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BRIEF REPORT

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Traumatic disclosures in the life stories of older Vietnam era veterans

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Abstract

Background: Eliciting life stories is an important component of person-centered care that may aid in understanding how an individual's unique background and narrative impacts their health. Such life stories, especially when gathered from older military Veterans, may include traumatic events, raising the urgency that clinicians be prepared to provide care that is trauma-informed and ensure Veteran's experiences are acknowledged and treated effectively.

Methods: We examined the prevalence and type of potentially traumatic and/or adverse life events spontaneously shared by 231 older Veterans participating in a life story intervention while receiving care within the U.S. Veterans Health Administration system. Veteran life stories were extracted from the electronic medical record and deductive qualitative content analysis was used to code potentially traumatic or adverse life experiences based on a codebook adapted from the Brief Trauma Questionnaire and Adverse Childhood Experience questionnaire.

Results: A majority (71.0%) of Veterans described at least one traumatic disclosure in their life story. Among narratives with a disclosure of any type, more than half (53.0%) included descriptions of combat trauma, 21.5% noted a history of life-threatening illness, and 9.5% reported having been in a serious accident. Fewer noted adverse childhood experiences (19.5%).

Conclusions: Elicitation of life stories among older Veterans may advance person-centered care and life stories frequently include disclosure of potentially traumatic and/or adverse life events. These findings underscore the normative experience of traumatic events among older Veterans and highlight the importance of developing age-sensitive trauma-informed care competencies.

KEYWORDS

combat, life stories, older veterans, patient narratives, PTSD, trauma

This work was presented as a poster entitled "*Traumatic Disclosures in Medical Storytelling: A Thematic Analysis of My Life My Story*" at the 2020 International Society for Traumatic Stress Studies Annual Meeting.

INTRODUCTION

Providing person-centered care (PCC) requires shifting from a strict biomedical approach to a collaborative care model framing illness in the context of a person's life.[1,2] Within PCC there is growing awareness of the role trauma plays in shaping an individual's lived experience. A trauma-informed care (TIC) approach incorporates this awareness to improve care delivery.[3,4]

Approximately half of American men over 65 are Veterans.[5] Among older adults, 50%–90% experience traumatic events over their lifetime with traumatic exposure more common among Veterans.[6,7] Among male Vietnam Era Veterans, 30.9% experience post-traumatic stress disorder (PTSD) during their lifetimes. For older Veterans accessing VA care, 17.88% having a confirmed mental illness.[8–13] Many Veterans' experiences of trauma may reverberate throughout life, exerting lasting health impacts contributing to the development of physical illness, depression, substance use disorders, and cognitive impairment.[14–16]

Despite the wide-ranging impacts of trauma, most individuals experience resilience and recovery, incorporating the experience of trauma into their life narrative.[17] For some older Veterans, illnesses and other age-related stressors bring increased reflection on past traumatic events, particularly military experiences. This process of re-engagement may lead to efforts to integrate earlier trauma into a meaningful and coherent life story.[17]

My Life My Story (MLMS) is a nationally implemented life story intervention to humanize the experience of Veterans and foster deeper connections between Veterans and their healthcare professionals.[18] MLMS involves a guided interview of open-ended questions such as: *What would you like your clinicians to know about you*?[18] It uses VA clinicians, health professional trainees and volunteers to interview Veterans and document their life narratives in the electronic health record (EHR). Narratives are typically 1000 words and take approximately 2 h to complete.[19] Such a program may improve PCC and be relevant to TIC if it encompasses recognition of and response to trauma.[2,3,18,19] Despite wide use of MLMS in VA, little research exists on the content of Veteran narratives. Given the importance of life story work to PCC, and the increasing emphasis on deploying TIC, this study aimed to quantify and categorize examples of potentially traumatic events and adverse experiences that emerged from Veteran's life stories through the MLMS project.

Key points

- Veterans spontaneously disclose potentially traumatic events and adverse life experiences in the telling of their lives.
- A majority of Veterans describe at least one traumatic event during their lives.
- Understanding that many Veterans receiving care have trauma histories indicates the importance of providing trauma-informed care.

Why does this paper matter?

Clinicians providing person-centered care to Veterans and those eliciting life story narratives should be prepared for individuals to share potentially traumatic experiences that have occurred across their life span.

METHODS

This study consisted of a retrospective analysis of MLMS narratives recorded between January 10, 2016 and January 2, 2019 and entered in the EHR. No prompts in the MLMS interview guide specifically request disclosure of traumatic events. MLMS narratives were collected by healthcare workers and volunteers, including trainees from multiple medical specialties. Individuals who gathered narratives were trained on introducing MLMS, conducting interviews, completing the narrative write-up, and providing a copy to the Veteran for edits before entering it in their EHR. Additional details on MLMS are described elsewhere.[20,21]

Participation in MLMS is open to any Veteran who wishes to have their story recorded. Veterans were approached during inpatient and outpatient encounters and were excluded if they were deemed too medically or psychiatrically ill to complete the interview or provide informed consent.

Deductive qualitative content analysis was used to identify and quantify potentially traumatic experiences and followed three phases: preparation, organizing and reporting.[22] In the preparation phase, the unit of analysis was identified. A total of 505 Veteran narratives and accompanying demographic information from all service eras were extracted from the EHR by hand. We focused on Vietnam Era Veterans as they are the largest group of older Veterans receiving VHA health care. After selecting for service era, removing duplicates and narratives used to test coding methods ($n = 5$), 231 stories remained. Seven Veterans had two MLMS narratives, in these cases only the first was included. Stories came from Veterans whose average age was 71.4 ($SD = 4.7$) years. 228 Veterans were male, and 205 identified as White (Table 1).

TABLE 1 Veteran participant characteristics ($N = 231$)

Variable	Range	*M*	*SD*
Age	61–85	71.4	4.7
Variable		*N*	%
Gender			
Male		228	98.7%
Female		3	1.3%
Race/ethnicity			
African American		19	8.2%
Asian		0	0%
Native American		3	1.3%
Non-White Hispanic		0	0%
White		205	88.8%
Missing		4	1.7%
Service branch			
Airforce/Air Guard		34	14.7%
Army		98	42.4%
Coast Guard		4	1.7%
Marines		31	13.4%
Navy		61	26.4%
Missing/Other		3	1.3%
Location story was collected			
Inpatient medical unit		127	55.0%
Outpatient medical clinic		22	9.5%
Outpatient mental health clinic		13	5.6%
Hospice, Rehabilitation, or Long-Term Care Units		59	25.5%
Other (Veteran's Home, Emergency Department/Urgent Care, Missing)		10	4.3%
Training status of interviewer			
Trainee (Health Professional Student, Resident, Fellow)		177	76.6%
Staff clinician		29	12.6%
Other (e.g., volunteer)		25	10.8%

Stories were collected across multiple settings, with the majority (55.0%) from medical inpatient units.

The organization phase began with coders initially reading and discussing five stories to develop an understanding of the source material. A subsequent categorization matrix was developed in Excel to code potentially traumatic and adverse experiences based on the Brief Trauma Questionnaire (BTQ) and Adverse Childhood Experience (ACE) Questionnaire.[23,24] The BTQ characterizes 10 potentially traumatic events (e.g., served in a war zone). The ACE categorizes 10 adverse events from childhood (e.g., emotional neglect, physical abuse). Questions in the BTQ and ACE were converted into individual codes with item wording as definitions. Overlapping codes between the BTQ and ACE were condensed into single codes, while codes describing sexual abuse were split into descriptions during childhood and during adulthood. Several life challenges not represented within the BTQ and ACE questionnaires were identified. Inductive qualitative analysis was used to derive new categories from these experiences and were included in the categorization matrix.

The coding team consisted of seven individuals including mental health professionals. Three teams of two coders initially coded 65 stories. An independent individual served as arbiter. The team met regularly to rectify coding discrepancies and refine the categorization matrix. After pairs reached an overall inter-rater reliability of >90% (96.3%), a final codebook was established. The remaining 166 stories were coded individually, with continued meetings for consultation. The original 65 stories were then reviewed for consistency with the final categorization matrix. Once coding was complete, totals were tabulated within each story and across categories of traumatic experiences.

The project was approved by the Institutional Research and Development committee.

RESULTS

Across the 231 Veteran narratives, a combined total of 434 disclosures of potentially traumatic events, ACEs, and additional life challenges were found. 71% ($n = 164$) of Veteran narratives included descriptions of potentially traumatic events corresponding to the BTQ or ACE questionnaire, 58.4% ($n = 135$) described additional life challenges, and 13.4% ($n = 31$) did not describe any coded disclosures. Figure 1 shows the most frequently disclosed potentially traumatic events, ACEs, and additional life challenges.

Potentially traumatic events

Deductive coding using the BTQ criteria yielded a total of 214 disclosures of potentially traumatic events. Combat trauma was most common, occurring in 53.0% of stories where a disclosure was found ($n = 200$), followed by life threatening illness (21.5%) and experiencing a serious accident (9.5%) as shown in Table S1. All 10 items of the BTQ appeared in Veteran narratives. Descriptions varied in the level of detail used to describe traumatic events. One Veteran described his combat experience as clearly traumatic: "We were hit and my ankle was dangling outside. The plane lands, I'm lying flat on my back. I didn't

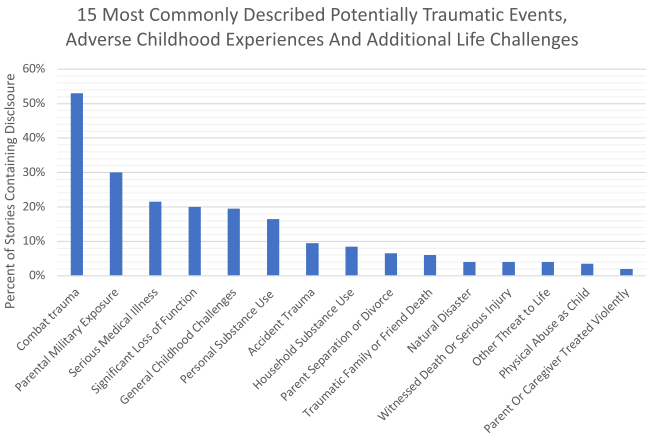

FIGURE 1 Fifteen most commonly described potentially traumatic events, adverse childhood experiences and additional life challenges found in Veteran narratives containing a disclosure

think I'd make it. I thought we'd die landing." Other Veterans were more veiled in their descriptions: "[In Vietnam] I saw and did things I did not always agree with." Veteran descriptions of serious illness included varying amounts of detail, from simply naming being diagnosed with a serious illness to the existential impact of having such an illness: "I am getting to the end now and this is so hard. I hate to say goodbye."

Adverse childhood experiences

Deductive coding yielded a total of 49 ACE disclosures, with 19% of disclosure containing stories including at least one ACE. Descriptors of household substance, like: "My father was an alcoholic and made our childhood really challenging" were most common (8.5%), followed by parental separation or divorce (6.5%) and physical abuse as a child (3.5%). Descriptions of physical abuse included individual episodes, like: "I ended up taking a beating from my father and could not sit for three months. That moment changed me." and descriptions of more pervasive abuse across childhood. Examples of physical neglect and having a household member who was incarcerated were not found.

Additional life challenges

Other additional coding categories were added to account for life challenges outside of the BTQ and ACE (Table S1). The two most common additional life challenges were descriptions of significant loss of function (20.0%) and personal substance use (16.5%). Descriptions of significant loss of function allowed for expansion of possible medical trauma when a specific illness was not mentioned, but the impact of declining health was significant to the Veteran. For instance: "Suddenly there are all these things that I can no longer do like drink a cup of coffee or write my name. You take those things for granted until you can't do them anymore. All of these new problems are a shock to me." Veterans also mentioned parental service in the military (30.0%), sometimes followed by the Veteran describing their parent never speaking of their service. The category "general childhood challenges" (19.5%) was used to capture implied childhood traumatic or adverse events described in language too vague to allow for coding in other sections. For example: "My father was very mean and brutal" did not clearly fit in the ACE category of physical or emotional abuse.

DISCUSSION

This is the first study to examine potentially traumatic and ACEs in the content of MLMS narratives told by Vietnam Veterans. A large majority (71.0%) of these Veterans included descriptions of at least one potentially traumatic event or ACE in the telling of their life stories while more than half (58.4%) of narratives included additional life challenges not captured in the BTQ and ACE. These findings fit within the currently understood range of lifetime trauma exposures for older adults.[6,7]

Previous research has shown Veterans and clinicians view MLMS participation favorably.[18,19,25,26] MLMS fosters improved PCC by helping clinicians understand their patients, deepening empathy, and informs treatment options.[26] This study aids in our understanding of the adversity older Veterans have faced and incorporated into their narratives. Our findings may serve to empower Veterans and staff to recognize the resiliency of Veterans who have survived and overcome past events and support TIC principles of recognizing and describing the widespread impact of trauma.

These analyzed MLMS narratives were provided in a healthcare setting with knowledge that such stories would be included in the Veteran's medical record. Within such a context, the content of these narratives may be viewed as a communication to the medical team. They provide valuable context that may aid in understanding factors that shape Veterans' views on health. The medicalized environment in which stories were recorded may also serve to have Veterans emphasize particularly traumatic or life-threatening medical experiences. This research builds on recent work that identified key themes in 17 Veteran MLMS narratives, including early hardships, facing mortality, and recounting harrowing combat experiences.[27] Although many Veterans may have opted not to disclose such experiences, it appears that a large number do wish for their medical team to know

about their experiences confronting past adversity. This finding calls on clinicians to become more competent in responding to trauma disclosures.

Many descriptions of traumatic events or ACEs were vividly told, while others were merely alluded to. Having health profession trainees complete MLMS interviews, as occurs in many VAMCs including our own, provides an opportunity for clinicians to recognize the ubiquitousness of trauma and develop skills in responding to disclosures. These skills can then be implemented in other clinical encounters, empowering clinicians to become stewards of TIC. Absent skillful training, however, the listener might feel ill-equipped to respond. Recent efforts have been made to make healthcare education more trauma-informed, but greater training is needed across health professions.[28]

While descriptions of traumatic exposures are common in MLMS narratives, MLMS is not a mental health intervention and does not replace psychiatric evaluation or treatment. VHA screens Veterans for PTSD across primary care settings and specialty clinics. Further research is needed to understand if participation in MLMS increases engagement with mental health services, but documentation of the narrative in the EHR serves as another opportunity for clinicians to enquire with their patients if further support is needed.

There are several limitations to this study. We only included stories from Vietnam Era Veterans, who currently make up the largest cohort of older Veterans served by VHA. Vietnam Era Veterans faced unique challenges and traumas related to their service, including fighting in a deeply unpopular war, the failure to be welcomed home after serving overseas, and the prolonged periods of combat that were unconventional at the time. Focusing on Vietnam Era Veterans, those on the leading edge of receiving geriatric care, also served to acknowledge the significant debt this cohort of Veterans incurred and their sacrifices in service of improving care and health access for younger Veterans. While this cohort's unique experiences limit the generalizability to Veterans from earlier wars, similarities between Vietnam and more recent American military excursions provide a window into care for aging younger Veterans. A further limitation is stories came from one healthcare system serving New England and predominantly White male Veterans.

In conclusion, potentially traumatic or adverse experiences are woven into the fabric of Vietnam Veteran's life stories. The commonality of such disclosures raises important questions about the pervasiveness of hardship and the meaning people make of such challenges in life narratives. This study has important implications for the clinician–patient relationship, the training of future healthcare workers, and the delivery of health care in an increasingly trauma-informed and person-centered manner.

AUTHOR CONTRIBUTIONS

Zachary Sager contributed to study design, project management, data analysis, and drafting of manuscript. Susan Nathan contributed to project management, data acquisition, data analysis, and drafting of manuscript. Kelly Doherty contributed to data management and data analysis. Anica Pless Kaiser, David Topor, Jennifer Moye, Nicholas Morrison contributed to data analysis and drafting of manuscript. Katherine King contributed to drafting of this manuscript.

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CONFLICT OF INTEREST

The authors have no financial or personal conflicts of interest to report.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

Table S1 Types of potentially traumatic events disclosed, their description, number of occurrences in our sample and frequency.

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