'Brien et al. 2004; Videbach & Ravnkilde, 2004) The hippocampus is essential for new learning and memory and hippocampal atrophy is associated with impaired memory and ultimately with developing dementia. (Byers & Yaffe, 2014) A history of depression has been found to increase density of the microscopic elements in the brain that define the presence of Alzheimer's disease (neurofibrillary tangles and amyloid plaques). (Rapp MA et al. 2006) Increased inflammation in the brain of depressed people has been documented and is thought to contribute to the neuronal damage that accelerates cognitive decline. (Maes et al., 2009) Finally, depression appears to decrease the production of brain chemicals ("neurotrophic factors") that are necessary to maintain brain health, memory and learning ("neuroplasticity") (Byers & Yaffe, 2014).

We've already discussed the relationship of TBI and dementia, but TBI also increases risk for depression, thereby increasing dementia risk by another factor. Depression appears to increase the cognitive impairment of

veterans who have suffered TBI (Vasterling et al., 2012).

Health-Related Risk Factors

In a study of veterans receiving care in the VA system, 16% of patients had diabetes and 37% had high blood pressure. (Yu et al., 2003). Between 25 and 36% veterans have high cholesterol or triglycerides (Richlie et al., 1991). These chronic health conditions increase risk for both vascular dementia and Alzheimer's disease later in life (Yaffe et al., 2014). High blood pressure through the middle age years may be particularly risky for more rapid cognitive decline in later years (Sharp et al., 2011; Power et al., 2011). High cholesterol levels increase risk for heart disease and stroke, but may also accelerate the development of dementia from Alzheimer's disease (Shepardson et al., 2011).

Adult onset diabetes (Type II), which is increasing in prevalence, has long been known to increase dementia risk, including dementia from both stroke and Alzheimer's disease (Ott et al., 1996; Profenno et al., 2010). The risk may even be greater in those treated with insulin: poor diabetes control is typically associated with elevated blood sugars, but episodes of low blood sugar (hypoglycemia) from excessive insulin dosing may also lead to cognitive decline (Yaffe et al., 2012; Fox & Kilvert, 2014).

Diabetes risk is increased in obese individuals, and fat tissue itself may increase risk of dementia because of the secretion of pro-inflammatory proteins that accelerate brain aging (Zeki & Hazzouri, 2012). Similar to the general population in the US, more than half of veterans are overweight and one-quarter meet criteria for obesity (body mass index ≥ 30) (Almond et al., 2008).

A significant minority of veterans (25%) have several of these cardiovascular and dementia risk factors, a combined disorder called "metabolic syndrome" (Keane et al., 2009), which is also thought to accelerate cognitive decline (Misiak et al., 2012). The prevalence of cardiovascular risk factors and metabolic syndrome may be especially high in veterans with mental health disorders, such as depression and PTSD (Yaffe et al., 2014).

Health-Promoting Lifestyle

Several health-promoting habits have been associated with reduced dementia risk. Physical activity, a healthy diet, social contact, adequate sleep, minimal or moderate alcohol intake, and minimal tobacco use have all been shown to reduce risk of dementia later in life (Yaffe et al., 2014). Veterans without mental health problems generally do as well (or as poorly) as the general civilian population with regard to lifestyle habits that promote healthy brain aging, but that still means that large numbers of veterans lead sedentary lives, eat diets rich in animal fats and high glycemic foods and deficient in antioxidants and anti-inflammatory nutrients (e.g. omega-3 fatty acids), are socially isolated, suffer sleep disorders, and drink and smoke too much.

Providing Services for Veterans at Risk for Dementia

Veterans with histories of TBI, depression and PTSD, especially those over 60, should be routinely screened for cognitive impairment and declines in activities of daily living. They should receive counseling and support in lifestyle changes that may reduce their risk of developing dementia. Theoretical projections of the effects of increased physical activity and reductions in other cardiovascular and cognitive risk factors on dementia incidence suggest that such efforts may prevent many cases (25%) of dementia in the future (Barnes & Yaffe, 2011). These theoretical estimates are being tested in programs that promote healthy lifestyles in both veteran and non-veteran populations to determine impact on cardiac and dementia risk (Yaffe, 2014). Once cognitive impairment develops, veterans need expert assessment for accurate diagnosis and multidisciplinary interventions to keep them safe and reduce excessive disability from medications and co-morbid health conditions. Active case management has been found to reduce caregiver stress and patient readmission to hospital (Robert Wood Johnson Foundation Report, 2012). Treating symptoms related to dementia in veterans

with co-morbid TBI, PTSD and depression can be especially challenging and requires rapid response and coordination among discipline within the medical and social service communities.

References

Article References

Topics: Dementia, Post Traumatic Stress Disorder (PTSD), Veterans

One thought on “Dementia Risk Factors in Veterans”



1. Patricia J. Lim, PsyD says:

March 25, 2018 at 12:22 pm

Excellent article I plan to share with psychology and social worker students!

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Journal

Serving Our Older Veterans: Current Issues
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How is Caring for Veterans Different than Caring for Elders in the Wider Community? The View from Geriatric Psychiatry

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Introduction

This article is written from the perspective of my work as a geriatric psychiatrist in a rural state (Maine). Because physicians trained in geriatric psychiatry are sparse here, I have had the opportunity to see patients in multiple settings across the spectrum of care, including VA facilities, community hospitals, nursing homes, and in a private practice. The goal of this article is to provoke thought and discussion, and one hopes, to enrich a wide range of health and mental health practitioners' clinician-patient relationships.

One of the big differences in caring for aging patients at the VA rather than in the community at large is of course, working within the huge VA bureaucracy. Administratively, the VA has a centralized, top-down organization. This structure works well for global functions such as efficient pharmacy services or the development of the VA's excellent system of electronic medical records. However, as recent scandals in the news demonstrate (i.e. some VA hospitals were found to have deliberately produced fraudulent claims about providing timely access to care for veterans), the push to meet goals set from on high in a bureaucracy can lead to uncomfortable or twisted outcomes at the local level (New York Times, 2014).

With that said, it is worthwhile reviewing what the VA does better than the wider community: providing services to aging patients. The VA provides transportation, has developed Medical Foster Homes, Home Based Primary Care, Day Programs, Geriatric Assessment Services, Respite Services, Hospice and Palliative Care and Burial Services, as well as some nursing home care and a dedicated geriatric research program.

As good as the geriatric services are at the VA, there are major gaps in the care continuum for older veterans. There is no assisted living or boarding home level of care, for example, and only certain veterans are eligible for admission to nursing homes paid for by the VA. After having received care at the VA for most of their adult lives, many veterans (and their families) are shocked to find that they are on their own to find residential placement.

Given the ratio of men to women in the armed services during World War II (WWII), the Korean Conflict, and Vietnam, it's not surprising that there is a preponderance of male patients in VA geriatric services. In the VA, it can be rare to have a female veteran appear in one's outpatient geropsychiatry clinic, and even more rare in a residential care setting. In contrast, about 70% of community nursing home residents are female (Houser, 2007). As the rules of combat change to include women, that reality will slowly change. Care professionals and family need to take into account the clinical consequences of placing survivors of Military Sexual Trauma into

an environment that is overwhelmingly male. The residential environment also needs to respect LGBT veterans, given the Military's reluctance until relatively recently to accept openly gay soldiers.

In terms of residential arrangements, the older wards that house two to four veterans in a large room are giving way to smaller rooms with more privacy as facilities are re-modeled. Even as privacy and confidentiality improve, echoes of the camaraderie veterans felt during their military service will fade (for a description of the comforts of old style wards, please see the book, *God's Hotel, A Doctor, A Hospital and a Pilgrimage to the Heart of Medicine* by Victoria Sweet (2013)).

In addition, the unbalanced gender environment does lead to challenging clinical situations. Except for visitors, the world on a VA residential unit is divided up for the most part into (male) patients and (female) nursing staff. As more men enter the nursing field, this balance is changing, but sexual dynamics and frustrations can lead to conflicts and behaviors that require professional consultation.

In large units with very little privacy, patients have no ability to have their need for intimacy (emotional or sexual) met in any practical way. Given expanding lifespans, patients can live for more than a decade in residential settings with no access to sexual outlets of any type. Frustration and declining executive function may lead to acting out or inappropriate touching of staff (or other residents). After long association, patients may propose relationships or act on "crushes" out of genuine affection. This kind of situation needs to be handled with tact, rather than accusations of sexual misconduct on the part of the veteran. Unfortunately there is no good therapeutic solution to solve the dilemma of sexual frustration in these residential settings that I am aware of.

In addition, geriatricians and psychiatrists are frequently consulted to medicate patients who would be much less likely to be having violent interactions with others if the environment was set up differently. Even if older units get remodeled, the basic structure still typically involves long, institutional hallways. I have witnessed male residents with dementia pacing opposite sides of a corridor, getting more and more hostile toward each other as they pass. If they both happen to get stuck at the end of the hallway, or one drifts across into the path of the other, fights sometimes occur.

Institutional design can also create clinical dilemmas. Staff and patient safety are involved if violence erupts, so something needs to happen, but using "chemical restraint" is unethical and may have deleterious effects. Budgets frequently do not allow for needed staff let alone new or more effectively designed units. Usually, working with staff and nurse managers, a non-medication intervention can be devised to keep feuding patients apart or to protect a nurse from a patient's lack of boundaries

Alcohol abuse is much more prevalent in veterans later admitted to nursing homes compared to residents of community nursing homes. In fact, a substance abuse history increases the risk that a veteran will need nursing home placement. Per Lemke and Schaefer (2010), 1.4% of community nursing home residents have a substance abuse history. In veterans, it's 15-18% of those over 55 years old. Statistically, veteran nursing home residents with substance abuse histories tend to be younger, more likely to smoke, more mobile, to be verbally disruptive, and to have serious mental illness including PTSD than those without substance abuse histories.

The biggest difference in working with veterans compared to patients in the community is their combat exposure and high risk for PTSD. Post-Traumatic Stress Disorder is also an issue for elders in the community, but tends to be less obvious and more likely to be related to having experienced childhood abuse or domestic violence. Even though childhood abuse survivors were also potentially put into emotional double binds by their experiences, there is a difference in the late life issues of having survived violence vs. having been made to perpetrate it as veterans were trained to do.

Post-Traumatic Stress Disorder is a tricky thing. Combat exposure definitely increases the risk of developing PTSD, but it sometimes does not emerge until late life. In combat veterans, there is a sort of “bulge” in diagnosis of PTSD through the first three years post-combat, and almost as big a bulge 20 years later. Close to 17% of veterans had PTSD emerge for the first time later in life as reported by Horesh et al. (2013). The emergence of PTSD symptoms in late life (after retirement age) has been noted to correlate with the onset of dementia (Johnston, 2000).

These symptom delays may be biological, as the dementing brain seems to go backwards in time through old experiences. Some of it may be Ericksonian, as retired or aging veterans review their lives. There is a phenomenon called LOSS, or Late Onset Stress Symptomology, which is not the same as PTSD. It tends to happen in veterans who, although they had exposure to high stress combat, functioned well after they returned from their military service and into middle age. LOSS tends to come on with a major life event (e.g., retirement) and involves increasing combat related thoughts and reminiscence (Potter et al., 2013).

For some, increasing physical disability recalls experiences of being wounded or helpless—the old terrors return. Providing comfort measures for the physical symptoms may help put those terrors back to rest. For example, a long time patient, Mr. R, who as a young soldier had been hospitalized for 18 months after a near-fatal chest wound, began having nightmares and flashbacks of his buddy bleeding to death in his arms on a battlefield (the same battle where he himself was also critically wounded). The emergence of these troubling symptoms correlated with his increasing physical pain and shortness of breath as his body aged and he developed kyphosis. So those were the symptoms we treated to ease his PTSD: the gero-psychiatry clinic helped get this man a hospital bed, and coordinated with his primary care doctor to get him lidocaine ointment to put over the area of his scar. Once he could sleep without pain, the nightmares and flashbacks abated.

Based on my clinical work with veterans, most returning veterans kept and continue to keep their war experiences to themselves. Even we, their therapists and doctors, may never know what they truly experienced. In *War is a Force That Gives Us Meaning*, Chris Hedges writes “Many of those who set out to write their memoirs, or speak about the war, do so with shame. They know war’s perversion. It corrupts nearly everyone. To be greeted by an indifferent public, by people who would rather not examine, in the end, their own darkness, makes the effort Herculean. After each war some struggle to tell us how the ego and vanity of commanders leads to the waste of lives and needless death, how they too became tainted, but the witnesses are soon ignored. It is not a pleasant message.” (p.115–116)

When the War in Iraq started, it was remarkable how many of my patients, WWII and Korean veterans for the most part, spontaneously expressed anger at our country’s leaders for starting that war. They did not want young men to have to go through what they had endured. Images of the new war on television brought them in to the clinic with their own terrible memories.

Combat is the ultimate double bind, kill or be killed. There is also the possible shocking self-knowledge that war was the high point of one’s life, or guilt or shame that the idea of killing was enticing at some level. Hedges posits:

“The enduring attraction of war is this: Even with its destruction and carnage it can give us what we long for in life. It can give us purpose, meaning, a reason for living. Only when we are in the midst of conflict does the shallowness and vapidness of much of our lives become apparent...And war is an enticing elixir. It gives us resolve, a cause. It allows us to be noble...” (p. 5)

Soldiers may have acted counter to their core values during their military service, actions which may later come back to haunt them:

“...The myth of war entices us with the allure of heroism. But the images of war handed to us, even when they are graphic, leave out the one essential element of war—fear. ..[I]t takes the experience of fear and the chaos of battle, the deafening and disturbing noise, to wake us up, to make us realize that we are not who we imagined we were...” (p. 83)

“...In the midst of slaughter the only choice is often... between hate and lust. Human beings become objects, objects to extinguish or to provide carnal gratification. The widespread and frenetic sex in wartime often crosses the line into perversion and violence. It exposes the moral void. When life becomes worth nothing, when one is not sure of survival, when a society is ruled by fear, there often seems only death or fleeting, carnal pleasure.” (p.167)

Working with veterans makes us confront our feelings about War, and our feelings about those who chose to go to war. For example, my father and all of my cherished uncles were veterans, so our family celebrated their service and survival. In contrast, I came of age at the end of the Vietnam War, so my formative years were very focused on the Anti-War movement. Ultimately, the military-like structure of the VA was uncomfortable enough for me that I went back to community practice.

Obviously, people who have served their country are entitled to and deserve the best in medical care and rehabilitation. They aren't the ones who started the wars. While war creates a double bind for us on a societal and individual level, acknowledging this dilemma may help us act to prevent further war and casualties—essential to begin to break the cycle of trauma. We as healers and therapists have to ask ourselves: what is the best way to serve our patients?

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Article References

Topics: Dementia, Post Traumatic Stress Disorder (PTSD), Veterans

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Addressing Secondary Trauma and Compassion Fatigue in Work with Older Veterans: An Ethical Imperative

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“The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet.” –Dr. Rachel Remen

This quote comes from a book by Dr. Rachel Remen, *Kitchen Table Wisdom*. Dr. Remen is a physician and was one of the first women chosen to be on the faculty at Stanford Medical School, and has since retired and taken up a second career as a natural healer in California. Dr. Remen’s quote eloquently illustrates the inevitability of compassion fatigue, especially for those in the helping profession. Consistent with the theme of this special issue, understanding and preparing for work with older veterans experiencing trauma, requires geriatric care managers to be mindful of the stressors which require their attention and the development of strategies which support their resilience.

The purpose of this article is to note the implications of ‘helping’ for the geriatric care manager; specifically, I focus on the secondary traumatic stress and compassion fatigue. Awareness regarding the inevitability of occupational stress phenomena such as compassion fatigue is an important first step in building resilience among helping professionals who work with long-term survivors of trauma. However, it is first important to clearly define these occupational stress phenomena.

Terminology

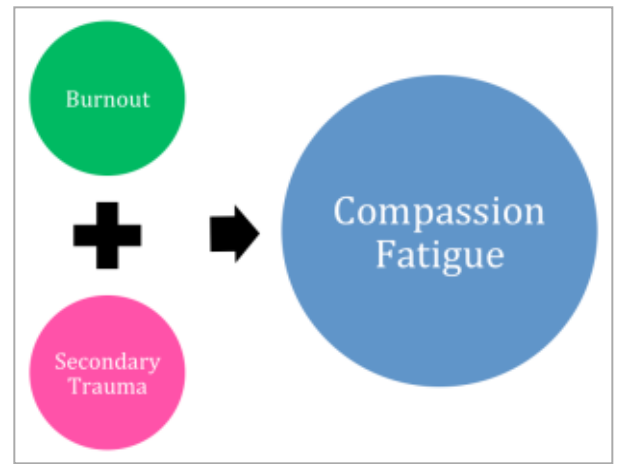
The occupational stress of helping professionals serving traumatized populations is a significant workforce issue for human service organizations. Terms to describe this phenomenon are varied. The most common terms include: compassion fatigue (Figley, 1995), secondary traumatic stress (Figley, 1995; Stamm, 1995), and vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Although overlap exists between the concepts underlying these terms, there are distinct differences. Correctly diagnosing the condition will lead to the most appropriate intervention.

Compassion fatigue is often referred to as the formal caregiver’s reduced capacity or interest in being empathic or bearing the suffering of clients, and is the natural consequence of behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by a person and consists of two parts: burnout and secondary trauma (Figley, 1995). For the purposes of this article, I am adopting the term “compassion fatigue” as defined by Figley, who is a preeminent researcher in this field, and how the two components—burnout and secondary trauma combined result in compassion fatigue. This diagram visually depicts this relationship.

Figure 1: Compassion Fatigue: Conceptual Model

Secondary traumatic stress presents as a cluster of symptoms nearly identical to PTSD, which results from the

stress of working with or intimately knowing somebody who has been traumatized or is suffering (Figley, 1995; Stamm, 1995). Vicarious trauma is grounded in Constructivist Self-Development Theory and involves profound changes to professionals’ cognitive schemas and core beliefs about themselves, others, and the world, that occur as a result of exposure to graphic and/or traumatic material relating to their clients’ experiences (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Burnout is a distinct construct that includes “a prolonged response to chronic emotional and interpersonal stressors on the job” and is typically identified within “the three dimensions of exhaustion, cynicism, and sense of inefficacy” (Maslach, 2003, p.189).



Because compassion fatigue involves both secondary trauma and burnout, let’s further define both of these terms and how we can identify them in our work with older veterans experiencing trauma in order to prevent compassion fatigue. If you, as a helping professional or supervisor, can learn to identify and then deal with each of these issues, compassion fatigue will be minimized. As such, it is important to distinguish between burnout and secondary trauma.

Burnout occurs in organizations typified by high demands and low personal rewards, and it is the increased workload and institutional stress, (not trauma), that serve as the precipitating factors. The bad news is that there is not much that the individual worker can do about burnout other than joining large-scale, evidence-supported efforts to change the organizational culture (e.g., The Sanctuary Model®) or changing where one works. In contrast, there are effective interventions for secondary trauma that can be implemented by the individual helping professional, and that is the good news. In a nutshell, they are separate issues and thus, require different types of interventions, as depicted in Table 1 below.

Table 1: Distinguishing Between Secondary Traumatic Stress and Burnout

It is the nature of our work to show compassion, and yet our work can be exhausting because of the burnout and secondary trauma that are so typical in our field. In the case of severe burnout, the cure may involve quitting the job or taking a long sabbatical. In contrast, secondary traumatic stress can often be addressed and successfully treated while staff remain on the job. In a recent training with geriatric care managers who reported very high levels of compassion fatigue, I asked them to describe their experience of compassion fatigue in their own words. Several of them identified with the description offered by one of the most fatigued workers in the group as “...the wear and tear of working with traumatized clients and unhealthy and unsupportive systems.” Thus, the combination of burnout and secondary traumatic stress within the context of work with older veterans can result in compassion fatigue.

Secondary Traumatic Stress	Burnout
Can occur as a result of a single exposure or traumatic event	A process that develops over a period of time
May contribute to burnout	May be a variety of causes for burnout
Faster recovery rate	Can occur independently of secondary trauma or in conjunction with it
Affects the individual worker	Often characterized as an organizational problem, not as an individual problem; but can be both
Comes from the helper’s relationship with a traumatized client or clients	Systematic factors, such as poor supervision or lack of resources, often contribute to burnout
Individuals can take steps to reduce secondary trauma (e.g., intentional self-care strategies)	Organizations can take steps to reduce burnout (e.g., rotate work assignments, encourage staff to take time off)
Can often be addressed and treated while the staff remains on the job	The cure may involve quitting the job or taking a sabbatical

Prevalence of Secondary Trauma and Compassion Fatigue

Secondary traumatic stress (STS) is now viewed by many as an occupational health hazard of working with traumatized populations (Bride, 2007; Figley, 1999; Middleton, 2011; Munroe, Shay, Fisher, Makary, Rapperport, & Zimering, 1995; Pearlman, 1999). While this view is supported by many studies documenting STS in professionals working with traumatized populations, the prevalence of STS differs across studies and occupation groups. For example, when measured with the Secondary Traumatic Stress Scale (STSS) (Bride,

Robinson, Yegidis, & Figley, 2004), criteria for PTSD-like symptoms due to the indirect exposure to traumatic events through clinical work with traumatized populations were met by 15.2% of social workers (Bride, 2007), 16.3% of oncology staff (Quinal et al., 2009), 19.2% of mental health providers working with military and veteran patients (Cieslak et al., 2013), 20.8% of providers treating family or sexual violence (Choi, 2011), 32.8% of emergency room nurses (Dominguez-Gomez & Rutledge, 2009), 34% of child protection workers (Bride, Jones, & Macmaster, 2007) and 39% of juvenile justice education workers (Smith-Hatcher et al., 2011).

Based on these statistics, the prevalence of STS among professionals serving military and veteran populations is somewhat lower compared to other helping professionals. While these findings are encouraging, they do suggest a need for continued research within this population. For example, the current studies do not distinguish between work with older veterans and younger veterans. Trauma and PTSD in the elderly must be considered within the context of normal aging, particularly since PTSD in the older age groups presents unique aspects not seen in younger cohorts. Evidence suggests that trauma-related symptoms in the elderly do not follow a simple clinical trajectory, and can emerge and develop in several ways (Lapp, Agbokou, & Ferreri, 2011). Additionally, the types of war-related traumas experienced by older veterans (e.g., Vietnam, Korean War, World Wars I and II) are distinct from those experienced by the younger veteran (Operations Enduring Freedom/Iraqi Freedom in Afghanistan and Iraq). Furthermore, findings of these studies suggest the need for interventions for professionals serving military and veteran populations. Although overall symptoms of STS were low, participants reported experiencing symptoms (Cieslak et al., 2013). Furthermore, a small percentage reported experiencing moderate to high levels of STS (Kintzle, Yarvis, & Bride, 2013).

Risk Factors

In general, we know that younger workers and workers with less experience in the field are more affected by STS (Bride, 2007; Bride et al., 2007). In addition, helping professionals who experienced childhood trauma are more likely to experience higher STS scores as well (Nelson-Gardell & Harris, 2003). However, there are risk factors specifically associated with working with older adults (Leon, Altholz, & Dziegielewski, 1999). Countertransference is the most commonly discussed risk factor in work with older adults (Leon et al., 1999), and is especially relevant to geriatric care management work. While trying to help the client, the care manager is also forced to confront issues with regard to his or her aging, the aging process of loved ones, as well as issues surrounding mortality. In situations like this, typical counter-transferential (Freud, 1959) feelings related to one's own perceptions of aging and dying can become significant and intrusive to the helping process and lead to compassion fatigue. In addition, the greater the degree to which the helping professional has unresolved trauma, and/or has prolonged exposure to the suffering of her clients, the greater the possibility of compassion fatigue. Since many of our values and beliefs have their roots in our family experiences, care managers working with this population must also be aware of how their own families of origin handled fears and concerns related to the process of aging and death. Other common risk factors associated with work with older adults include unjust system failures; increased frustration regarding limited financial, social and medical services for the elderly; the unpredictable nature of the work (often crisis-driven); the intensive nature of the work (often in home and ongoing); and working in rural settings (Leon et al., 1999). Awareness of these risk factors is important for geriatric care managers in order to develop intentional self-care mechanisms aimed at mitigating the impact of these risk factors on their overall work experience.

The Impact on Turnover and Client Outcomes

There is a connection between secondary trauma and turnover. A combination of secondary trauma, burnout, and compassion fatigue is one of the primary reasons why many helping professionals leave the field (Figley, 1999). According to a study by Sexton (1999), secondary trauma has been associated with early resignation, greater staff turnover, decreased effectiveness of clinicians and increased difficulties with interpersonal relationships outside of work life. Additionally, according to a more recent study of over 1100 child welfare

workers, vicarious trauma negatively impacts a worker's professional satisfaction and professional efficacy, and has a direct effect on a worker's intent to leave their agency (Middleton, 2011).

By the same token, secondary trauma and compassion fatigue can impact case outcomes. Specifically, compassion fatigue is believed to impair the ability of professionals to effectively help those seeking their services (Figley, 1999). Professionals experiencing compassion fatigue are potentially at higher risk of making poor professional judgments such as misdiagnosis, abuse of clients, or poor treatment planning than those not experiencing vicarious traumatization (Rudolph, Stamm, & Stamm, 1997). When you connect the dots as I just described above, it seems clear that we have an ethical imperative to deal with the issue of secondary trauma and compassion fatigue. If a desire for sanity isn't sufficient, here's the other compelling reason for addressing compassion fatigue: we have an ethical obligation to our clients. "Self-care is an ethical imperative. We have an obligation to our clients – as well as to ourselves, our colleagues, and our loved ones – not to be damaged by the work we do" (Saakvitne & Pearlman, 1996).

Consequently, it is important to be aware of our own reactions as well as those of our colleagues. Do you experience compassion fatigue? Are any of your fellow care managers or supervisors experiencing burnout or secondary trauma, which can lead to compassion fatigue? Do you know your reactions and those of your colleagues? Perceptions are reality for you and your colleagues. It is important to pay attention to the risk factors and offer early intervention.

Understanding Stress and Trauma

Compassion fatigue is not just about stress and burnout; it is about trauma. As such, it is important to view compassion fatigue through a trauma-related lens. Trauma is a typical experience in our field; our clients experience trauma, our co-workers experience trauma, and we ourselves experience it as well. It is the combination of these trauma experiences that often leads to secondary trauma. That said, our work is also full of stress and that is also normal. While I already talked about secondary trauma, I want to make the distinction between 'regular stress' versus trauma. It is important to note this distinction. Stress is normal and comes from all aspects of your life (home, work, relationships). It can be situational, and can affect your ability to be resilient to the trauma experienced at work.

On the other hand, trauma involves the perception of threat to self or others and causes both physiological and psychological reactions. In general, responses are survival-based; a person reacts by engaging a fight, flight, or freeze response. It is important to be able to identify common responses to and symptoms of trauma. These symptoms have been specifically identified as responses to PTSD, but STS often mirrors these symptoms. As such, coping behaviors experienced during STS exposure include hyper-arousal, anxiety, and dissociation. These often prolong post-secondary trauma exposure in the form of extended hyper-arousal, intrusive re-experiencing, and avoidance or numbing. Furthermore, they can take on a more pervasive, cumulative impact, which may include changes in the helping professional's worldview, belief systems and relationships/intimacy.

In our work, there are direct and indirect causes of trauma. Traumatic events can be experienced 'directly' as well as 'indirectly' and it is these indirect events that may lead to secondary trauma. Examples of "direct" exposure to traumatic events include: physical assaults by clients or coworkers, vandalism to property (e.g., cars), verbal abuse by clients, threats of assault (e.g., telephone or mail, against employee or family member), stalking, and witnessing physical or verbal abuse against a client. Examples of "indirect" exposure to traumatic events include: hearing or reading about traumatic events occurring to clients, such as: child deaths, serious injuries, sexual maltreatment, physical abuse or egregious neglect, domestic violence; criticism by the press; layoffs of staff; health issues experienced by staff; and the day-to-day adversity experienced when doing this work.

Trauma Recovery

Trauma recovery occurs when the information regarding the trauma moves from the primitive, survival-oriented part of the brain, the amygdala, to the cortex, where you have “top-down” control (executive functioning) over the traumatic memories. What we know about this process of trauma recovery is based on research regarding primary trauma survivors. However, the process of secondary trauma recovery mirrors this process and is referred to as trauma integration. In order to integrate the experience, or make sense of the situation, it’s important to: 1) manage your emotions and not be emotionally overwhelmed by the information; 2) be aware of body and emotional reactions to trauma; 3) keep yourself open and not shut down to protect yourself; 4) connect to your support systems; and 5) identify some transformational meaning associated with the trauma. How can this event be understood from a big picture perspective? Why did this happen to you at this point? This manner of processing and self-reflection helps us to re-encode and reshape our memory so that we gain control over the traumatic memory and establish a new meaning (what we learned versus what was done to us). The core skill in building resiliency to secondary trauma and compassion fatigue is an awareness of our physical, emotional, and cognitive reactions. Awareness allows us to recognize trauma reactions, choose responses and control reactions, and develop plans for managing secondary trauma and strengthening our resiliency long term.

The Four Quadrants of Self-Care

You and your colleagues can recover from trauma, through purposeful interventions and practicing strategies for coping with STS and CF. One basic framework that I have found useful when helping practitioners and students implement intentional self-care planning is the four quadrants of self-care. This framework was initially developed by Marilyn Kruegel, a therapist in Boulder, Colorado who works with professionals (e.g., forensic interviewers, law enforcement officers) routinely exposed to secondary trauma as part of their work. Informed by what we know about trauma recovery and the importance of awareness of our physical, emotional, and cognitive reactions to trauma, the four quadrants of self-care provide us with the context for promoting resilience in our work. When first introducing this tool, I draw a quadrant on the board and ask participants to list activities they can do to practice good self-care. As they call out responses, I categorize them in one of the four quadrants without telling participants what each quadrant stands for. Likely, most of the responses will fall in only two of the four boxes or quadrants. Once the participants are finished providing ideas for good self care activities, I point out the uneven distribution across the quadrants and asked them to take a guess and try to label each quadrant. Participants are typically unable to identify the appropriate labels for the quadrants, so after a few minutes, I label each of the four quadrants, starting from the top left box, moving clockwise: “before,” “during,” “right after,” and “later/ongoing.” Figure 2 depicts the four quadrants of self-care. The shaded quadrant is the one most commonly identified by practitioners. The “neglected” quadrants are “before,” “during,” and “right after.”

Figure 2: The Four Quadrants of Self-Care

Seasoned geriatric care managers may already participate in some of the “before” self-care activities as they prepare for interactions with clients that may be emotionally charged and/or may include exposure to clients’ traumatic stories and experiences. However, they may not necessarily be aware of their use of these strategies, despite the fact that awareness of our reactions to trauma and intentional use of self-care strategies are critical to trauma integration. Perhaps most primary, physical self-care is a given – we all know that it is important to get good sleep, eat a healthy meal, and hydrate before tackling a workday or client interaction that may be particularly challenging. However, the reality is that we do not always engage in these activities and we often suffer the consequences by feeling fatigued, drained,

<p style="text-align: center;">BEFORE</p> <p>Physical self-care Transitions to work Transitions to trauma Grounding self check-in Recognize and anticipate potential triggers</p>	<p style="text-align: center;">DURING</p> <p>Focus on the task at hand Stay present and grounded Breath, posture, and body awareness Create distance or protection: A space around yourself, take a half step back; take a moment Mantras Limit imagery Notice reactions and plan for intervention later Leave the trauma when you leave</p>
<p style="text-align: center;">LATER/ONGOING</p> <p>Regular practice of relaxation techniques and/or physical movement and exercise Build and use broad support Take care of your physical health Have a life outside of work Practice spiritual renewal Transforming meaning Transitions: to and from trauma; to and from work</p>	<p style="text-align: center;">RIGHT AFTER</p> <p>Body awareness: relaxation or movement techniques Breathing exercises Visualization exercises Redirected thinking or reframing Utilizing support Transitions: from trauma Transitions: from work</p>

or getting a headache partway through our day. So, it is important to be reminded — physical self-care is an absolute must.

Transitions to (and from) work and to (and from) trauma exposure are useful and important to adequately prepare you for what may come next. Transitions can include simple activities such as putting on a name badge, reviewing your schedule for the day while driving into work, or putting on a “uniform.” Visualization activities also aid transitions. For example, a caseworker I supervised several years ago described her transition visualization as being very helpful:

“The office where I worked had a wall of employee mailboxes along the entrance to my building. Whenever I left for the day, I visualized myself shelving each of my cases in these boxes while walking out the door. In this way, I was able to leave them at work, knowing they would be there the next day when I arrived. Then, when I came in for my next shift, I visualized myself sliding each case out of the mail cubbies and taking them with me to my desk. This helped me mentally prepare myself for the day.”

As part of transitioning to work or to a traumatic exposure event, it is also helpful to conduct a self “check-in” in order to ground yourself and focus on the task at hand. One of my favorite check-ins is based on the questions used in the “Community Meeting,” a transition ritual intended to psychologically move people from one activity into a new activity or psychological space paving the way for collective thought and action (Bloom, 2005). The Community Meeting is a tool of The Sanctuary Model®, a trauma-informed organizational change intervention, in which all staff begin meetings by answering three questions designed to promote feelings identification, a focus on the future, and a connection to a community or support system. In order to adapt this framework for self check-ins, you ask yourself the following three questions: 1) How am I feeling today? 2) What is my goal for today/for this interaction? and 3) Who can help me with this? The outcomes of this deliberate and repetitive transition ritual are increased awareness of feelings, improved ability to focus on the future rather than dwell on the past, and a stronger sense of community and support (Esaki et al., 2013).

While it may initially seem challenging to facilitate, self-care strategies employed while a practitioner is in-exposure, during the traumatic event, are perhaps the most important for successful trauma integration. Most helping professionals are able to identify when they are in-exposure, and often describe it as being “on.” In that moment, it is important for the professional to focus on the task at hand, stay present and grounded, and be aware of their physical responses such as breathing, posture, and body awareness. In order to minimize the body’s chemical reaction in-exposure (e.g., cortisol dump), helping professionals can create distance or protection by taking a half step back or facing their palms forward in what is commonly referred to as a non-defensive stance. This subtle change sends a signal to the brain that you are safe and can immediately halt the fight, flight, or freeze reaction that may have been initiated due to a perceived threat. Additionally, the use of mantras can also be effective in initiating top-down control of trauma responses. One mantra that I use quite regularly is: “I can help and understand those I serve without having to live their pain.” It can also be useful to simply notice your reactions and plan for an intervention later, while conceptualizing that you leave the trauma when you leave the situation.

Immediately after exposure to a traumatic event or traumatic material, while still at work, is another important time (quadrant) to employ intentional self-care strategies in order to successfully process the recent exposure. Positive self-care strategies include: body awareness, relaxation, movement techniques (e.g., simply go for a walk); breathing exercises (focus on breathing fully from your belly); visualization exercises (particularly those related to letting go of images; transitions to and from the trauma); and redirected thinking or reframing. Even something as simple as drinking water can help to dilute the effect that the in-exposure chemical dump may have on your mind and body.

By the same token, it is important to utilize support while you are at work, still processing exposure. Support in the workplace may include: supervision with your assigned supervisor, supervision with a colleague, collaborative supervision, less formal debriefing, learning circles, and case reviews. The three key words that are most important for a colleague or supervisor to facilitate recovery from STS are: listen, listen, and listen. Also known as qualitative listening—that is when you put everything aside and park yourself in front of that person and just listen. Dr. Rachel Remen has a great quote in her book, *Kitchen Table Wisdom*: “Perhaps the most important thing we ever give to each other is our attention, especially if it’s given from the heart” (page 143). Helping professionals need to be validated and supported.

Perhaps one of the most commonly utilized debriefing scenarios involves debriefing with colleagues after a particularly emotionally charged or traumatic interaction with a client. In order to turn this into an effective debriefing activity as well, it is important to transform these informal “bitching” or “venting” sessions into intentional, structured debriefing sessions, during which you follow several important agreed-upon rules. Following these four rules will help you to successfully integrate your traumatic memory into one that you have top-down control over, and also avoid contagion and “burning out” your support system:

1. Ask for permission: this will allow your colleague (or loved one) to plan, prepare, and have input regarding what happens next.
2. Avoid bombardment.
3. Focus on your reaction to the traumatic material, versus the actual material itself.
4. Use a structured self-reflection framework (e.g., what went well, what did not go well, what I would do differently next time).

Self-care strategies that can be implemented later (outside of work) and in an ongoing fashion are typically the most commonly described self-care activities. These may include: regular practice of relaxation techniques (e.g., meditation) and/or physical movement and exercise; building and using broad support; taking care of your physical health (e.g., healthy eating, sleeping); having a life (and friends) outside of work; practicing spiritual renewal; and focusing on the positive ways you have been impacted by your work, by creating transformational meaning and identifying vicarious resilience.

Conclusion

Information has been found to be the key to mitigating the effects of secondary trauma and compassion fatigue on workers (Bell, Kulkarni, & Dalton, 2003). Informed by what we know about trauma recovery and the importance of awareness of our own reactions to trauma, the four quadrants of self-care provides us with a context for promoting resilience in our work. In addition, agencies that employ geriatric care managers can implement and promote several strategies to help mitigate the impact of secondary trauma and compassion fatigue on the care managers including: 1) describe the work realistically, 2) educate workers at the beginning about ST/CF, 3) encourage workers to address personal traumatic stress and unresolved trauma, 4) clarify the agency’s responsibilities to the care manager regarding ST/CF as an occupational hazard, 5) clarify the care manager’s responsibility for self-care, and 6) give extra care to new and younger care managers. While experiencing ST and CF in our work with long-term survivors of trauma is inevitable, we have an ethical imperative to work together to build resilience among care managers and other helping professionals in our community.

“The best and most beautiful things in the world cannot be seen, nor touched...but are felt in the heart.” – Helen Keller

References

Article References

Topics: Post Traumatic Stress Disorder (PTSD), Veterans

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Serving Those Who Have Served: A Guide to Veterans Services and Supports

Jennifer A. Crittenden, MSW

Introduction

With nearly 10 million veterans in the U.S. over the age of 65 and 1.4 million over the age of 85, understanding available programs and services for this population is a critical need for health and human services professionals (“Profile America Facts,” 2013; Shay, 2013). Older military veterans, by virtue of their high rates of chronic disease, have a high level of need with regards to health promotion, healthcare, chronic disease management, and activities of daily living. As with many non-military populations, the need for chronic disease management is intricately connected to poverty and a lack of education. Both factors should be taken into consideration when selecting services and resources for older veterans (Villa, Harada, Washington, & Damron-Rodriguez, 2003).

Sorting through the myriad of benefits, programs, and resources for this population can be a difficult task. The aim of this article will be to provide a starting point for some benefits available to this population rather than attempting to provide an exhaustive list. One caveat to note is that benefits and services available to this population may be affected by funding availability and national policy. However, all benefits information provided is current as of the submission date of this article.

Geriatric care managers who work outside of the military system or who lack personal military experience should obtain education and training on military culture in order to effectively serve this population. As Savitsky, Illingworth, and DuLaney (2009) note, two tenets of military culture which include “mobility and an emphasis on mission readiness” (p. 328). During their military service it is likely that older veterans experienced frequent relocation (hence the need for mobility) while focusing on readiness for their next military assignment (or mission readiness). It is also important to note that military members have traditionally experienced a high level of involvement of the military in their personal lives in order to ensure they were in fact “mission ready” (Savitsky, Illingworth & DuLaney, 2009). For this reason, for some veterans there may have a lingering sense of distrust or reluctance to seek military benefits. The WWII era veterans are reluctant to obtain any benefits including health benefits as they feel it was their duty to serve their country and then they resumed their day to day when the war ended. These veterans typically do not initiate the benefits on their own. It usually takes a concerned family member or outside professional to intervene before help is accepted.

It is also important to note that even for those who do receive military benefits, the military cannot meet all the needs of our older veterans. For this reason, tapping into community-based services and supports will be crucial for effective care management. Connecting older veterans with the services and supports they need starts with the recognition that in many instances, services and programs available to older adults may generally serve the needs of this special population. These programs include Area Agencies on Aging, senior centers, local Senior Corps programming, healthcare organizations, etc. Older veterans will qualify for and can

participate in many existing community programs. In the following sections, we will explore both military and non-military sources of support.

VA Benefits

The U.S. Veteran's Administration (VA) offers a wide range of benefits generally to service veterans in addition to benefits specifically designed for older veterans. Benefits are administered through the branches of the VA: the National Cemetery Administration (NCA), Veterans Benefits Administration (VBA), and the Veterans Health Administration (VHA). To illustrate the scope of VA benefits, health care services provided by the VHA alone amount to nearly 7 million older adults who represent more than 50% of VA patients (Shay, 2013). General VA Benefits include healthcare services, life insurance, pension and income replacement, education and employment services and benefits, home loans, and burial benefits ("Summary of VA Benefits," 2012). A few key benefits for older veterans are highlighted below.

Eligibility for VA benefits is determined by a number of factors including the type of military service performed, service/non-service disability and injury, service during a recognized war time period (including World War I, World War II, Korean Conflict, Vietnam Era, and the Gulf War), duration of military service, means testing, and the character of discharge from the service ("Claims for VA Benefits," 2014; "Eligible Wartime Periods," 2013). Any discharge designation that falls within honorable discharge status generally qualifies a veteran to receive VA benefits. For those whose service discharge falls outside of honorable status, benefits cannot be rendered unless the VA determines that the discharge condition falls into the category of "under conditions other than dishonorable." This determination is made on a case-by-case basis. However, in some situations, healthcare benefits can be received if one has a dishonorable discharge status but needs treatment for a condition determined to be service-related ("Claims for VA Benefits," 2014). It is also important to note that eligibility varies by VA benefit type. The first step to accessing these services and determining eligibility is to visit www.ebenefits.va.gov or call the VA at 1-800-827-1000.

Home Improvement and Structural Alterations

Home Improvement and Structural Alterations (HISA) grants are available to veterans who need medically necessary home improvements made to their primary residence. Grants are available in varying amounts (up to \$6,800) depending on whether or not the disability is service related, and the extent of the disability. Those veterans with non-service related injuries may be eligible for HISA grants of up to \$2,000. In order to qualify, individuals must have a prescription for the alteration from a VA physician or another physician who can certify the need ("Home Improvements," 2014).

Burial Benefits

Burial benefits are available to veterans and their families and recent changes to the application process make this benefit easier to access than ever before. Burial benefits range from a few hundred dollars to a couple thousand dollars depending on several factors including whether or not the individual's death was service-related, whether or not the individual was hospitalized by the VA at the time of death, and whether or not burial will take place in a national cemetery. In addition to burial benefits, government headstones markers or medallions, burial flag, and a presidential certificate are available to families of veterans at no cost ("Burial Benefits," 2014).

Integration of Services and Innovative Models

Over time veterans' services are becoming increasingly integrated into traditional aging services making them less siloed and more accessible to veterans and their families. Many programs that receive federal funding are turning their priorities toward serving and supporting older veterans and their families. For example, the Senior Community Service Employment Program (SCSEP), a national program tasked with providing stipend job training services for low-income adults 55 and older, places an emphasis on engaging older veterans and their

spouses as clients (“Senior Community Service,” 2014). In 2008, a partnership was formed between the U.S. Veterans’ Administration and the Administration on Aging to serve veterans at risk of institutionalization through local services provided by Area Agencies on Aging. This pilot, which gives local seamless access to service for veterans, started with 10 states in 2008 and has since expanded to 19 states and the District of Columbia as of 2011 (“Community Living,” n.d.; “Veteran Directed,” n.d.).

An innovative example of how federal programs are integrating to better serve our veteran population is the Housing and Urban Development–Veterans Affairs Supportive Housing Program (HUD–VASH), collaboration between VA and HUD to address homelessness among veterans. This program marries the HUD Housing Choice Voucher Program with VA case management services. This innovative program provides more flexibility than the traditional Housing Choice Voucher program and allows for the delivery of clinical services to occur either at VA medical centers or community–based agencies (“HUD–VASH Vouchers,” n.d.). This program supports permanent housing options for veterans and their families and the use of case management and supportive services is intended to help support an individual both obtain and maintain housing. To qualify, veterans must meet the McKinney Homeless Assistance Act homeless criteria, be able to live independently in the community, and should demonstrate a need for case management services based on substance abuse, mental health issues, or physical disability (“HUD–VASH Eligibility Criteria,” 2012). Homelessness can include residing in a shelter, public location, or experiencing a real and immediate threat of becoming homeless through eviction, lack of resources to maintain adequate housing, etc. (“McKinney–Vento Homeless Assistance Act,” n.d.). The VA determines eligibility for this program and it can be accessed via the National Center for Homeless Veterans (1–877–4AID–VET).

State–Level and Local Benefits

In addition to federal veterans’ benefits, many states offer local benefits and supports for veterans. It is important to understand that such benefits can only be accessed through a state–level department of veterans’ affairs office and should not be confused with federal veterans’ benefits programs. Local benefits can include special business loans for veterans, property tax relief programs, park passes, nursing and rehabilitation services, local burial benefits, and advocacy services. Contact information is provided later on in this article for connecting with your local department of veterans’ affairs.

Special Considerations for Spouses and Dependents

In some instances spousal and dependent benefits may be available for family members of older veterans. Specific benefits for spouses and dependents include burial benefits, Dependency and Indemnity Compensation (DIC), Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), educational assistance, and survivor’s pension for low–income surviving spouse and children (“Summary of VA Benefits,” 2012). Research indicates that spousal caregivers of frail older veterans are likely to take advantage of a mix of VA and non–VA services. One key factor influencing use of services is the perceived availability of services (Dorfman, Holmes, & Berlin, 1997). Geriatric care managers can assist in this process by raising awareness of service availability for caregivers whether those services are provided by the VA or non–VA providers.

Helpful Veterans Benefits Websites and Contacts

Figure 1: Important VA Phone Numbers

U.S. Department of Veterans Affairs eBenefits Portal & Benefits Line
Visit this website for essential information on VA benefits. Offers an online portal for applying for benefits. Web:

<https://www.ebenefits.va.gov/ebenefits-portal/ebenefits.portal>

Connecting with the VA: Important Numbers

Benefits: 1-800-827-1000

Health Care: 1-877-222-VETS (8387)

VA Inspector General: 1-800-488-8244

Veterans Crisis Line: 1-800-273-8255 Press 1

To locate a local VA branch office: <https://www2.va.gov/directory/guide/home.asp>

Phone: 1-800-827-1000

State Department of Veterans Affairs Office Locator

Visit this webpage to connect with your state department of veterans affairs.

Web: www.va.gov/statedva.htm

U. S. Department of Veterans Affairs Home and Community-Based Services

This website provides an overview of services that assist veterans to age in their homes and communities. Web:

www.va.gov/GERIATRICS/Guide/LongTermCare/Home_and_Community_Based_Services.asp

Federal Benefits for Veterans, Dependents and Survivors Online Guide

This guide provides an overview of federal benefits programs administered by the VA and other federal agencies. Web: <https://www.ebenefits.va.gov/ebenefits-portal/ebenefits.portal>

National Center for Homeless Veterans

Get in touch with the National Center for Homeless Veterans to access services and benefits for homeless vets or to learn more about the issue of homelessness among veterans. Web: www.endveteranhomelessness.org

Phone: 1-877-4AID-VET

Veterans Crisis Line

Visit the Veterans Crisis Line website for more information on crisis intervention services available for veterans. A live chat feature is also available on the website.

Web: www.veteranscrisisline.net

Phone: 1-800-273-8255 Press 1

Text: 838255

American Legion Service Officer Locator

The American Legion's Service Officer Program provides free information, referral, and benefit assistance to veterans and their families. Use the Legion's website to locate your nearest Service Officer. Web:

www.legion.org/serviceofficers/CO

VeteranAid.org

This grassroots nonprofit supports veterans and their families by providing web-based information and resources. Web: www.veteranaid.org

Veterans Civic Organizations

Beyond traditional benefits available to older veterans, connecting such individuals to local community civic groups will open up opportunities for socializing, peer support, and learning which can be beneficial to older veterans. The following organizations and programs may be of interest to older veterans and their families and represent only a very small sample of groups that can be tapped locally. The VA publishes a comprehensive listing of recognized veterans' service organizations. In order to be listed in this publication, an organization must be a nonprofit with a strong reputation, national reach, and at least 1,000 members or congressional recognition. This compendium can be found online at: <https://www1.va.gov/vso/>

American Legion

The American Legion is a longstanding community institution associated with veteran's issues. Chartered by Congress in 1919, the American Legion is "a patriotic veterans' organization" that honors and demonstrates a focus on fellow service members and veterans. The legion offers a variety of opportunities for older veterans to socialize, volunteer, and advocate. There is a fee associated with joining the legion which goes toward its programming (American Legion, n.d.). Web: www.legion.org

Veterans of Foreign Wars (VFW)

Like the American Legion, the VFW focuses its work on supporting veterans, their families, and local communities. Volunteer work is central to its mission. Membership is available for a fee and open to those who have “honorably served in foreign wars” (Veterans of Foreign Wars, n.d.). Web: www.vfw.org

Conclusion

The services and benefits available to help older veterans and their families can seem like a complicated maze even to the most seasoned professional. For those receiving help in navigating services directly from the VA, consider being a partner in that journey and supporting your client through this process. The search for the right services and supports can be a long but rewarding one. Figure 2 provides some quick summary tips for assisting older veterans through the geriatric care management process.

Figure 2: Quick Tips for Serving Older Veterans

Serving Older Veterans: Tips for GCMs

- Ask about military service as part of intake/screening –
- Focus on physical and mental health as priorities
- Familiarize yourself with military culture
- Learn more about VA benefits and connect clients with VA intake as early as possible
- Support your client through VA benefits process –
- Explore all non-VA community service options available

References

Article References

Topics: Veterans

2 thoughts on “Serving Those Who Have Served: A Guide to Veterans Services and Supports”



1. A J S says:

July 18, 2017 at 8:49 am

I have a friend I've known for more than a decade. Good dude. But after Vietnam he went through hell—as well as several prisons. His last (felony) charge—to my understanding—was in the mid nineties. Fast forward after prisons and years into sobriety, he's facing serious health problems from agent orange (when does it end). He says his benefits, because of his past crimes, were largely done away with during the reagan years. How can I help him? Military vets and personnel like him paid dearly for us and many continue to pay. Those who had serious problems after fighting war were ostracized then and now. I'd like to help—please advise—name withheld.

Reply



2. Monica Chavez says:

June 21, 2018 at 4:35 pm

You make a great point that the military cannot meet all the needs of our older veterans, so tapping into community-based services can really help. It must be really helpful for veterans to have community-based services that are willing and able to help and serve them so that they are not completely on their own. I wonder what kind of organizations are out there. It would be awesome if my husband and I could get involved in some of that stuff so that we can serve the older veterans more. <https://www.disabledveterans.org/>

Reply

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Introduction to the Practice Articles in the Special Issue on Older Veterans

Roxanne Sorensen, BSW, MA, LMHC, SW-G, CMC
Guest Editor – Practice Articles

The Department of Veteran Affairs is a complex system and appears difficult to navigate. As Aging Life Care Professionals™ / care managers, we need to educate ourselves about what is offered through this maze of health and financial benefits so we can provide assistance to the veteran and their families. When dealing with a veteran, we must be familiar with the veteran's time of service as the perception of the VA differs by these years and if he/she served during war time. It is with this in mind that the following articles are designed, to provide an understanding of the services available to the veteran and his/her family member:

Sue Engel sets the stage by providing a new strategy for caregivers when working with a veteran with memory loss. She provides insight on how to approach the veteran from a team perspective by working with the Geriatric Evaluation and Management (GEM) team and the caregiver. As veterans are aging, the likelihood of developing some form of memory loss increases and this perspective gives guidance on how to service not only the veteran but the caregiver. In Tom & Lori's Story – a case study, Roxanne Sorensen shares the story of a career military man and the struggles in obtaining assistance needed in later in life when his health and memory declined.

We then navigate the silo of monetary benefits. Roxanne's article provides a foundation of the pension and compensation benefits that the veteran and/or his/her spouse may be eligible for. Veterans and their families are not aware of the monetary benefits available to them which can be utilized for in home care, assisted living, and skilled nursing. Utilization of these benefits can make a significant difference in creating and implementing plans of care.

In addition, as we see in the news, the increase of PTSD within the military has become significant. We often associate PTSD with the veterans who are currently returning from war, but there is a large population of veterans from WWII, Korea, Vietnam, and the Gulf War that is still struggling with the effects. A person may be labeled with dementia or display behavior problems when in truth he/she could be suffering from PTSD. The reality of treating these disorders together is complex and requires the utilization of resources which is depicted in the interview Jennifer Voorlas conducted with Dr. Susan McCarthy of Minneapolis VA PTSD Clinic.

In years past, veterans would return to their daily lives and try to cope with the effects of war on their own, but now there are services so he/she does not have to suffer in silence. Finally, it is with honor that we present A Soldier's Story written by Joan Brogdon. This story is near and dear to her heart as she honors her father by sharing his story which provides us with some historical lessons. This veteran was a proud family man who served his country and asked for nothing in return. We not only honor him but all military personnel who have served and currently serve our country with pride and dignity.

Topics: Dementia, Editor's and Guest Editor's Message, Post Traumatic Stress Disorder (PTSD), Veterans

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Journal

Serving Our Older Veterans: Current Issues
and Best Practices

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Memory Care A New Way of Thinking For Veterans' Caregivers

Susan Engel RN-BC, MSN, CNS, CCM

In 1975, one of my responsibilities as a new nurse at a skilled nursing facility was to create a daily bulletin board for patients with organic brain syndrome (OBS). At the beginning of my shift, I stood at attention with my starched whites and proudly adorned nurse's cap and announced to my patients what was written on the board.

"Today is Tuesday, April 29, 1975. It is a cool 66 degrees and breezy outside. The President is Gerald Ford. The United States is beginning to evacuate US citizens from our embassy in Saigon. It is expected the North Vietnamese will takeover." I was glad the war was over; however there was no one in the room sharing any connection to this information.

There were approximately twenty patients with scattered remains of breakfast eggs on their clothes and lost in a world I was not able to enter. I never imagined I would be caring for soldiers coming back from Vietnam and eventually suffering the same illness under a different name, dementia. Today we know that in a predominantly male Veteran cohort, those diagnosed as having PTSD are at a nearly two-fold-higher risk of developing dementia compared with those without PTSD (Yaffee, K. et. al. 2010).

As our Veteran population grows older and illnesses involving dementia increase, the cost of care also increases because the trajectory of the illness can continue for years. The journey for everyone dealing with irreversible cognitive impairment waxes and wanes, and therefore, to consistently walk with the Veteran and family through the hills and the valleys is the goal of the memory care coordinator (MCC). This is why the initiation of a trusted relationship with a healthcare team to provide education and planning is essential when the initial diagnosis is made.

At VA WNY Healthcare System our first priority is to obtain a definitive or conclusive diagnosis for the memory loss. Within the Geriatric and Extended Care services we have a Geriatric Evaluation and Management (GEM) team. The team consists of a geriatrician, social worker, RN and psychologist. With their assessment we are able to determine if this is a reversible condition or not and begin treatment.

ABOUT THE AUTHOR

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Memory Care Coordinator
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Susan has been a nurse for almost 40 years. She earned a Masters of Science degree in Nursing at Daemen College in Amherst, New York. She is NY State certified as a Clinical Nurse Specialist in Oncology. In addition, she holds an ANCC certification in Gerontological Nursing and a CCMC certification as a case manager. Susan is a member of the American Holistic Nursing Association and the National Gerontological Nursing Association. She was instrumental in developing the Memory Care Coordination program at the VA Western New York healthcare system.

Susan has written for the Gerontological Nurse Counseling Points, an Official Publication of the National Conference of Gerontological Nurse Practitioners and the National Gerontological Nursing Association.

To contact Susan, please email susan.engel@va.gov, or call 716-862-3158 during business hours.

Once a diagnosis is determined to be progressive, the MCC may be consulted. At VA WNY Healthcare System, the MCC offers support, education, and services to the Veteran and his or her caregiver throughout the trajectory of the illness. The initial focus is to discover everything that makes the Veteran an individual. This information is used as a way of connection presently and for the future.

With permission from the Veteran, the MCC interviews the primary caregiver. The MCC is interested in the caregiver's health, relationships, and expectation of the disease process, as well as their source of strength and coping mechanisms they have utilized in the past during difficult times. The MCC explains the indications for medications prescribed and the importance of non-pharmacological interventions for behavioral challenges. The MCC initiates dialogue regarding driving and general safety concerns, fall prevention, wandering, advanced directives, and plans for the future.

Through the evolution of working with this population, my nursing practice has transformed since the early days of attempting to orient patients to what is happening in the real world. Evidence-based practice teaches us that connection can be accomplished with the keys of therapeutic communication (a low, soft tone, face-to-face, being fully present), and a familiar memory, song or photo. The power of being present can help the Veteran feel grounded and validated. These moments can become pivotal forces of transformation that we may strive to create over and over again, seeing the benefit that is derived. MCC is able foster that awareness with professional as well as personal caregiver education. Thus, caregiving can be a chapter of growth instead of decline, and our goal is to provide the tools required to not merely survive the experience but to be positively transformed by it.

How Caregiver Thoughts Effect Care

The medical evidence is mounting for caregivers to become instruments of care. This means instead of relying on medication (with its potential for adverse reactions), the first intervention begins with the caregiver's approach, diversional activities, and nonverbal communication to bring calm to the patient. However, a caregiver cannot provide care until they are able to care first for themselves. We know that angry, exhausted caregivers can trigger challenging behaviors, and once a caregiver becomes ill due to the stress, the Veteran is at high risk for placement (Elliott & Pezent, 2008).

In recent years, Dr. Jill Bormann, a researcher at the VA San Diego Healthcare System, began to teach the practice of a Mantram, which she terms as a "portable Jacuzzi for your mind" (Borman, 2005). A Mantram is a repeated spiritual word, chosen from a list and repetitiously practiced to bring peace of mind especially during turbulent times. This practice is based on the work of Eknath Easwaran, a world-renowned meditation teacher. The teaching also involves one-pointed attention with a focus on living in the moment. The same technique was trialed successfully for Veterans with Human Immunodeficiency Virus (HIV) (Borman, et. al. 2009), Veterans and employees (Borman, et.al. 2006), Veterans with Post Traumatic Stress Disorder (PTSD) (Fontana, A., et.al. 2008), and family caregivers of Veterans with dementia (Borman, et.al. 2009).

Dr. Dolores Gallagher-Thompson, PhD at the VA Palo Alto Medical Center along with Davide Arguello, PhD, and Carmen Johnson, MA of San Jose, California, developed a course for caregivers based heavily on the work of Dr. David D. Burns on identifying thought distortions and labeling them. This practice readily identifies the toxic thoughts common to caregivers that cause high risk for burn out and illness. Once identified, these thoughts are analyzed to see if they are true. A majority of the time they prove false and lose their power.

Both of these courses have been implemented successfully throughout the VA system with high caregiver satisfaction ratings. Caregiver ratings were increased as a result of reduced depression, missed work days due to caregiver responsibilities, and increased coping mechanisms.

Note: caregiver satisfaction outcomes were measured with the Caregiver Strain Index and subjective self-reporting measures.

VA Services for Veterans with a Memory Deficit

I encourage all case managers to assist Veterans in adding VA providers to their health care team. If a Veteran has not applied for VA health care benefits, the website, www.va.gov provides all the information needed to begin the process. There is also information at the site regarding other Veterans benefits such as compensation, education, home loans, life insurance, and burial benefits. 1-800-827-1000 is also available for more information.

If the Veteran is already enrolled for health care benefits, encourage connection with their VA social worker to explore services that are locally available. They will be able to assist in obtaining a diagnosis for memory concerns, respite services, adult daycare, available supplies, caregiver counseling, support groups, caregiver classes, durable medical equipment, and other benefits and services.

Topics: Dementia, Post Traumatic Stress Disorder (PTSD), Veterans

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Tom & Lori's Story



Serving Our Older Veterans: Current Issues
and Best Practices

Roxanne Sorensen BSW, MA, LMHC, SW-G, CMC

Tom was a career military and obtained the rank of a 3 Star General. He was a Vietnam vet who thrived on the structure of his duties. Lori, his wife, was the homemaker, and had raised their two children, while Tom built his career and served abroad. When Tom returned home he had difficulty adjusting to “civilian life.” He became verbally and physically abusive to Lori, and began to turn to alcohol in hopes of dulling the effects of war. Lori considered leaving many times but stuck with him, even after she began to question her own sanity.

Tom had all the classic symptoms of PTSD but refused to acknowledge there was an issue or to obtain treatment. In his words he felt that acknowledging it would “damage his career.” Lori was hopeful and kept a log of the events, but Tom would refuse any help she sought. To add further to the emotional pain, Lori's daughter (“daddy's girl”) always felt her mother was the issue and that her father could do no wrong, which reinforced the family denial.

Adding further to the layer of hurt, Lori never felt appreciated by her daughter but made herself available to babysit her grandchildren, giving more of herself. Their son lived out of town and was also a career military, absent much of the time. He tried to help when he could but his efforts were far too infrequent.

Tom's negative behaviors began to increase as he approached 60 years old. He was diagnosed with dementia and it became difficult for Lori to care for him at home. His confusion and PTSD episodes escalated beyond her control. After careful consideration and heart ache; Lori admitted Tom into a local Specialized Assisted Living facility. Within a couple months he was evicted because he didn't “fit the mold.” Tom was a powerful looking 6'3”, 240lbs, and looked like an everyday visitor at the facility instead of a resident in need of care. If you sat and spoke to him for a few minutes you would never have known he had dementia or PTSD.

Unfortunately, Tom was sent to the hospital after receiving the 30-day eviction notice, and the facility refused to allow him to return. His wife Lori remained in the dark and was told later that the reason her husband was evicted was because he became angry with a 90-year-old female with dementia who provoked him. When he asked her to leave him alone, she refused, not understanding what he was saying. Tom, feeling out of control, decided to use his hands to push her out of his way.

While the female resident did not fall and sustained no injuries, the facility claimed he was just not their “normal” client and they could not handle him. It was ironic that the very facility that enjoyed his private pay monies for several months, which boosted their ability to care for his behaviors and difficulties, discharged him as fast as they could.

ABOUT THE AUTHOR

Roxanne Sorensen is a Certified Geriatric Care Manager and Co-Owner of Elder Care Solutions of WNY, LLC located in Western New York. She holds a Bachelor's in Social Work and a Master's in Counseling. Roxanne has an extensive background working with the elderly population and their families. Her career spans to working in nursing homes, HUD housing, social adult day care program, assisted living, community case management, and finally geriatric care management.

Tom bounced to two more facilities in our area within a two month time period, each time only to be hospitalized because he “didn’t fit in”. This is when his wife Lori reached out to our company for help. She was frustrated and on the verge of a nervous breakdown. All the facilities in our area rejected him due to his “history.” After much deliberation and work on our part, Tom was moved to another “specialized community” which was recommended by the Department of Health as a facility that can handle difficult cases. It was over an hour and a half away from his family, and unfortunately he lasted there one month.

Tom was not a stupid man. He would watch the visitors and blend right in. By his careful observations he figured out how to use the key pad to exit the locked unit. He was creative man; remember he was in combat. So, back to the VA Hospital in Buffalo Tom goes. Tom was placed in the Psych Unit at the hospital, being the only secure unit they have; however, he didn’t fit there either. We had to work with the social workers and physicians to barter for time and secure an appropriate placement.

Because Tom never claimed his PTSD, it was a labor of love to have him classified. No one wants to be labeled, but in this case it was a good thing. With a diagnosis of PTSD he would automatically be a “100% Service Connected” and be entitled to the Federal Nursing Home, which is the only facility he had the option of getting into. Tom stayed on the Psych floor for over two months although he did not belong there. His daughter blamed her mother as she couldn’t imagine her father being the person everyone was describing.

Where did Tom fail? Why didn’t anyone consider this? Did Tom fail or did the system fail Tom? Lori, his wife, felt like a failure. She often wondered if she let her husband down and felt badly that she couldn’t care for him. Her daughter’s attitude did not help either. Lori’s guilt ate away at her each and every day. Meanwhile, Tom continued to have behaviors. His last incident required the MPs of the VA to be on site to speak with him. That was the best moment we had; as a 3 Star General the last thing you want on your record is an altercation with the MPs.

When the voice of authority spoke, Tom immediately settled down and complied with what he needed to do. Tom was able to function in a military setting but could not adapt to civilian life. After much arguing and perseverance with the VA, we were able to obtain the PTSD diagnosis. He was granted a “100% Service Connection” and moved to the Federal Nursing Home in Batavia which is 40 minutes away from his family.

Lori, his wife, finally found peace after many years of very difficult times. With Tom settled in Batavia, she decided to go to visit her son and grandson down south. Finally free after many years of caring for Tom, Lori was enjoying her visit, and then abruptly and unexpectedly she fell ill.

Lori’s daughter reached out to tell us that two weeks after Lori’s arrival, her mother collapsed. Lori had been so stressed and worried about Tom that she failed to see that she herself wasn’t feeling a hundred percent. Lori collapsed, was rushed to the hospital, placed on a ventilator, and the family was told there was no hope for recovery. Her body had an infection that was never detected, and it had done its damage. The life sustaining ventilator was removed and Lori died a short time later. She was only 60 years old. Her life was finally her own but fate had other ideas.

Here is where we are going to list the old adage of the caregiver who doesn’t care for themselves and something happens to them first. Lori’s story broke our hearts. We had never cried so hard for someone, as we did for Lori. She was such a special woman. Two months after her death we received a call from her daughter who had become the primary caregiver for her father. She told us she finally understood what her mother was dealing with in relation to her father. She saw the “real” Tom and not the father that she had previously seen through rose-colored glasses. She stated that her biggest regret was not supporting her mother and the way she handled it was something she would have to live with for the rest of her life.

Four years later, Tom is doing great. He remains in the Federal Nursing Home without any physical or mental declines. He thrives because he is in a military environment which he is accustomed to. However, now Tom's children have no mother. Every time we meet with a caregiver who reminds us of Lori, we use her story to show that his or her own health is just as important as the person they are providing care for. We can't say that Lori would still be alive if she had better supports, but there is one thing we know for sure: undoubtedly the stress contributed to her death. We will always remember Lori as she will have a special place in our hearts. She was genuinely a wonderful person who did everything in her power to support and care for her husband, despite the multiple obstacles before her. Lori's story is one of thousands, perhaps millions.

Our systems are ill-equipped and unprepared to deal with the upcoming Vietnam Vets who have PTSD, TBI, or dementia, and our system is still grappling to solve the problem. This population just does not fit the mold and they especially do not fit into a residential setting with frail and elderly (predominately female) residents. I still haven't found a facility just for our aging veterans with PTSD/dementia. I keep asking but it falls on deaf ears. Maybe someday it will happen. We need to remain strong advocates for these clients and take on the systems even if they are as complex as the VA.

Topics: [Dementia](#), [Post Traumatic Stress Disorder \(PTSD\)](#), [Veterans](#)

One thought on “Tom & Lori’s Story”



1. [John A Perazzo](#) says:

March 5, 2019 at 5:48 pm

Thank you.

[Reply](#)

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Journal

Serving Our Older Veterans: Current Issues
and Best Practices

of AGING (ife CARE™

Veteran Federal Financial Benefits: What Care Managers Need to Know!

Roxanne Sorensen BSW, MA, LMHC, SW-G, CMC

Non Service Connected Disability Pension – Income Medical Expensed NSC Pension

There are three levels (Basic, Homebound, and Aid & Attendance) to the NSC Pension Benefit. The benefit is an income based program that extends to Veterans and their spouses/widows who are unable to care for themselves and need assistance with Activities of Daily Living (ADL's) (i.e.: bathing, dressing, ambulating, transferring, feeding, protecting individual from hazards of daily environment):

- Benefits can be utilized in individuals “home,” Assisted Living, and Skilled Nursing Facility
- If Veteran is caring for spouse and utilizing monthly income on medical needs or spouse is in a facility, the Veteran can apply for this benefit
- Veteran and/or widow can be receiving private in home care through an aide and/or family member – must pay for services as a medical expense as earned income that is for the caretaker being paid by the veteran or widow
- If the Veteran or widow/widower passes away during the process and a decision has not been made by the VA, no monies will be awarded
- Monies are retroactive to the date of application. Current process can take up to six months or longer. If the veteran or widow/widower has a diagnosis of dementia, the retroactive monies will be held until a fiduciary is appointed. This normally adds at least six months to the process or can be requested at the initial application with Power of Attorney
- Working with VA Accredited Representatives in your area is essential. They will complete the application on behalf of the client and make sure it is completed properly
- Medical Form VA-2680 must be completed by the MD even if institutionalized
- Widow/Widower does NOT qualify if they are divorced from the Veteran. Only can apply if they are remarried and that person was a veteran

Qualifications

- Must have served in the military for 90 days with 1 day during wartime. Time periods are non-negotiable. If you served a day after the required dates, you will not qualify.

Approved War Times:

- WWI – 4/6/17 – 11/11/18
- WWII – 12/7/41 – 12/31/46

- Korea – 6/27/50 – 1/31/55
 - Vietnam – 8/5/64 – 5/7/75
 - Gulf Era – 8/2/90 – Present
- Must have the DD214 (discharge record) or Equivalent– Veterans seeking a VA benefit for the first time must submit a copy of their service discharge form (DD–214, DD–215, or for World War II Veterans, a WD form), which documents service dates and type of discharge, or provides full name, military service number, and branch and dates of service.

If the individual does not have the DD–214 you can possibly obtain the document at the following:

- County Clerk’s Office if the veteran filed it upon return from the service
 - National Archives – this form can be downloaded at www.archives.gov/veterans – this document can be mailed in or faxed. It can take 8 weeks to obtain if it is in their records. Many records were destroyed during the flood and fire but all efforts are made to locate the item. If you only have the veterans name, date of birth, social security number, and branch of service you can still try to obtain the documents. I have located many of documents with the minimum information.
- Assets cannot exceed \$80,000 (Primary home, life insurance, burial, and car not included)
 - Monthly income (after subtracting cost of all medical expenses) must be less than \$1758(veteran) and \$1130(spouse/widow) or \$2085 (both veteran and spouse. The amounts listed above reflect for 2015 and are adjusted yearly by the VA.
 - Must need assistance with Activities of Daily Living (see above)
 - Veteran can apply for benefit if utilizing his income to support spouse in an Assisted Living facility or Skilled Nursing but will receive a lower benefit. The Veteran has to also require assist with Activities of Daily Living
 - Benefit will only be \$90 if receiving Medicaid in the home, ALP, or Nursing Home.
 - The Aid and Attendance benefit can be utilized in the home although the misconception is that it is only used in Assisted Living Facilities

Income	Assets
Social Security	Checking/Savings
Pension	IRA
Annuity	CD
Interest	Stocks/Bonds
Dividends	Trust
Rental Income	Additional Properties

Medical: (Monthly costs) – Must be Recurring (Not One Time)

- Medicare Part B & D Premiums

- Lifeline
- Oxygen
- Health Insurance
- Adult Day Program
- Home Care
- Durable Medical Equipment – i.e. Hospital bed rental
- Copayments – all medical providers
- Assisted Living/Nursing Home

Case Example of Aid and Attendance Benefits

Earl and Helen

Earl and Helen resided in their own home but their health was starting to decline and their only child lived across the country. There were no local supports other than a few neighbors to check on them every once in a while. Their son hired our company to assess the situation and facilitate the services needed to keep his parents at home.

We placed a private aide in the home to assist them both with their ADL needs, use of Lifeline, Meals on Wheels, and assistance with medical appointments. By placing the private aide into the home and utilizing the medical expenses incurred, Earl and Helen were able to apply for A/A benefits. Once the monies were awarded, Earl and Helen were able to increase the number of hours for the aides. As a result, they were able to remain in their home for an additional four years.

Helen's health rapidly declined, and she required 24-hour care. With their direction, we were able to locate a nursing home for Helen and facilitated a Medicaid application on her behalf. After much deliberation, Earl chose to admit himself into an assisted living facility closer to his wife. Earl's VA A/A benefits were utilized as an additional source of income to maintain his needs in the facility. When Earl passed away, we were able to obtain the reduced benefit of \$90 for Helen while she resided in the nursing home. It was spending money for ancillary items Helen might want or need.

With our assistance Helen was enrolled into the VA Health Care System. Earl's medical needs were met by participating in the health care programs available to him. He obtained a Lifeline for free, received free incontinence products, durable medical equipment, home care for a couple hours a week (in addition to his private aide), and had an option of attending a social day program which he did not participate in. Upon Earl's death his family received monies for his burial due to his enrollment into the A/A benefits.

The VA financial and medical benefits were able to provide a quality of life for both Earl and Helen. This also provided a level of comfort to their son. He was grateful that his parents were able to remain home together for an additional four years which he felt would not have occurred without the assistance of the VA. Sadly, these benefits are not well known but with our assistance this family was able to benefit from them, and as a result, their quality of life was enhanced.

Service Connected Disability Compensation – tax free monetary benefit

Veteran had to have a war time injury or subsequent illness or disease that occurred or aggravated related to active duty service

Example: Vietnam Veterans Exposure to Agent Orange – must have been in Vietnam (including brief visits ashore or service aboard ship that operated on the inland waterways of Vietnam from 1/9/62–5/7/75 or in or near the Korean demilitarized zone between 4/1/68–8/31/71)

Example: My father served in Vietnam and was exposed to Agent Orange. He has heart disease, diabetes, neuropathy, COPD, and Asthma that have all been correlated to his exposure to Agent Orange. As he ages and his health declines, we will request ongoing reviews to increase his rating to obtain a 70% or higher so his medical needs are covered in full along with his nursing home care if he requires that.

1. Vets who have the following can be entitled to financial benefits and a service connected rating:

1. Prisoner of War – Automatic 100%
2. B Cell Leukemia
3. Ischemic Heart Disease
4. Parkinson's Disease
5. ALS (Lou Gehrig's Disease)
6. Asthma/Lung Issues including COPD
7. Diabetes
8. PTSD
9. Prostate Cancer
10. Respiratory Cancers
11. Non-Hodgkin's Lymphoma & Hodgkin's Disease
12. Multiple Myeloma
13. Peripheral Neuropathy, Acute & Sub-acute

2. Veteran does not have to provide income or financials to qualify for this benefit.

3. Veteran must provide medical documentation and attend a medical exam.

4. Veteran, if qualified, will receive a Service Connected Rating which will entitle him/her to a certain dollar amount. As health declines request for an increase in benefits should be done.

5. 70 % and higher – all medical care will be provided at no cost and any skilled nursing needs will be covered in full. Their rate of income also increases.

6. Depending on the rating and cause of death – the widow/widower is entitled to a portion of the benefit upon the death of the veteran.

Topics: Dementia, Post Traumatic Stress Disorder (PTSD), Veterans

2 thoughts on “Veteran Federal Financial Benefits: What Care Managers Need to Know!”



1. Sharon Vincent says:

June 20, 2015 at 4:00 am

This is the best article & compilation of information about VA benefits that I've ever read. Thanks Roxanne!

[Reply](#)



2. Rebecca Auyer says:

October 10, 2015 at 4:26 am

The information is provided in a clear and concise manner that can be followed and implemented easily. Thank you Roxanne for your well constructed and informative article!

[Reply](#)

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Interview: Minneapolis VA Post Traumatic Stress Disorder Clinic

INTERVIEW: Minneapolis VA Post Traumatic Stress Disorder Clinic
Interview with Susan McCarthy MD by Jennifer E. Voorlas MSG CMC

Note: The answers in this interview primarily speak to the Minneapolis VA, not necessarily the VA at large. While there are some similarities among clinics across the country within the VA system, care professionals should inquire within the region the older veteran resides in order to obtain the most accurate information regarding client needs and eligibility for services.

Q. We strive as care professionals to help our clients not only find/seek treatment for trauma, but many veterans have cognitive issues as well. How do you treat Post Traumatic Stress Disorder and dementia simultaneously? Should you?

A. Depends on the level of dementia. Post-Traumatic Stress Disorder (PTSD) treatment at the Minneapolis VA is evidence-based, using both medications and/or therapy. Evidence-based therapies, including Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE) utilize a cognitive-behavioral model of treatment. Other VAs in the country provide Eye Movement Desensitization and Reprocessing Therapy (EMDR), which is similar to PE. We also use medications approved by the FDA for treating PTSD, like paroxetine (trade name Paxil) and sertraline (trade name Zoloft), as well as other medications in similar classes.

While medications are effective for treating PTSD, studies show the evidence-based therapies have greater effectiveness than medications. We often encourage veterans to try therapy, but we will use just medications to treat PTSD, depending on the veteran's needs. A veteran's degree of cognition can dictate which treatment would be favored. If his dementia is mild (pre-DSM5 called Mild Cognitive Impairment; now called in DSM 5: Mild Neurocognitive Disorder), we could consider going ahead with the therapies above. Those veterans with more severe dementia would likely need to be treated with medications alone.

Q. Are most of the therapies for treatment of PTSD available in most all VA clinics? –

A. Evidence-based therapies are being provided nationwide to veterans to treat PTSD. In general, the VA does provide CPT, PE, and EMDR to veterans, but perhaps not all of them at every VA. For example, the Minneapolis VA has CPT and PE, but not EMDR.

Q. Can you differentiate between PTSD and dementia? Most individuals are automatically diagnosed with dementia and the other symptoms are ignored or misdiagnosed.

A. PTSD does have a set of criteria that could include many different symptoms, but the primary criteria are intrusion symptoms, avoidance patterns, negative alterations in mood and thinking and marked

ABOUT THE INTERVIEWEE

Susan McCarthy, MD works at the Minneapolis VA Medical Center in Minneapolis, MN. She has been a staff psychiatrist with their psychiatry department for the past eight years and did her psychiatry residency at the University of Minnesota. Recently, she was appointed the Medical Director for Team L clinic, which specializes in PTSD treatment at the Minneapolis VA.

arousal/reactivity. Within these criteria, many different symptoms can exist, and there can be symptom overlap with many other mental health diagnoses, including dementia, but also depression and anxiety disorders, substance use disorders, and psychotic disorders. Some PTSD diagnoses include dissociative symptoms, which can further complicate the diagnostic picture.

Typically a structured, clinical interview can help to differentiate between mental health diagnoses. For PTSD, a Clinician-Administered PTSD Scale, or CAPS can be used; for patients with dementia, a Montreal Cognitive Assessment, or can guide providers as to the severity of a veteran's dementia. There are similar scales and tests for other disorders, such as depression and anxiety. These tests are well-validated and helpful in determining not only diagnosis, but also the level of care that would provide effective treatment.

Q. Do you add Traumatic Brain Injury into the mix with PTSD and dementia? How will addictions impact the proper diagnosing (drug /prescription and or alcohol use)?

A. At the Minneapolis VA, we have a Traumatic Brain Injury (TBI) clinic that comprehensively evaluates veterans and provides treatment matched with providers in multiple specialties: psychiatry, psychology, neuropsychology, general medicine, speech pathology, occupational therapy, physical therapy and social work, dependent upon the veteran's needs. Addictions are often comorbid with PTSD, here again is where a structured interview format can be helpful in diagnosis. Seeking Safety is an evidence-based therapy that treats both PTSD and substance use disorders simultaneously and is used by the VA nation-wide.

Q. What financial resources are available for vets to pay for ongoing counseling for trauma?

A. Veterans with benefits at the VA often have no costs or only co-pays for mental health treatments, such as therapy and/or medication management.

Q. What is the best way to approach a veteran who has multiple medical issues on top of psychiatric and or dementia? Isn't it difficult to know what to treat first?

A. I think the best approach is to involve mental health providers early on to provide specialized assessment, assist with treatment planning, and access available resources. This multidisciplinary, integrated approach works best, both for the veteran and the provider. At the Minneapolis VA, we are fortunate to have strong collaboration between general medicine, psychiatry and other professions. In some of our primary care clinics, a psychiatry resident is now part of the treatment team, so that when mental health issues arise in a primary care visit, the resident can see the veteran during that visit, and make recommendations and referrals right away. Additionally, within psychiatry, we have a dedicated Geropsychiatry clinic that can assist us with veterans who have dementia. The multidisciplinary, integrated approach is still a growing movement and has not yet been fully implemented, but I hope will soon become the norm.

Q. What resources are available for families needing counseling especially when this pertains to caregiving issues?

A. We provide counseling to family members of veterans at the Minneapolis VA with our staff if the focus of treatment is related to the veteran. For example, if the spouse needs support/counseling around caregiving issues for the veteran, we can provide counseling focused on those issues. Spouse, parents, and adult children can receive this service. Our TBI clinic does this kind of therapy often. Also Veteran Centers, affiliated with the VA provide individual counseling for families of combat veterans. They also hold support groups for families and veterans.

We also have an education group series for family on mental health. Most of our therapists are trained in and provide couples counseling. We also have parenting therapy for people with young children and provide child care while the parents are in their counseling sessions.

Q. Are there any mobile psych teams for the home bound veteran?

A. We work in connection to primary care, who can provide a social worker and therapist/counselor to meet veterans in their homes. Typically there needs to be medical issues pertaining to the need for in-home services. We also have the Home Health Buddy, basically a computer device in the home that the veteran is able to use to contact mental and physical health providers, who monitor that system on a daily basis. The veteran is also required to check in on the “Buddy” each day, so if the providers do not hear from the veteran, they will do outreach to contact him and provide care if needed. We also use Tele-health to connect providers from the Minneapolis VA to our community-based clinics, so if a veteran lives in out-state Minnesota, they can connect with a therapist in Minneapolis by going to a local VA clinic and then talking to the therapist via TV monitor screen in real time. The VA has plans to provide monitors in veteran’s homes, however, this is an early phase of roll-out and has not yet been fully implemented.

Q. Do you find that many veterans do not seek mental health treatment for fear of being stigmatized as “weak”?

A. I do think mental health issues are still stigmatized in our culture as a whole, including military culture. Add to that a generational divide where some older veterans have been taught over the course of their lives to not seek treatment or even talk about mental health problems. Also, the issue of gender can play a role, as acknowledging emotional issues and problems historically has been considered a “weakness” in men versus women. Changing a society’s view on any issue takes significant time and effort, and we are further along in accepting mental health care as a standard part of an individual’s overall medical health than we were 20 years ago. Embedding psychiatric providers into general medical health care settings is one way to address this, providing immediate mental health services, rather than a referral and consult process that veterans can opt out of once they leave the primary care clinic. It also suggests to veterans that mental health care is as just as important as their other medical issues and is really a part of their primary care, rather than a separate, disconnected specialty. I would encourage community providers to consider utilizing the mental health services of the VA, as we are moving towards this more integrated model of care and can provide a broad array of services for veterans to meet their needs.

Topics: Dementia, Post Traumatic Stress Disorder (PTSD), Veterans

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A Soldier's Story



Serving Our Older Veterans: Current Issues
and Best Practices

Joan Brogdon, AM, LCSW, CCM

A pristine German officer's waistcoat, a rusty sword, and pistol were a few of the items William L. Brogdon brought home at the end of WWII, but their story has never been told. Family legend – that a young William enlisted at the end of the war but never saw combat for the Allies – persisted for decades. While William's military tombstone identified him as a Sergeant, only one solitary story of a German mother running up to him in tears, thinking he was her son returning from war, was known to William's family from his time overseas.

My last two memories of my father are vivid. The night of his death, at age 33, my family was gathered around the television, watching "Twilight Zone," except for my father, who was resting in bed. When the familiar sound of an alarm was heard, signaling a fire and calling all volunteers, my father got up, put on his coat, and said "good-bye." This was to be his final good deed. Equally vivid is the image I remember of the man whom I came upon several months prior, sitting in his room, holding a hostess cupcake lit with a single candle. When I asked him "Why?" he told me it was his birthday and no one had remembered. Though I was a young child, I understood this man had a heavy heart, but I never understood why.

Always searching for the man behind the candle, I periodically queried my mother and family members for stories about his life and character. The narratives were limited, tinged with sadness and hinted at the complexities of the young man who enlisted in the army out of high school: D-Day had just occurred and he was to become a member of Patton's 3rd Army. Bright and well-liked, good-looking, never met a stranger, loved his family, hard-worker, great father, had a jealous stepfather, drank too much after the war, left no money but had insurance The American Legion was very important to him.

I would visit my father's grave in southern Illinois, atop the hill among the farmlands next to his only son, in a plot among his beloved in-laws, and look at the stone at the foot of the grave. Sergeant, Company D, 2nd Infantry, that, along with the limited narrative, was all I knew about his service, as his discharge papers said he was a file clerk at Ft. Campbell. With his personal records destroyed in the 1972 fire at the regional storage facilities of military records in St. Louis, and his close army buddy long ago deceased, the relics were mysteries. While the narrative had puzzling gaps, with no oral history that anyone could recall, when coupled with the lack of historical records, my father's story did not exist. In January, 2015, 55 years after his death, I discovered the man behind the candle, the man who volunteered to join the army; the man who met his final fate while in service to others. Another set of discharge papers had been found.

October 6, 1944 was the day William L Brogdon enlisted in the Army. He had just turned 18 the prior August, and although the horrific D-Day invasion in June had been a success, the war was far from over. Brogdon's 5th

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Joan has a Master's degree in Social Service Administration (Social Work) from University of Chicago and a Bachelor's degree in Psychology from University of Missouri, Columbia. She is Founder/CEO Kin Care, Inc., providing comprehensive care management services to older adults and individuals with disabilities in Chicago and surrounding suburbs. Joan is married with three adult children.

Division had come ashore in the second wave in early July, leading the charge from the beaches of Normandy, in Operation Cobra. Over the next several months, they captured the town of Rheims (where the unconditional surrender of Europe would be signed) and then Metz. By January, 1945, shortly before William completed four months of training, they were engaged in the Battle of the Bulge, Hitler's last major offensive, where the Regiment successfully battled its way across the Sauer River and then helped battle the Siegfried Line, a 390 mile stretch of 18,000 bunkers, traps and tunnels intended to serve as an impenetrable barrier. Brogdon soon learned he was a skilled marksman and was headed to the European Theatre to join them.

William arrived in the European Theatre on March 7, 1945 as a member of Company D, 2nd Infantry Regiment, Fifth Division, 3rd Army, serving under George C. Patton. The Rhineland Campaign was coming to a close and Patton's army was preparing to cross the Rhine where the final campaign of the war, Central Europe, would begin. Hitler's defeat at the Battle of the Bulge was a turning point in the European Theatre of Operations, as the Allies now thought they would be ultimately victorious, but they still had to cross the Rhine to get into Germany. Everyone understood the battles that lie ahead would continue to be fierce and bloody as Hitler's forces would make a last stand or risk final defeat. The three infantry regiments of the Fifth Division would spearhead the crossing of the Rhine.

By this time, the ranks of the infantry were severely decimated – most estimated they were operating at only 2/3 capacity; thousands of soldiers had lost their lives and the ranks were becoming thin. So infantrymen were increasingly brought in from other ranks, individuals who had previously been determined better suited for other areas of service, as well as newly trained young men from the states. To support and honor them, the Combat Infantry Badge had been established in 1943, retroactive to December 6, 1941, for soldiers who personally fought and distinguished themselves in direct combat, who held one of several occupations: ranging from light machine gunner to squad leader to rifleman. To receive this highest honor that could be bestowed, a soldier/officer had to hold a rank of Colonel or below and be recommended by his commanding officer. General George Marshall always had a special fondness for the infantry, as he noted they had the greatest battlefield hardships, and suffered the most casualties. Shortly after the war, Marshall led an effort to award Bronze Stars to members of the infantry who had earned the Combat Infantry Badge.

While with a formidable reputation among his foes, Patton's troops were positioned on the southern end of the river near Oppenheim, with no easy crossing, while Montgomery's British troops were positioned further north, where the only bridge remained. Eisenhower had decided Montgomery was to go first, and selected March 23, 1945. Patton's troops were to cross the next night. But Patton, who was known to push forward aggressively, stopping only when lack of supplies forced a pause, did not intend to let Montgomery lead the effort and ignored orders. Just before midnight, the three infantry regiments of the 5th Division started crossing in boats. The 10th went first, then the 11th and then the 2nd. They established a bridgehead five miles inland, which enabled the building of a bridge for the rest of the U.S. army to cross into Germany. Montgomery's troops crossed the next day. On the 24th, as he had promised to do once he crossed the Rhine, George C. Patton "pissed in the Rhine River," standing on the bridge his troops had built

During his two months of combat service, young William was promoted from Private to Sergeant, and became a Squad Leader of a heavy weapons unit, commanding up to 20 fellow soldiers. He was awarded a Combat Infantry Badge for as yet unknown reasons. Finding his discharge papers led to an internet search, a discussion with family members and the surprise recall of a few additional memories. His wife remembered he had jumped into a foxhole and found everyone dead; he also had ringing in his ears. His brother recalled William watched a bridge being built over a river....probably the Rhine. The German soldier artifacts remain a mystery.

William Lee Brogdon served in active combat from March 7, 1945 until the cease fire on May 8, 1945. He returned home on July 18, 1945, ostensibly to train for the invasion of Japan. Japan ceased fired on August

14–15, 1945. The official end of the war was declared on September 2, 1945, aboard the U.S.S. Missouri. William was discharged on January 11, 1946, and then reenlisted, serving as a file clerk at Ft. Campbell for one more year. William Lee Brogdon became a volunteer fireman and died in a car accident on his way to fight a fire in January, 1960. In Clayton, Missouri, his name is listed first on a plaque commissioned by the Backstoppers, along with other firemen and police officers, who died in the line of duty for St. Louis County. The Backstoppers, honoring fallen firefighters and policemen, had just been formed. George C. Patton died 1945, in Germany, from catastrophic injuries suffered from a car accident. He is buried among his soldiers in a cemetery in France.

William Lee Brogdon's story is one of 16,100,000 U.S. military who served in WWII. On this 70th anniversary year of the end of WWII, we salute him and all the military personnel who served with him, including our fathers, mothers, uncles, and those who now proudly serve.

Topics: Veterans

One thought on “A Soldier’s Story”



1. Emily Saltz says:

May 21, 2015 at 12:28 pm

Thank you for sharing this touching story and for persisting in uncovering his wartime saga. There are so many veterans stories that go untold and you honor all of their memories by telling us about your father's journey.

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