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## Impact of September 11th on older American veterans

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IMPACT OF SEPTEMBER 11TH ON OLDER  
AMERICAN VETERANS

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work

---

by  
David Lee Baptist  
Tamra Denise Snook

June 2003

IMPACT OF SEPTEMBER 11<sup>TH</sup> ON OLDER  
AMERICAN VETERANS


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A Project  
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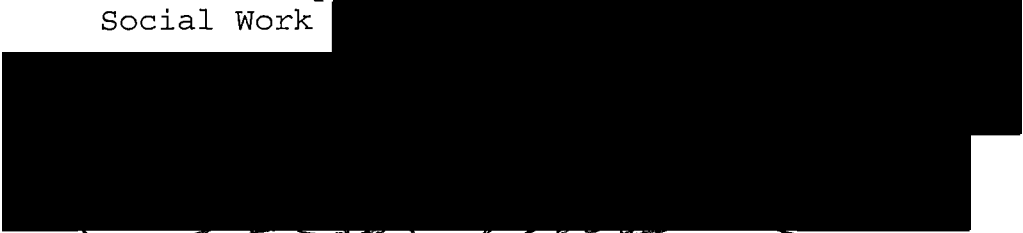
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by  
David Lee Baptist  
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June 2003

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Dr. Rosemary McCaslin, Faculty Supervisor  
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5/30/03  
Date

  
Dr. Rosemary McCaslin,  
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## ABSTRACT

The terrorist attack of September 11<sup>th</sup> has been widely viewed as a traumatic event. Traumatic events have demonstrated psychological, emotional, behavioral, developmental and physiological detriment to individuals. Among older adults there may be compounding factors such as losses of function, resources, friends, family, and support. Among veterans there may be factors such as prior traumas, reduced support, and preexisting depression and anxiety. Developmental theorists indicate that older persons may be moving into a stage in which it is vital to integrate with the environment, pass on knowledge, and share wisdom to future generations. This exploratory study attempted to gain insight into the actions taken by older veterans following the September 11<sup>th</sup> terrorist event. Results indicated that the most common advice was to remember and the most common action was to seek out another person. Most older veterans had contact with 50 or more persons. Surprisingly, no significant correlations were found between social support or losses and PTSD symptoms; however those who were married showed decreased PTSD symptoms compared to those who were unmarried.

## ACKNOWLEDGMENTS

It is with great admiration and respect that we sincerely thank Dr. Rosemary McCaslin for her invaluable time and support throughout the duration of this project.

It is also with great respect that we thank the many veterans who so willingly aided us in this project. We appreciate their honesty and the sacrifices they each made in serving our country.

## DEDICATION

To my loving wife and daughter, this project is an extension of our enduring love. Thank you for your support and understanding. - David

To my husband David, thank you for being there every step of the way. It is with great honor that I dedicate this project to you. I love you. - Your Wife Tami

To my daughters, thank you for your love, your commitment to helping me, and your invaluable support. Thanks to you (and dad), I have finally been able to accomplish my goal. I love you. - Love Your Mom

And last but certainly not least, this project is dedicated in memory of my dad, a 25-year veteran of the Naval Air Force who served in World War II, the Korean War, and in Vietnam. - Tamra

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## CHAPTER ONE

### INTRODUCTION

#### Problem Statement

On September 11<sup>th</sup>, 2001 the world watched in horror as an unknown enemy attacked the United States. People from around the world watched in disbelief as the mighty twin towers, symbols of America's power and prestige were toppled and destroyed as an estimated five thousand people lost their lives (BLS Mulls, 2001). The impact was instantaneous and catastrophic. During and immediately following the terrorists' attacks all media attention was focused on Ground Zero. Many Americans hid in their homes, watching the news coverage on television, and wondering if the end was near. The entire world watched in shock and disbelief as mighty America was dealt a devastating blow.

This catastrophic strike caught the United States completely off guard. The population was shocked and horrified over this disastrous event (Scurfield, 2002). Citizens from New York to California sobbed and shook their fists with explosive emotions at this heartless and cowardly act of abhorrence.

Among those watching the continuous news coverage were nearly 25 million American veterans (World Almanac,

2002) who had fought to protect the United States from such enemies. As these veterans now watched in horror, it was obvious that the fight had come home, to their soil, and to their beloved America. This study was interested in how these same veterans coped with the events that took place on September 11<sup>th</sup>. Furthermore, this study sought to understand what behavioral and social changes may have occurred in the lives of veterans following the events of September 11<sup>th</sup>.

All Americans were impacted by September 11<sup>th</sup> in some way or another. With such a surprising and devastating catastrophe it is normal to experience intense emotional reactions (Hall, Dobb, & Hall, 2001; Tyler, 2000, van der Kolk, McFarlane, & Weisaeth, 1996; Weiss, 1993). However, if these trauma-induced emotions are not dealt with in a healthy psychological way they may result in a negative reaction by the individual (Aldwin, Levenson, & Spiro, 1994; Alker, 1968; Allen, 1995; Butler & Lewis, 1977; Weiss, 1993). Studies indicate that many combat veterans continue to suffer years later from the effects of combat (Hyer & Stanger, 1999; Sleek, 1998). These effects can manifest themselves in conditions such as depression (Hyer & Stanger, 1999) and posttraumatic stress disorder [PTSD] (American Psychiatric Association, 2000; van der Kolk et

al., 1996; Weiss, 1993). It is possible that the attacks of September 11<sup>th</sup> exacerbated these conditions in some veterans.

In response to the intense reaction people can have to such catastrophes (Aldwin et al., 1994; van der Kolk et al., 1996; Scurfield, 2002), Institutions working with "at-risk" populations may implement crisis teams or pamphlets to address the psychological implications of such a traumatic and stressful event (Follette, Ruzek, & Abueg, 1998).

Institutions such as schools, hospitals, businesses, and churches may have clergy, social workers, or counselors on staff to address issues of trauma and to help their employees or parishioners understand their feelings and explain healthy ways to cope with these emotions. However, many people do not have access to such counseling. These would include those who are socially isolated and who are unable to access the necessary interventions to help coping with trauma.

Older veterans may be included in this group of isolated individuals who come from all walks of life (Elder & Clipp, 1988; Matsakis, 1994). Since some are thought to have little or no contact with family or friends and since many have no living family members,

social support can be an important factor in minimizing the negative effects of stressors (Chou & Chi, 2001; George, 1989; Krause, 1986; Krause & Borawski-Clark, 1994; Krause, Liang, & Keith, 1990). Also, due to a lack of resources and social supports, isolated adults can be at an increased risk of developing acute or chronic health problems when such traumatic events occur (Coe, 1983; Fry, 1986; Rosow, 1967).

There are additional factors that can complicate the ways in which older adults cope with such catastrophes. For example, older adults may have experienced multiple losses of family and friends during their lifetimes (Coe, 1983; Fry, 1986). In the case of America's veterans, some may have suffered traumatic losses during combat (Elder & Clip, 1988). Many older Americans also vividly remember events such as the Depression, Pearl Harbor, the uncertain times during World War I and II, and the Korean War. Many may have lost loved ones in Vietnam or had children and grandchildren who fought in Desert Storm. These past memories could exacerbate any psychological trauma that occurs when catastrophes such as September 11<sup>th</sup> take place (Clines, 2001).

Evidence shows that individuals who have suffered acute traumas may be more susceptible to the negative

effects of future traumatic events (Aldwin et al., 1994; King, King, Keane, Foy, & Fairbank, 1999; Matsakis, 1994; van der Kolk et al., 1996). It would seem that for those who have been directly involved in combat and who have witnessed first hand the horrendous effects of such conflicts, September 11<sup>th</sup> would only serve to increase the likelihood of a negative reaction. For WWII veterans the acts committed on September 11<sup>th</sup> parallel those committed during the attack on Pearl Harbor (Clines, 2001). For these veterans, attacks such as September 11<sup>th</sup> may arouse emotions connected with the experiences of war and cause veterans to fear that another World War may be eminent. Many older veterans are at a stage of life when they have limited outlets for expression and limited social supports (Elder & Clipp, 1988; Matsakis 1994).

#### Purpose of the Study

When considering the possible risk factors faced by older veterans such as isolation, decreased resources, increased health problems, and a history of loss and trauma, it would be beneficial for Aging and Adult Services, Veterans Administration, and certain Veterans groups to have a greater understanding of what impact disasters of this magnitude have on older veterans and

older adults. This study proposed to provide a clear conceptualization of how veterans respond and cope with crises such as the September 11<sup>th</sup> attacks. This information will guide the outreach and interventions of agencies that are in contact with older veteran populations by understanding their unique reaction to such traumatic events. Agencies such as the Veterans Administration, veterans groups and the Department of Aging and Adult Services may all be interested in knowing the impact of September 11<sup>th</sup> on older American veterans.

This study determined how veterans reacted to the events of September 11<sup>th</sup>. In particular, the study was interested in how veterans coped with the trauma. Socially isolated veterans may have attempted to contact old veteran friends or veterans groups as a way of coping with such a traumatic event. Veterans who were unable to reach out to others may have suffered from additional trauma due to the isolation and the inability to reconnect with the outside world after the attacks. Veterans who were able to connect or reconnect with other veterans may have coped better than those who did not. The researchers examined if the veterans with strong social supports were better able to cope than those who had little to none. Veterans who had little or no social support may have benefited by



agency social workers. Visits by agency social workers may prove invaluable in helping isolated veterans cope with such traumatic events if another were to happen in the future.

#### Significance of the Project for Social Work Practice

Certain agencies such as the Department of Aging and Adult Services have in place a protocol (Department of Aging and Adult Services, 1996) for contacting older adults when a disaster takes place. Currently, the department requires that a 'Disaster Preparedness' sheet be kept in each of the client's files. This sheet indicates if the older adult is in need of immediate contact by a social worker following a disaster. The sheet indicates if the client has family or support systems nearby or if the client is socially isolated and what physical limitations and medication needs the client may have. For the purposes of Aging and Adult Services, disasters are usually defined as a crisis that would immediately effect the client such as an earthquake, fire or flood. In the event of a disaster, social workers would then contact those who are considered high-risk based on a rated score in the categories of social support, health, mental health, and necessary medical interventions. Since

there was no immediate physical effect on clients in the case of September 11<sup>th</sup> the disaster kit was not utilized.

The information gathered in the current study could be valuable to those agencies that serve older veterans and older adults. The current study could also be significant in helping agencies determine whether older veterans or older adults should be contacted after catastrophic events such as the attacks that took place on September 11<sup>th</sup> even though the disaster had no direct impact on them or their home. As identified, even without direct physical harm there can be ramifications in psychological, behavioral, and physiological reactions to such emotion provoking incidents.

With ever changing political and world events, it is nearly certain that terrorist acts, wars and threats of war will continue. Also, at this time the full impact that these events on our older veteran population is unknown, therefore, when these factors are combined, it is necessary to determine if older adults and specifically older veterans are in need of additional attention after such catastrophic events. If it is found that older veterans were seriously effected by the events of September 11<sup>th</sup> then perhaps these various agencies should consider a change in protocol to cope with such disasters.

In doing so, the agencies could have social workers contact the clients in their caseloads that are considered high risk. The social worker could then inquire as to how the elder is dealing with the event and how well the elder is coping. If it is found that the elder is having trouble coping with the event, the social worker could then work more closely with the client and possibly provide any additional needed services.

In conclusion, it was for these reasons that the researchers asked the question, "What was the impact of September 11<sup>th</sup> on older American veterans?"

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

Chapter Two consists of a discussion of the relevant literature, specifically, the conceptualization of trauma and various research findings on the human response to trauma. These findings directly relate to the unique manner in which later life developmental stages (Erikson, Erikson, & Kivnik, 1986), previous life crises (Freedy, Kilpatrick, & Resnick, 1993; van der Kolk et al., 1996), and veteran experiences may impact individual responses to traumatic events. Findings from past research identify vulnerabilities that are often consistent in combat veterans and older adults (Coe, 1983; Follete, Ruzek, & Abueg, 1998; Summers & Hyer, 1994; Matsakis, 1994). When examining the effects of these risks it is obvious that older veterans have an incredible challenge when faced with severe stressors (Coe, 1983; Fry, 1986). These stressors are often expressed in extraordinary ways among elders (Epstein, 1976; Fry, 1986; Reis, Ross, Brodsky, Specht, & Joh, 1976). How these intense feelings impact veterans when combined with vulnerabilities has yet to be examined.

## Human Response to Trauma

The Diagnostic and Statistical Manual IV-TR (American Psychiatric Association, 2000) states that a person has been exposed to a traumatic event when: 1) "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity to self or others, and 2) the person's response involved intense fear, helplessness, or horror" (463-464). Whether witnessed directly or through media, when such a trauma occurs a wide range of changes may occur in response to stress situations. Some of the possible negative effects include anxiety, depression, and PTSD (Tyler, 2000; van der Kolk et al., 1996; van der Kolk, Boyd, Krystal, & Greenberg, 1984), cognition (Johnson & Magaro, 1987), anger, self doubt, hopelessness (Matsakis, 1994), helplessness (van der Kolk et al., 1996), pushing away of support systems (Matsakis, 1994), reliving previous trauma (Follette et al., 1998), cognitive impairments (Litz & Keane 1989), health problems (Irwin, Daniels, Bloom, Smoth, & Weiner, 1987; Turner & Avison, 1992), and developmental problems (Allen, 1995; Follette et al., 1998).

With such an array of possible negative responses it is difficult to pinpoint individual reactions. Each individual's response will be influenced by a complex matrix of biological, social, temperamental, and experiential issues. Not everyone who experiences trauma has overwhelming symptoms (van der Kolk et al., 1996). Some individual risk factors include a history of exposure to trauma, prior victimization, and a history of mental illness (van der Kolk et al., 1996). Similarly, Follette, Ruzek, and Abueg (1998) identify the myriad of factors related to the nature of the trauma, such as duration, intensity, reoccurrence, and threat, the balancing of risk and resiliency components, cognitive coping strategies, the social network, and predisposing factors interact to produce a response to trauma. Certain groups have been particularly at risk for psychological stress: they include children, the elderly, and low-income individuals (Summers & Cowan, 1991).

#### Coping with Trauma in Late Life

While both children and the aged are identified as at-risk populations, research for the most part has been unbalanced. While an immense amount of research has focused on a child's response to trauma, there has been

little or no research on how the aged respond. With age there also comes a variety of life experiences, and as individuals age they are faced with multiple losses. These losses not only include family and friends, but also the elder's independence, financial resources, health, and cognition (Coe, 1983; Fry, 1986). Evidence suggests that an elder's sense of control diminishes because of these reoccurring losses (Chou & Chi, 2001), and quite often this leaves the older adult with feelings of helplessness and despair (van der Kolk et al., 1996).

As the older adult attempts to reconcile these losses it becomes increasingly difficult to move forward into the natural stages of development, especially when faced with unexpected stress and trauma (Freedy, Kilpatrick, & Resnick, 1993; Matsakis, 1994). To gain an understanding of how older adults adjust to traumatic events, research depends to some extent on knowing the chronological status and lifespan trajectory of events (Follette et al., 1998). Due to the multiple losses incurred in late life, Hyer and Stanger (1999) argue that those who suffer from PTSD may suffer from an anxiety disorder in which depression plays a major part. Later life is often fraught with life challenges, and unresolved crises of the past and present

may impede the ability to successfully integrate further stress experiences (Erikson et al., 1986).

### Veterans and Trauma

The often debilitating effects of trauma were first brought to the public's attention after World War I (van der Kolk et al., 1996). Incidents of combat trauma suffered during the first World War were called shell shock and those who suffered from it were considered moral invalids (Leri, 1919). This ideology was carried through to World War II, during which time little effort was made to understand the effects of psychological traumas (Herman, 1992). It was not until the high incidence of PTSD identified after the Vietnam War that research began to specifically investigate wartime trauma (Barnes & Harvey, 2000).

While dysfunctional stress responses such as PTSD are more probable after psychological stressors such as combat (van der Kolk et al., 1996), approximately 70-75% of veterans are not identified as having these symptomologies (Perry, Difede, Musngi, Frances, & Jacobsberg, 1992; Shalev, Schreiber, & Galai, 1993). With regard to combat trauma, while 20% are symptom free, and 60% experience intermittent symptoms, approximately 20% continue to



suffer some type of symptoms continuously (Summers & Hyer, 1994). Risks for relapse in later life include poor coping skills, physical illness, functional impairment, and a history of stress (Follette et al., 1998). For some veterans, the effects of the trauma they suffered while in combat can continue as a stress factor throughout their lives (Hyer & Stanger, 1999). Veterans who suffer symptoms throughout life are often faced with the challenge of learning how to resolve novel stressors while still attempting to cope with past traumas.

Research suggests that some traumatized individuals who showed no symptoms of PTSD as young adults or middle-aged persons find themselves beset with PTSD symptoms in their later years (Sleek, 1998; van der Kolk et al., 1996). As trauma survivors age, the risk of experiencing physical and cognitive impairments due to advancing age and diminished health increases (Coe, 1983; Fry, 1986). In particular, neuropsychological impairments that lead to a disinhibition of affect, behavior, and memories may uniquely affect survivors of trauma and contribute to delayed PTSD (Matsakis, 1994). In addition, a study conducted by Sutker and Allain (1996) indicates that Major Depressive Disorder is reported to be prevalent in 13% to 42% of World War II and Korean combat veterans. Hyer and

Stanger (1999) would suggest that this is a representation of the comorbidity of PTSD and Depression.

It is noted that when trauma survivors encounter present-day stressors, they often become overwhelmed or dysfunctional (Matsakis, 1994). With these factors in mind, researchers must be aware that PTSD, which may not have manifested at an earlier age, may now become an issue for an older veteran, especially in reaction to catastrophic events. This study examined several indicators of PTSD to assess for such possible negative coping styles that would be triggered by September 11<sup>th</sup> events.

#### Theories Guiding Conceptualization

This study's conceptualization of response to trauma is based on Erikson's (1959, 1984) developmental late life stage of integrity versus despair. This stage of development challenges older adults to make peace with their past and to integrate their past experiences with their life as it is presently (Erikson et al., 1986). In Erikson's theoretical framework (1986) he purports the concept of life stage crisis. Erikson explains that during each developmental stage individuals encounter certain crises in relation to internal and external factors.

Resolution of these crises is imperative and their positive or negative outcomes will determine whether the individual will adapt functionally or dysfunctionally to further life crises.

The assertion that life stressors bring about gain versus loss would indicate that there is a dichotomy in response to crisis. It is hypothesized that those who overcome become stronger while those who do not overcome become more vulnerable. In other words, some become more resilient to future crises while others become more vulnerable. As Klein and Lindeman (1961) identify:

"hazards provide opportunity for promotion of emotional growth as well as occasions for preventative measures"

(p. 305). Janis (1951) found that civilian populations under repeated stressors tend to make increasingly effective adaptations. Baltes' (1987) ontological model suggests that there is no gain without loss and no loss without gain. The effects of combat exposure have been shown to have both vulnerability and resiliency factors (Aldwin et al., 1994; Elder & Clipp, 1988; King et al., 1999).

Resolution of the last stage indicates increased integrity, internal locus of control, passive mastery, reminiscence, and a self-orientation that seeks to set the

past right (Erikson et al., 1986). Perhaps the most important of these is a natural retrospective focus that seeks to meld with present concerns to allow for self-change. This retrospection inspires the last-stage adult to review the values and meaningfulness of life in an effort to meld it into an integral self. This integral self is one which is at peace with the past and able to move forward into the future.

At this stage of life, the account-making model (Barnes & Harvey, 2000) blends well with Erikson's integrity stage. Based on a narrative theoretical perspective, the account-making model (Harvey, Weber, & Orbuch, 1990) presumes that people develop an account of their major experiences in life as part of an overall life story. This 'account' is comprised of both positive and negative experiences. As an indicator of the uniqueness of late-life integrity, research has found that most war veterans do not open up and reminisce about their wartime experiences until approximately 40 to 50 years after they have served in combat (Barnes & Harvey, 2000; Slick 1998). Also, to reinforce this theoretical concept, Elder and Clipp (1988) found that older veterans seeking interaction from comrades, most often spoke of the course their lives took, how they have searched for inner peace and self

understanding and the importance of the 'unity of self'. Bar-Tur and Levy-Shiff (2000) found that in old age the goal is one of surviving loss and integrating oneself into a new social context and identity. The evidence found in Bar-Tur and Levy-Shiff's (2000) study integrates well with the last of the developmental tasks purported by Erikson. These are the tasks of life-love, care, and wisdom (Erikson et al., 1986). If these developmental tasks are present in the life of the older adult, then they are assured that a sense of integrity has been achieved.

Integrity in love, care, and wisdom requires intimate interaction (Erikson, 1959). Erikson's formulation emphasizes the individual's constant and active intercourse with the environment, which is considered crucial for development. Similarly, Bar-Tur and Levy-Shiff (2000) assert from their treatment of PTSD veterans, that successful adjustment is based on mental and emotional engagements that are needed to ensure developmental gains. Barnes and Harvey (2000) reinforce the concept of an elder's need to express their experience, which is evidenced in their account-making study of veteran narratives. Their study demonstrated the older veteran's need to make a life story to express their experiences.

Social support is also a necessary component in the adjustment to stress and trauma, which can occur as individuals age (Barnes & Harvey, 2000; Billings & Moos, 1985; Chou & Chi, 2001; Feld & George, 1994; George, 1989; Glass, Kasl, & Berkman, 1997; Krause, 1986; Krause & Borawski-Clark, 1994; van der Kolk et al., 1996). Social support seems to enhance the emotional processing necessary for the relief of anxiety as well as depression (Chou & Chi 2001; Potts, 1997) in the older adult. While social support is vital to the well-being of the aged, it unfortunately tends to decrease as relatives and friends die, move away, or become seriously ill or incapacitated (Follette et al., 1998; Fry, 1986). Also, in rare cases social supports may also be rejected by the traumatized individual who may feel as though they are not needed (Matsakis, 1994).

#### Summary

The world watched the events of September 11<sup>th</sup> in shock. Among those who stared in disbelief and horror were older veterans who had risked their lives for America. With such a surprising and devastating trauma, one wonders how did these older American veterans coped with such a catastrophic event. With the myriad of risk factors and

traumatic life experiences with which older veterans are faced, feelings of anxiety and depression are an expected response. These factors coupled with the limited support and social outlets of aging, also impact the veteran's ability to cope with such intense traumatic stressors (Chou & Chi 2001; Potts, 1997). It compels the social agencies in contact with veterans to better understand how these coping mechanisms are crucial to their later-life development.

The research has identified the varied cognitive, behavioral, emotional, physical, and social effects of stress on individuals. Further, the research reviewed for this study indicated how older adults and veterans uniquely respond to trauma. The various responses are based on certain vulnerabilities, resiliencies, and life experiences, as well as late life stressors. When considering the vulnerabilities of both the veteran and the older adult, one must ask how they will adjust to or manage possible life stressors.

The literature review identified the developmental framework that this study uses to conceptualize life trauma in old age. Specifically, identifying the developmental tasks as theorized by Erikson which occur in late life and which are required to necessitate the

integration of past experiences into life, love, care, and wisdom. As research has shown, without achieving these developmental milestones the elder's life is sure to be lived out in a state of despair. Therefore, this study sought to examine the behavioral responses to September 11<sup>th</sup> in an attempt to understand whether older veterans are able to resolve traumatic experience to move forward in later life development or if such traumatic events instead thwart natural life processes.



## CHAPTER THREE

### METHODS

#### Introduction

This exploratory study used open-ended and quantitative questioning in assessing the reaction of American Veterans to the events of September 11th. As the design section discusses, the instrument was created in order to ascertain the unique response of the older veteran population to these events. The sampling section of this study outlined the procedures and criteria by which participants were selected for participation. The instrument composed and used by researchers was based on knowledge and experience with regard to the assessment of the sample population. The possible strengths and weaknesses of the instrument were also discussed. The researchers implemented the instrument and all individuals participating in the study were assured of their anonymity. Participation was voluntary and participants were asked to give prior consent. After participants completed the study, they were provided with referrals in the event that the survey was hyper-arousing. Due to the qualitative nature of the study, data analysis used a Chi-square statistical test to assess the significance of

the reaction between grouped participants. Participants were grouped into several categories based on chosen research criteria. Finally, the analysis provided general information on participant demographics.

### Study Design

This study was designed to explore the type of behavioral reactions that occur in response to catastrophic events such as September 11th. Since nearly no published data has addressed this specific area qualitative as well as quantitative questions were utilized. Response validity was limited due to the decline of cognitive functioning in old age and the time-lapse of events since September 11<sup>th</sup>. Further, assessing veterans who had a strong emotional response was difficult due to the fact that they may have incurred both mental and physical health problems, which resulted in institutionalization or withdrawal from groups from which the study was drawn.

### Sampling

Forty-three participants were solicited by the researchers from places known to be frequented by veterans. These places included the VFW and American Legions in both rural and urban Riverside and San

Bernardino Counties. Researchers attempted to attain a balance between able and disabled veterans by surveying veterans from organizations such as the VFW and American Legion.

Researchers used contacts from the VFW and American Legions as a base in order to contact veterans in other VFW's and American Legions in neighboring areas. All participants were 55 years of age or older and had been active members in one of America's armed forces.

#### Data Collection and Instruments

Exploring the behavioral reaction of participants involved the creation of a unique instrument, since no prior measure had been designed for this purpose. The measure (see Appendix A) was designed to assess what behaviors correlate with the veteran's external social environment. The measure also addressed the veteran's response to September 11th and examined health factors in relation to the September 11th event.

Behavioral reactions were distinguished as specific reactions to external social stimuli. The dependent variables that measured these reactions focused on the interaction between the veteran and his social contacts. Social contacts included spouse, non-veteran friends and

acquaintances, veteran friends and acquaintances, VFW club members, other veteran affiliates, counselors/social workers, medical professionals, fellow church parishioners, neighbors, children, grandchildren, and other relatives. The dependent variable included the amount of interaction such as phone calls, visitations, letter writing, and e-mails with each social contact. The study allowed for interpretations of increased involvement versus withdrawal or pushing away of social supports.

Independent variables included demographics of age and marital status. The amount of exposure following September 11th was reported at multiple time intervals of 24-hours, 1-week, and 1-month. Exposure was measured by determining the amount of time the veteran spent listening to the radio, watching television, and reading newspapers.

The veteran's involvement in the service was evidenced by years in service and time in combat. The veterans current association with the military (open-ended) was also measured. In addition, a subjective 5-point Likert scale measured the veterans perceived social support network. The scale was designed to determine the amount of social support each contact provides. This was measured in seven areas: 1) non-veteran friends 2) veteran friends, 3) children, 4) grandchildren,

5) spouse or significant other, 6) relatives, and 7) professionals such as caregivers, therapists, and social workers. Finally, any risk factors that intensified the veteran's reaction to the events of 9/11 were measured. These included: 1) the veteran's health status and whether it is excellent, good, fair, or poor; 2) How well the veteran ambulates and whether the veteran is dependent upon a cane or a walker; 3) Whether the veteran is wheelchair or bed bound; 4) What transportation is available to the veteran: none, public transportation, asks a friend, drives self, or other; 5) If there is a history of mental illness such as a current or prior anxiety disorder, depression, anger control, or other (to be specified); and, 6) Has the veteran lost anyone close to them in the last year and if so, how many and who.

The instrument that was created was based on an extensive literature review of veteran's reactions to trauma and stress, various preliminary discussions with veterans, and the reactions of older adults in general to stressful events. The researchers also used the experience they have gained in working with the aged to help guide the formation of questions used in the study. Using such an exploratory measure allowed the researchers to acquire

a wider array of responses however, the strength of the instruments validity and reliability was limited.

#### Procedures

Data were collected between August 2002 and February 2003, from approximately 11-months to 17-months following the disaster. The researchers solicited participants at veterans clubs such as the VFW and the American Legion in order to seek out veterans involved in their communities. The 20-minute study was designed to assist governmental agencies, social workers and counselors as well as future generations to understand the impact of such an event on our veterans and older adults. After volunteering, participants were given the survey packet to fill out. The survey was printed in 14 Courier New for the visually impaired. If the veteran required assistance in reading or understanding the questions the researchers were available to assist. When finished, participants placed completed surveys directly into a collection receptacle.

#### Protection of Human Subjects

Each survey packet contained a cover letter as the first page (see Appendix B). The cover letter established informed consent by outlining the study's purpose, the volunteer status of the participants, the anonymity of the

survey, the possibility of a negative reaction to the survey, and the resources available to the veteran in the event that such negative reactions occur. Each participant made a mark on the informed consent prior to survey completion acknowledging their awareness of the expectations of the study and it's possible risks. The questionnaire provided by researchers had no particular marks or identifying data. This was done to protect the identity of all participants. The final page of the survey contained a debriefing statement (see Appendix C) reiterating the possible emotions that could be evoked by the survey, resources available in the event of a negative reaction, who the participant can contact for questions or concerns, and how the results of the research may be attained. In addition, researchers stored all completed surveys in random order. All surveys were kept secure and treated with the utmost care.

#### Data Analysis

Media exposure was based on three questions ascertaining the frequency of exposure in the first 24 hours, one-week, and one-month after the event. The responses on the Likert scale were summed for media exposure analysis.

The 10 likert items reflecting symptoms of PTSD were recoded in two ways for analysis purposes. First, the number of PTSD symptoms that participants stated occurred once a week or more frequently. Answers could range from zero positive symptoms up to 10 positive symptoms. Second, the sum of the Likert responses to all 10 PTSD symptoms. For this summed scale possible scores range from 10 up to 50.

For the open-ended variable 'type of action' researchers examined specific responses given by participants. Based on these responses categories were formed based on similarities. These grouped responses were used for comparative analysis among variables.

The variable 'type of advice', which was also open-ended, was examined by researchers to determine the similarities of individual responses given by participants. Based on these responses researchers formed categories for comparative analysis.

The survey question asking how participants coped with 'upset feelings' was categorized by researchers into healthy and unhealthy coping mechanisms. Healthy coping was identified as talking to someone they could trust, keeping busy, and staying away from additional stimuli. Unhealthy coping was identified as drinking alcohol or



displacing onto other people or objects. An option for 'other' was also given which was taking other possible coping techniques into consideration.

The concept of social support was ascertained by two variables. The first variable was the number of contacts participants had with others. This was a summed number of contacts from each contact area. This summed variable could range from zero to an unknown maximum based on how many contacts participants report. The second way of examining social support was by determining the subjective 'feelings of support' from each of the contact areas. This variable was an average of all of the contact's subjective ratings. A minimum average would be one, maximum average would be five.

The participant's ages were divided into older and younger groups based on an even distribution for the purpose of developmental analysis. Minimum age for participation was 55 years old, maximum is based on oldest participant's age. The younger age group was 55 to 69 years old. The older age group was all participants over 69 years old.

## Summary

This study was designed by researchers to understand the response of veterans to events such as 9/11. At this time, the study is unprecedented in its scope. The researchers explored the reactive behaviors of veterans to traumatic events and also investigated the responding interaction the veterans have with their surrounding social environment. Various demographics, risk factors, military experience, and social support variables may contribute or alter the particular reaction. Having no prior instrument to address this, the researchers created the instrument based on interviews with veterans as well as the experience they have acquired professionally working with the aged. The survey instrument was administered at veteran affiliates and to the participant's associates by researchers. All efforts were made to protect the participants through informed consent, and by protecting the participant's anonymity as well as by providing referrals to the participants when needed. A chi-square statistical test determined the statistical differences of researcher grouped variables and to determine significance. While limitations exist in the study's sampling and instrumentation, this is part of the

nature of an exploratory study. Efforts were made by researchers to ensure accurate and reliable responses.

## CHAPTER FOUR

### RESULTS

#### Introduction

The nature of exploratory studies is to discover responses that would allow for future research concepts and a foundation from which to continue further research. The mere evidence of an individual's response in such an unprecedented study allows for a myriad of future investigations.

Findings from this study attempted to collaborate past findings for external validity, examined groupings of variables and correlations among scaled and summed variables for internal validity, and examined unique responses and demographics.

#### Presentation of the Findings

The study consisted of 41 males and two females. Of the study participants 26 were married, nine were divorced and four were widowed. The age distribution was 55 to 87 with the mean age of 68.7 (SD = 9.24). All study participants lived in rural areas.

Health status reported by participants indicates that prior to September 11, 2001, 10 reported excellent health, 22 good health, nine fair health, and one poor health.

After September 11, 2001, 10 reported excellent health, 26 good health, six fair health, and no one reported poor health.

Thirty-three respondents were located at local American Legions, seven were located at local VFW's and two participated during a 9/11 remembrance event (see Figure 1).

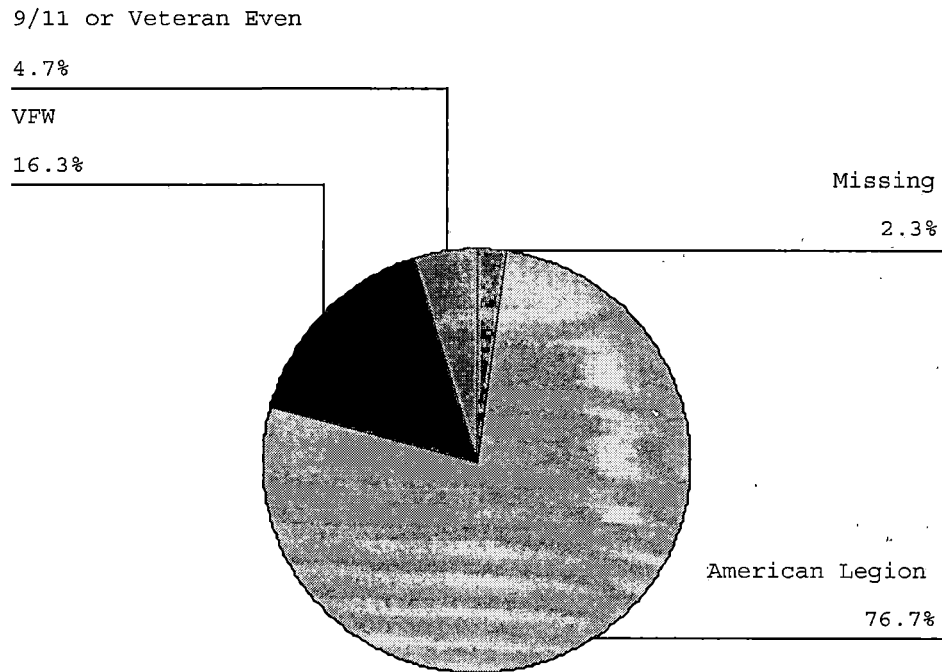


Figure 1. Where Participants were Surveyed

All participants indicated that they were able to ambulate independently (n = 43). Thirty-eight stated that

they were able to drive, two used public transportation, and one could not leave his home.

Fifteen participants were in the Army, 10 were in the Navy, eight were in the Air Force, and six were in the Marines, zero participants stated that they were in the Coast Guard.

Of the participants 14 served in WWII, 16 served in Korea and 20 served in Vietnam, with some serving in more than one war. Time in combat ranged from zero to 14 years with 2.01 as the mean (SD = 2.66). Years in the service ranged from one to 31 years. The mean is 9.24 years (SD = 9.53).

The average number of losses (loved ones) suffered by the veterans was .8 (SD = .97). Nineteen veterans had no losses, 14 had one loss, three had two losses, and four veterans had three or more losses.

The type of action that was taken after hearing of the attacks on September 11<sup>th</sup> was divided into six categories based on participant responses. The most common response category was to contact someone (n = 12) which represents responses such as "called my family," "called a vet friend," "called my children," etc. The category deep feeling (n = 5) is derived from statements such as "feeling angry," "devastated" and "hopeless." The act of

patriotism category (n = 4) is from answers stating that they "flew my flag," "flew my flag at half-mast" and "went to the post." Moving on (n = 5), is a category in which respondents stated that they "went to work" and "moved on." Prayer (n = 2) is another category indicating responses of "I prayed," and "I went to church and prayed." Last, the category of seeking information (n = 4) in which participants stated that they "turned on the TV," "bought a newspaper" and "turned on different TV stations" (see Figure 2).

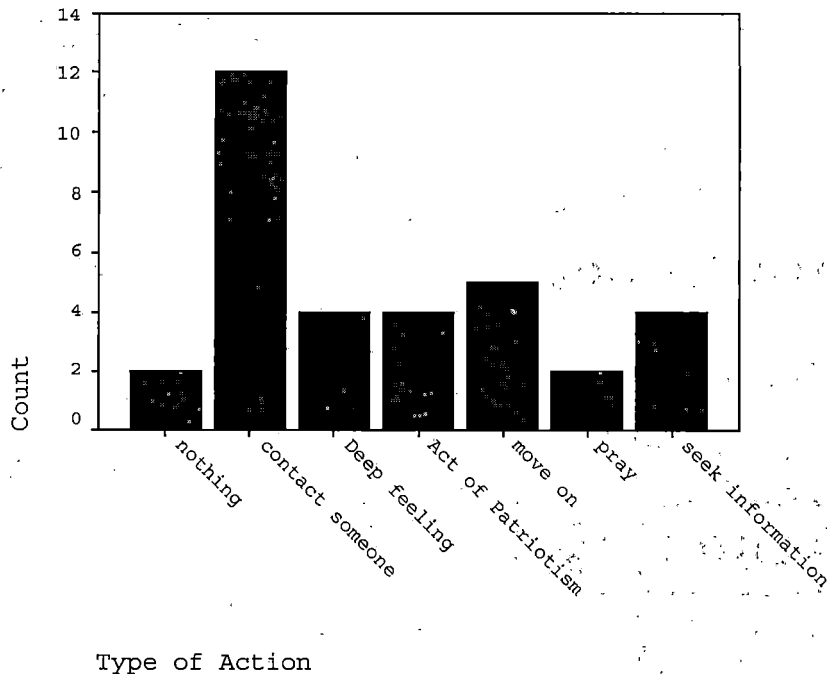


Figure 2. Number of Participants Taking Types of Actions

Advice categories were divided into the following:  
 would not give advice (n = 14), 2) preparedness [n = 6]  
 (e.g. "prepare for the worst," "be careful," "don't travel  
 to the Middle East," 3) seek revenge [n = 5] (e.g. "seek  
 revenge," "get even with those bastards") 4) get  
 information [n = 5] (e.g. "look at all angles," "find the  
 truth") 5) pray [n = 1] ("to pray") 6) help others [n = 1]  
 ("support victims") 6) remember [n = 8] (e.g. "don't  
 forget," "learn from the past," "never forget") [see  
 Figure 3].

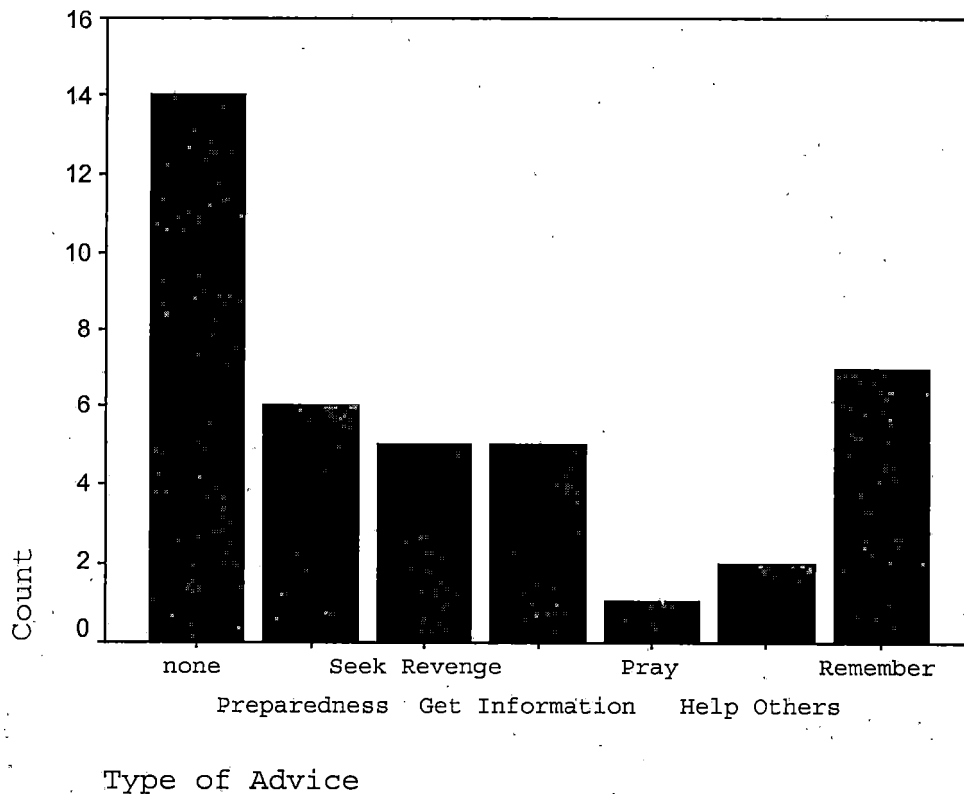


Figure 3. Number of Individuals Giving Types of Advice



Regarding social support, in the sample mean number of contacts is 103.31 (SD = 111.33) ranging from five to 424.

Interrater reliability for categorization of 'type of action' was tested using the Alpha reliability analysis test. The test showed a 100% reliability ( $\alpha = 1$ ). The interrater reliability for categorization of type of advice showed a high degree of agreement ( $\alpha = .97$ ).

PTSD Likert items from the instrument were tested for intercorrelations to determine whether a summation of scores would be valid. The Pearson's two-tailed test demonstrated high correlation values among the variables at a significant level (see Table 1).

The mean number of PTSD symptoms was 5.63 (SD = 2.71), ranging from zero to 10. For analysis purposes age was broken down into two categories based on the distribution of ages. The first category was from 55 to 69 ( $n = 21$ ) and the other 69 and older ( $n = 22$ ). Media exposure was calculated into a mean variable. Responses to contacts were divided into low and high amounts of contacts. Low amounts of contacts were put into less than 50 ( $n = 19$ ) and high amount being more than 50 ( $n = 20$ ), based on equal distribution.

Table 1. Correlations Among Posttraumatic Stress Disorder Variables

Frequency of	agitation	startle	focus problem	anger outburst	negative thoughts	military memories	Nightmares	trouble sleeping	feeling sad	easily tired
agitation	1	.354*	.103	.582**	.445**	.423**	.047	.153	.388	.268
		.027	.525	.000	.005	.007	.777	.353	.013	.099
startle		1	.588**	.599**	.373*	.450**	.532**	.328*	.450**	.045
			.000	.000	.021	.004	.001	.044	.004	.788
focus problem			1	.439**	.192	.358*	.302	.172	.276	.121
				.005	.243	.023	.061	.296	.085	.462
anger outburst				1	.400*	.311	.202	.197	.458**	.124
					.012	.051	.216	.229	.003	.453
negative thoughts					1	.468**	.236	.200	.490**	.262
						.003	.154	.228	.002	.112
military memories						1	.319*	.130	.388*	.061
							.048	.431	.013	.712
Nightmares							1	.434**	.275	-.018
								.006	.090	.913
trouble sleeping								1	.308	.183
									.056	.263
feeling sad									1	.568**
										.000
easily tired										1

\* Correlation is significant at the 0.05 level (2-tailed)

\*\* Correlation is significant at the 0.01 level (2-tailed)

For the subjective amount of social support Likert items were tested for intercorrelation in order to demonstrate whether a mean score would be valid. The Pearson's two-tailed test demonstrated high correlation

values among variables at a significant level (see Table 2).

Table 2. Correlations Among Social Support Variables

How supportive	Nonveteran friends are	Veteran friends are	Children are	Grandchildren are	Relatives are	Professionals are
Nonveteran friends are	1	.236	.445**	.315	.668**	.260
Veteran friends are		1	.621**	.226	.322*	.233
Children are			1	.505**	.557**	.407*
Grandchildren are				1	.481**	.343*
Relatives are					1	.439**
Professionals are						1

\*\* Correlation is significant at the 0.01 level (2-tailed)

\* Correlation is significant at the 0.05 level (2-tailed)

A one-sample t-test compared means of subjective contact support between different contact groups. The mean for veterans support ( $x = 4.52$ ) was significantly higher than for nonveteran support [ $x = 3.52$ ] ( $t = 19.46$ ;  $df = 41$ ;  $p < 0.01$ ). The mean for veterans support ( $x = 4.52$ ) was significantly higher than for children's support [ $x = 4.10$ ] ( $t = 22.43$ ;  $df = 38$ ;  $p < 0.01$ ). The mean for veterans support ( $x = 4.52$ ) was significantly higher than for grandchildren support [ $x = 3.22$ ] ( $t = 12.22$ ;  $df = 36$ ;  $p < 0.01$ ). The mean for veterans

support ( $x = 4.52$ ) was significantly higher than for other relative's support [ $x = 3.80$ ] ( $t = 20.16$ ;  $df = 40$ ;  $p < 0.01$ ). The mean for veterans support ( $x = 4.52$ ) was significantly higher than for professional support [ $x = 2.93$ ] ( $t = 13.54$ ;  $df = 39$ ;  $p < 0.01$ ). The mean for veterans support ( $x = 4.52$ ) was significantly higher than for spousal support [ $x = 4.19$ ] ( $t = 16.92$ ;  $df = 36$ ;  $p < 0.01$ ).

Using a One-Way ANOVA, the mean of the number of symptoms and the sum of the PTSD symptom scale were compared based on the number of losses reported by participants. No significant associations were found.

When examining the correlation between combat time and the summed PTSD symptom scale using a Pearson two tailed correlation test, no significant associations were found.

When examining the correlations between combat time and the number of PTSD symptoms using a Pearson two tailed test no significant association was found between the variables.

Using a One-Way ANOVA, the categories of 'first actions taken' by participants after September 11<sup>th</sup> were compared with the amount of contacts the participants had

after the event. No significant associations were found between groups.

Categories of actions taken by participants were compared with the mean support using a One-Way Anova. No significant associations were found.

Using a chi-square test it was compared whether respondents in older age group would use a different category of action compared with the younger group. However, due to low group numbers the test results were invalid.

Using an independent t-test, the mean scores of veterans using unhealthy coping (displacement, alcohol) were compared to those using health coping (moving on, confiding, avoiding triggers). No significant associations were found.

A Pearson's two-tailed bivariate correlate test compared the number of contacts with the number of PTSD symptoms, but no significant associations were found.

Again using a Pearson's two-tailed bivariate correlate test, the mean of contact support was compared with the sum of the PTSD symptom scale. No significant association was found.

When exploring the possible correlation between the mean of contact support and the sum of the PTSD symptoms

scale, a Pearson's two-tailed bivariate correlate test indicated no significant associations were found.

The mean amount of exposure to media was investigated for the relationship to the sum of the PTSD scale. A Pearson's two-tailed correlation test was used and showed that there was no significant correlation between the variables.

Using a Pearson's two-tailed correlation test no significant correlation was found between the variables of the mean exposure to media and the number of PTSD symptoms.

When comparing healthy versus unhealthy coping means an independent t-test revealed no significant associations were found between variables.

An independent t-test was used to compare the means of married and unmarried veterans (divorced and widowed). The sum of the PTSD scale revealed a significant difference (Married mean = 16.67, Unmarried mean = 22.38,  $F = 2.42$ ,  $t = -2.77$ ,  $df = 4.59$ ,  $p = 0.04$ ).

When comparing the means of married and unmarried (divorced and widowed) veterans, the number of PTSD symptoms revealed a significant difference (Married mean = 2.75, Unmarried mean = 5.94,  $F = 2.78$ ,  $t = -2.245$ ,  $df = 37$ ,  $p = 0.03$ ).

## Summary

Chapter Four reviewed the results extracted from the project. When comparing both social support variables with both PTSD symptoms variables the tests revealed no significant interactions. Participants viewed support from other veterans as significantly more important than other contacts. When comparing combat time and time spent in the service with both PTSD variables, tests revealed no significant correlations. The amount of losses were not found to be significant in either PTSD variable. Married participants showed significantly lower scores on both PTSD variables (the sum and number of symptoms) than unmarried participants. Interrater reliability on grouping first action and grouping of type of advice was very high. Further, there was high intervariable correlation for PTSD symptom responses and social supports which supported the validity for the recoding of variables.

## CHAPTER FIVE

### DISCUSSION

#### Introduction

This exploratory study sought to examine the possible behavioral responses of older veterans to the events of September 11<sup>th</sup>. The study's goal was to determine the effect of traumatic events on older veterans who may or may not suffer from PTSD symptomology and to determine if possible, how this experience may effect late life development. Some of the questions that the researchers hoped to answer were: would older veterans seek out others but especially other veterans after a traumatic event such as 9/11? Would veterans who had spouses suffer less trauma or PTSD symptoms than a veteran who was alone and without close social supports? Would older veterans suffer from more, less, or the same amount of PTSD and depressive symptoms in relation to suffering losses from an event such as 9/11? Would those veterans with more contacts or social supports have more healthy coping mechanisms than those who had fewer contacts or social supports? And would the action taken after 9/11 vary according to age? Researchers also examined whether more time spent in combat would mean more PTSD symptoms.



## Discussion

One of the most significant findings in the study had to do with support that veterans receive from others in their life after a traumatic event. Veterans indicated that they felt they received significantly more support from other veteran friends than they did from any other person in their lives, including their spouse (see Figure 4).

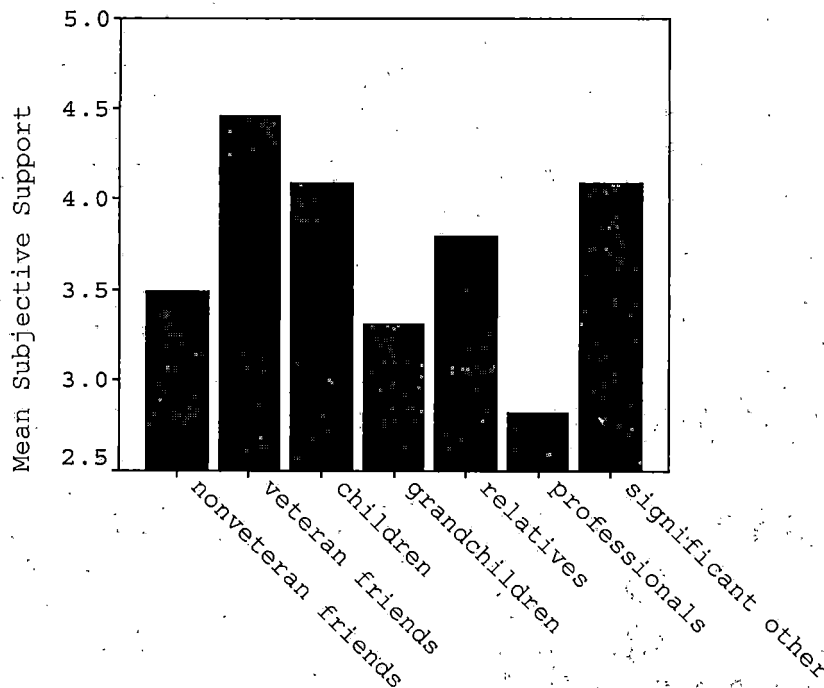


Figure 4. Comparison of Support by Contact Categories

As prior research has indicated, social support is a necessary component in adjusting to stress and trauma and is vital to the well-being of the aged (Barnes & Harvey,

2000; Billings & Moos, 1985; Chou & Chi, 2001; Feld & George, 1994; George, 1989; Glass, Kasl & Berkman, 1997; Krause, 1986; Krause & Borawski-Clark, 1994; van der Kolk et al., 1996; Follette et al., 1998; Fry, 1986). This study found that older veterans feel that their strongest allies and those they can depend on the most are other veterans which is consistent with the findings of Elder and Clipp (1998).

Another significant finding was the comparison between veterans who are married and those who are unmarried with regard to PTSD symptomology.

The research indicated that those who were married suffered significantly fewer PTSD symptoms than those who were currently not married (divorced, widowed, never married). This finding also agreed with findings of past research that states that intimate social supports are an important factor in dealing with trauma and loss.

While it would have been ideal to assess symptoms before and after the event to see the effect on PTSD symptoms, there is no way to predict such an event. However the majority of participants' subjective opinion was that they had more PTSD symptoms following the event (see Figure 5).

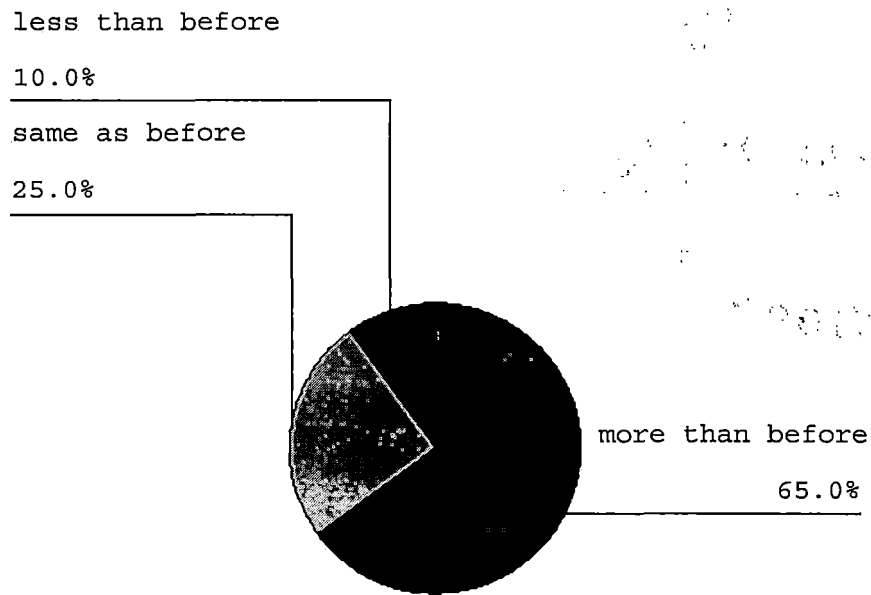


Figure 5. How do Post Trauma Symptoms Compare with Symptoms before September 11th

Actions that the veterans took after 9/11 and the advice they gave to others was also an area of interest in this study. It should be noted that although the sample of the types of actions taken or advice given was too small for analysis (according to age groups), this does not mean that a relationship does not exist. It would be expected that older veterans moving into the last stage of life would give advice that was concerned with preparing younger generations for the future. Giving advice such as "remember," "help others," "pray," and "prepare" is in

accordance with Erikson's theories on the advanced stages of aging. In conjunction with this theory, younger persons would be expected to fall into the "get revenge" category. This response is more likely to be found in those that haven't reached the love, wisdom, and social integration stage of development. Further research may also indicate that these types of answers by older veterans reinforce Erikson's theory regarding the last stages of development. Answers such as "remember," "help others," "pray," and "prepare," indicate that older veterans are concerned with life-love, care and wisdom and are attempting to bring about a sense of integrity in their final years and to future generations.

In other findings, there were a number of factors that were not found to have significant associations. As stated by Irwin, Daniels, Bloom, Smoth, and Weiner (1987) traumatic events in older adults can have a negative impact on older adults. One of the areas that they state a negative event can greatly impact is an older person's health. This study however showed no significant difference between the health of older veterans before 9/11 and after 9/11. The small differences that were noted indicated that the veterans in this study felt no significant health difference after 9/11 then before.

Other areas lacking significance included some surprising findings. One that is most noted is that there was no significant correlation between combat time (ranged from 1-14 years) and PTSD. It would seem on the surface that perhaps more combat time would be correlated with more trauma and therefore more PTSD symptoms, however in this study there was no significant association found between the two. Explanations for this could include resiliency factors or the possibility that once combat begins and the soldier faces the initial trauma of war and loss, the soldier then becomes desensitized to subsequent traumatic events. The latter merely a hypothesis that would require more study.

The correlation between coping mechanisms and PTSD was also explored however there was no significant association found between the two areas. For the purpose of the study, answers to the question "What did you do when you were feeling upset about it (9/11)?" were divided into two categories: healthy and unhealthy coping mechanisms. Limitations in this area could also be due to the fact that most participants in the study were found in social clubs where they both discussed the issue and where it is common for the veterans to drink together. It was also hard to determine how many veterans may have

withdrawn from friends and from the club as there was no access to those possible participants.

With regard to the face validity of the instrument, it was found to be adequate due to the direct and 'to the point' questions asked by the researchers.

Internal validity of the instrument proved to be adequate. Indicators of the internal validity included responses to questions regarding the participant's health before and after, the high correlation of PTSD symptom responses to PTSD questions and the high correlation of social support variables.

Research indicates that having more loss can exacerbate anxiety symptoms. Research in this area also indicates that social support is a factor in decreasing anxiety, however, no significance was found between the two in this project. While this may suggest invalid instrument measures, this could have been due to the fact that the sample was not diverse in support. In fact, most participants were found in a social club and most noted over 50 contacts with others. There may have been more difference had the participants had fewer contacts. This lack of diversity could have been a limitation on validity and inability to generalize findings. The sampling however

is a design flaw, not necessarily a factor with regard to the validity of the instrument.

#### Limitations

Limitations of the study were due to a number of factors. If the study had more participants to fill certain categories a chi-square could have been used for further analysis.

A more diverse sampling of males and females would have been favorable so that more comparative tests could have been run. As mentioned above and a more diverse social interaction sample would have been useful in comparing low and high social contact groups.

The study would have benefited from having more disabled and homebound veterans so that their reactions to 9/1 could have been studied. It was also assumed that having more urban veterans may have possibly given the study a different perspective.

Questions regarding injuries received during wartime experience would have added a different perspective to the study as would adding a depression scale along with the PTSD question.

## Recommendations for Social Work Practice, Policy and Research

Social work in general has been guilty of putting older adult issues on the back burner. It would behoove practitioners to pay more attention to the needs of older adults and older veterans.

Policies need to be developed that aid the older adult and older veteran in accessing the social supports that are needed in later life. One of the complaints that many older adults have is their inability to get out into the community once they are no longer able to drive.

Studies have shown time and again the importance of social supports in the lives of older adults. This study indicates that to veterans, other veterans are their most important and reliable support system. Policies should be designed to help older people to remain more independent and help them to access the supports they need.

Suggestions for future research include examining the effect of trauma on veterans using a more diverse and larger sample that includes disabled and homebound veterans and including questions with regard to war related injuries and depression. Further exploration of the spousal relationship with regard to PTSD symptoms would also be beneficial.



## Conclusions

Veterans, as other older adults, rely greatly on social support systems in order to deal with traumatic events in their lives. Veterans indicated in this study that they rely heavily on other veterans for support and, when a crisis occurs, are ready, willing and able to assist the younger generations in understanding what has taken place.

Veterans are a unique group of people, who in many cases have suffered severe trauma while serving and protecting our country. With this study and other such studies, we as practitioners can learn more about what support and help veterans and older adults need in times of crisis.

APPENDIX A  
QUESTIONNAIRE

1. How did you hear about September 11<sup>th</sup>?
2. Where were you when you learned about it?
3. Who was with you when you found out?
4. What was your first reaction to the news?
5. What were the first thoughts about the event?
6. How did you feel after learning about it?

For each time frame please circle approximately how often you were exposed to media covering September 11<sup>th</sup> (TV, Radio, Newspaper, Magazines):  
 1 = Not at all, 2 = Less than once a day, 3 = Once a day, 4 = More than twice a day, 5 = Every hour or more. (Circle one number for each question).

	Not at all	Less than once a day	Once a day	More than twice a day	Every hour or more
6. Within the 24 hours after event?	1	2	3	4	5
7. One week after event?	1	2	3	4	5
8. One month after the event?	1	2	3	4	5

How often have you had the following feelings since September 11th?  
 1 = Never, 2 = Once a week, 3 = Couple times a week, 4 = every day,  
 5 = more than once a day (circle one number for each question).

	Never	Once a week	Couple times a week	every day	more than once a day
9. Agitated	1	2	3	4	5
10. Easily Startled	1	2	3	4	5
11. Trouble focusing on tasks	1	2	3	4	5
12. Outbursts of anger	1	2	3	4	5
13. Unwanted negative thoughts	1	2	3	4	5
14. Memories of Military	1	2	3	4	5
15. Nightmares	1	2	3	4	5
16. Trouble sleeping	1	2	3	4	5
17. Feeling Sad	1	2	3	4	5
18. Easily tired	1	2	3	4	5

19. Compared with before September 11th these feelings are (circle one):

- a. More than before.
- b. Same as before.
- c. Less than before.

20. What was the first action you took after hearing the news?

21. What did you do when you were feeling upset about it? (circle all that apply)

- a. Stay away from media and places that were discussing it.
- b. Have a beer or another alcoholic drink.
- c. Talk to someone I could trust.
- d. Keep busy working.
- e. Take it out on something or someone else.
- f. Nothing.
- g. Other please specify: \_\_\_\_\_

22. Who did you contact (phone call, visit, letter, e-mail, etc.) after you heard the news? (Circle all that apply)

- a. Children
- b. Grandchildren
- c. Other relative
- d. Non-veteran friend
- e. Veteran friend
- f. Significant other
- g. Other please specify: \_\_\_\_\_

23. Did you give advice to younger generations? (circle one)

- a. yes
- b. no

24. If yes, what was the advice:

Who did you give advice to?:

If no, what advice would you give:

How often did you visit the veteran's club (example: VFW) 1 = Never, 2 = Less than once a month, 3 = Every month, 4 = Weekly, 5 = More than a few times a week. (please circle one for each question).

	Never	Less than once a month	Every month	Weekly	More than a few times a week
25. Before September 11 <sup>th</sup> ?	1	2	3	4	5
26. 1 Month after?	1	2	3	4	5
27. 3 months after?	1	2	3	4	5
28. Currently?	1	2	3	4	5

For the following, Contact means any type of communication whether it be a phone call, writing letters, seeing in person, or e-mailing. Please answer the questions below with a number.

29. How many non-veteran friends do you have contact with? \_\_\_\_\_
30. How many veteran friends do you have contact with? \_\_\_\_\_
31. How many children do you have contact with? \_\_\_\_\_
32. How many grand-children do you have contact with? \_\_\_\_\_
33. How many other relatives do you have contact with? \_\_\_\_\_
34. How many supportive professionals (Caregiver, Therapist, Doctor, Social Worker) do you have contact with? \_\_\_\_\_
35. Are you married or living with a significant other? (Please circle one)
  - a. yes
  - b. no

For each of the above how helpful would they be if you needed them? 1 = not helpful, 2 = a little helpful, 3 = somewhat helpful 4 = helpful, 5 = very helpful.

	not helpful	a little helpful	somewhat helpful	helpful	very helpful
36. Non-veteran friends	1	2	3	4	5
37. Veteran friends	1	2	3	4	5
38. Children	1	2	3	4	5
39. Grandchildren	1	2	3	4	5
40. Relatives	1	2	3	4	5
41. Professionals	1	2	3	4	5
42. Spouse or significant other	1	2	3	4	5
43. How many times did you visit your doctor in the 6 months before September 11 <sup>th</sup> ? _____					
44. How many times did you visit your doctor in the 6 months after September 11 <sup>th</sup> ? _____					
45. How would you rate your health before September 11 <sup>th</sup> ?					
a. Excellent					
b. Good					
c. Fair					
d. Poor					
46. How would you rate your health after September 11 <sup>th</sup> ?					
a. Excellent					
b. Good					
c. Fair					
d. Poor					



47. Have you ever been told you have had any of the following by a Doctor or other Professional? (circle all that apply)

- a. PTSD (post traumatic stress disorder)
- b. Depression
- c. Anxiety Disorder
- d. Anger Problem
- e. Other please specify: \_\_\_\_\_
- f. None of the above

48. How were you able to walk or get around on September 11th?

- a. Walk independently
- b. Use a cane
- c. Use a walker
- d. Use a wheelchair
- e. I was bedbound

49. How were you able to travel on September 11th?

- a. Drove my car
- b. Someone else drives me
- c. Public transportation
- d. I had no way to travel

50. What year were you born? \_\_\_\_\_

51. What is your marital status?

- a. Widowed
- b. Divorced
- c. Single (never married)
- d. Married

52. What branch of the armed forces did you serve in?

- a. Army
- b. Navy
- c. Airforce
- d. Marines
- e. Special Forces

53. Which wars were you active during? (Circle all that apply)
- a. World War II
  - b. Korean
  - c. Vietnam
  - d. other please specify: \_\_\_\_\_
54. How many years were you in the service? \_\_\_\_\_
55. Of your service how much time was in combat? \_\_\_\_\_
56. Are you currently associated with the military? (circle one)
- a. yes
  - b. no
57. If yes, how are you associated?
58. Have you lost anyone close to you in the last year? (circle one)
- a. yes
  - b. no
59. If yes, who have you lost?
60. With your experience, what suggestions would you give for this study or other research in this area?

APPENDIX B  
INFORMED CONSENT

## INFORMED CONSENT

We, David Baptist and Tamra Snook, are Master's in Social Work students at California State University, San Bernardino. This study is an attempt to gain knowledge and understanding of the way older American veterans respond to traumatic events such as September 11<sup>th</sup>. It is our hope that by gaining this knowledge it will help to change the way social service set up services if another such event occurs. We think that your perspective is unique and important, therefore needs to be heard.

This study has been approved by the Department of Social Work Sub-Committee of the Institutional Review Board at California State University and is being supervised by Dr. Rosemary McCaslin (Phone number: (909) 880-5507). If you have any questions or concerns about the survey you may contact Dr. McCaslin.

The following questionnaire will take approximately 20 minutes to complete. The questions are personal and require that you respond from your life experiences regarding military service, family life, and your personal response to September 11<sup>th</sup>. Your identity and your answers are completely anonymous. Since some of the questions are personal and they can cause painful memories or emotions for some people. You are free to skip any questions you don't wish to answer and also may stop at any time if you feel too upset or do not wish to continue. However, it is also possible that talking or writing about these feelings and memories may help you feel better.

If the questions in this survey brought up painful memories or you feel that you need to discuss your feelings with a professional, you can call the Veterans Administration Hospital (909) 825-7084 or Veterans Affairs at (909) 387-5516.

By placing a mark on the line below you are showing that you have read and understood the possible risks as well as benefits that may be involved by participating.

Please Mark Here \_\_\_\_\_

(PLEASE DO NOT WRITE YOUR NAME)

APPENDIX C  
DEBRIEFING STATEMENT

## **DEBRIEFING STATEMENT**

Thank you for your participation in our study. We are grateful for your time and effort. The survey you have completed will help us to understand the unique impact that catastrophic events such as September 11<sup>th</sup> have on older veterans and older adults. Your participation helps us to pass on information and insights that veterans have to offer.

If you had any questions or concerns regarding the content of the survey, contact research supervisor Dr. Rosemary McCaslin at (909) 880-5507. If you are interested in the results of this study, they can be found on the campus of California State University, San Bernardino in the Pfau Library after June of 2003.

If any of the questions you answered brought up uncomfortable memories or you feel that you may need to talk with a professional you can contact the Veterans Administration Hospital at (909) 825-7084 or Veterans Affairs at (909) 387-5516.

Thank you again for your invaluable participation.

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## ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

Team Effort: David Baptist & Tamra Snook

2. Data Entry and Analysis:

Team Effort: David Baptist & Tamra Snook

3. Writing Report and Presentation of Findings:

a. Introduction and Literature

Team Effort: David Baptist & Tamra Snook

b. Methods

Team Effort: David Baptist & Tamra Snook

c. Results

Team Effort: David Baptist & Tamra Snook

d. Discussion

Team Effort: David Baptist & Tamra Snook