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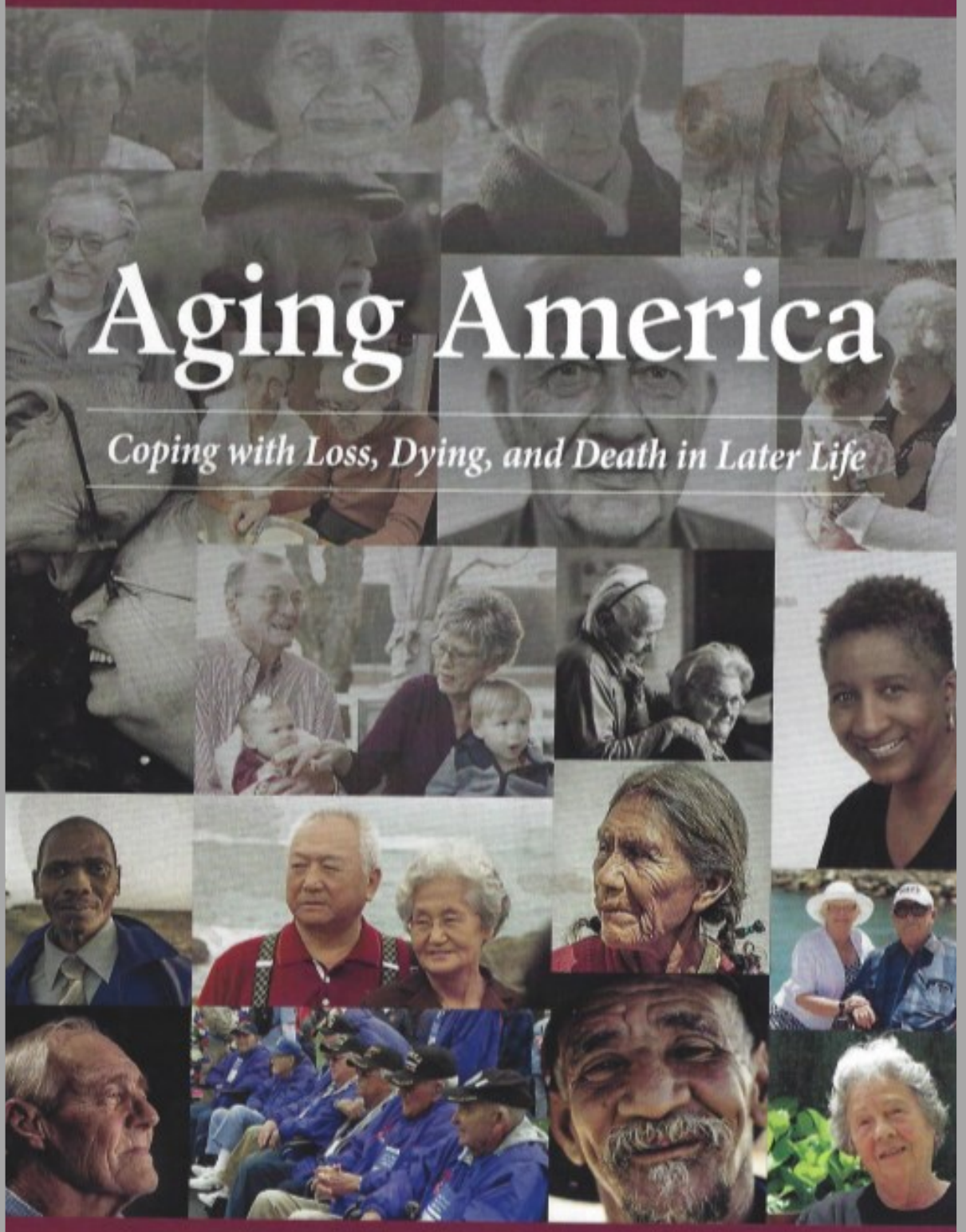

Aging America

Coping with Loss, Dying, and Death in Later Life

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Practice Tips
Supporting Elderly Veterans at the End of Life

In many ways, veterans experience loss and grief as non-veterans experience loss and grief. However, military culture may create special grief needs. Increasing dependency often accompanies the dying process. This can become especially problematic for veterans because they have been trained to be strong, in control, and independent. Traumatic memories are harder to suppress at the end of life, causing unbidden recollections to surface. Guilt and shame over things they thought they should or should not have done might also surface as veterans retire and are less distracted with work or other diversions. This chapter will focus on the influences that might alter a veteran's experiences of loss. These influences might include stoicism, Posttraumatic Stress Disorder (PTSD), and *Soul Injury*.

Stoicism

Stoicism is necessary on a battlefield, even essential. After discharge from military service, stoicism continues to be helpful because it allows veterans to fight hardships and provides protection from untrustworthy influences. "Sucking it up" and "biting the bullet" can be important ways to achieve self-mastery so goals can be achieved without getting diverted with every fleeting emotion that surfaces.

Yet many veterans also say that stoic walls sometimes create problems, especially at the end of their lives, when experiencing sad feelings, expressing love and connection with others, or asking for help becomes more important.

Because of their military training, older veterans or those facing the end of life may feel that either physical limitations or emotional

displays might cause embarrassment or a perception that they are weak. They may view "letting go" as admitting defeat or an act of surrender, something "good soldiers" don't do. Stoic control can prevent veterans from acknowledging failing health, physical weakness, or other changes. It might mean not listening to their own body or pushing themselves to do too much. Anything threatening control or independence can incite anger. Fear of being at the mercy of others also causes resistance.

Stoicism often keeps veterans from saying what they need or allowing others to meet their needs. These actions require vulnerability; for many veterans, this mask of invulnerability sometimes won't even allow them to admit they *have* needs. This attitude can cause frustration, not only for themselves but for their families or professional caregivers who want to provide support and help.

Clinical Support for Aging Stoics

Aging is a humbling experience. People lose much of their control, pride takes a blow, and independence is gradually taken away. Sooner or later, the stoic wall has to crumble. Later means fighting to the bitter end; sooner means that a weary soldier is finally able to surrender and hope for a peaceful death. This takes courage, and it is as heroic as facing any enemy in battle.

Clinicians can help veterans recognize that courage is not about covering up or "grinning and bearing it." Rather than erecting a stoic wall that might shut them off from others, ask the veteran to consider using stoicism like a door that they can open or close at will and as often as they want. This image allows veterans to learn how to start letting go of control when faced with the uncontrollable reality that their death is soon approaching. Help them consider how there is no shame in being human, and there can be freedom in being able to acknowledge and fully experience what they are going through, especially the grief they may feel. This recognition is not a weakness; rather it requires strength and courage, two qualities that veterans admire and hold dear.

The health care provider can help reeducate veterans by offering alternatives for them to consider: "I know a lot of veterans put on a brave front and don't want to take pain medication, but pain can consume your energy. You need your energy for other things now." Encourage veterans not to confuse stoicism with courage: "It takes courage to reach out to connect with others or to ask for help." Clinicians can explore with the veteran the merits of learning how

to become a gracious receiver: "You've given to your country; you've given to your family; you've given to your community. Now is the cycle in your life to learn how to receive."

PTSD and Dangerous-Duty Military Assignments

Stoicism permeates military culture, whether a veteran served in combat or not. For those who have served in dangerous-duty assignments, traumatic memories may also trouble them. For some, these memories crystallize into a constellation of symptoms known as Posttraumatic Stress Disorder (PTSD) (2013). Exposure to a traumatic event is often experienced with fear, helplessness, or horror; after the original trauma is over, the trauma is reexperienced through recollections, dreams, flashbacks, and physical/emotional distress at cues that symbolize the trauma. The distress causes people to exhibit avoidance behaviors and use emotional numbing in order to block out the trauma. In spite of their best efforts, however, there are times when the trauma is reexperienced with symptoms of arousal such as difficult sleep patterns, irritability or outbursts of anger, difficulty concentrating, hypervigilance (staying on guard and unable to calm down or relax), and exaggerated startle response to noises or being touched.

Traumatic memories are harder to suppress at the end of life, causing unbidden recollections to surface. Later-life PTSD manifests much like childhood PTSD, as the original trauma is acted out. A dying person might listen and speak metaphorically. If the metaphorical image relates to war, it might precipitate a flashback. If a veteran experiences helplessness while dying, the helpless feeling might act as a trigger for the helplessness of the original trauma, which might result in agitation that does not respond to usual anti-anxiety medications. The dying experience of a veteran may act as a trigger for past deaths experienced by the veteran, including deaths on the battlefield.

Clinical Support for Veterans with PTSD

It is important to not assume that a veteran (even a combat veteran) has PTSD; most do not. On the other hand, some veterans may have PTSD without even realizing it. They may have compartmentalized the trauma, banishing it into unconsciousness, or used a stoic wall to try to numb the symptoms. Unfortunately, as the veteran ages, it may be much harder to control the symptoms in this way.

Loss of control can be especially difficult for veterans with PTSD. Helplessness and loss of control experienced in the original trauma

play a crucial role in how veterans with PTSD sometimes face death. Their helplessness during the original trauma can subsequently incite overly controlling behaviors throughout their lifetime in order to ward off experiencing that helplessness again. As illness progresses, veterans may lose independence and control over their bodies, environment, and ability to exert their will. This reality acts as a trigger for the original helplessness they felt when traumatized which may cause anxiety and, if close to death, agitation. The agitation might not respond to benzodiazepine-type medications. In fact, anti-anxiety medications sometimes cause a paradoxical reaction; instead of decreasing anxiety, they increase anxiety. A chain reaction might be initiated in which the medication causes loss of control for the veteran, which increases feelings of helplessness, which acts as a trigger for the original helplessness, which causes them to fight even harder to counteract the effect of the medication so they can regain control, which is manifested as agitation.

Although interventions to maintain a sense of control should be provided, it is also important for clinicians to initiate dialogue about losing control, so the veteran can make peace with the losses: "Sometimes veterans say that feeling helpless makes them angry. It's often hard for a soldier to learn how to surrender or to let go," or "Some veterans say that asking for help is humiliating. How does helplessness make *you* feel?"

In addition to these shifts in behavior, language changes at the end of life. As a person dies, their conscious mind starts receding and the unconscious starts expanding. The language of the unconscious is symbols. Commonly, dying people start speaking in symbolic travel metaphors: "Help me pack my bags. I'm going on a trip." Dying people often hear metaphorically as well. A World War II veteran was admitted to an inpatient hospice facility. Unrolling an air mattress onto the bed, one nurse said to another: "Okay. We can blow it up now." The veteran became agitated for several hours, repeatedly shouting: "Where's the bomb? Get me out of here." If this same conversation had occurred just a few weeks earlier while his conscious mind was more intact, he probably would not have reacted; his conscious mind would have provided the appropriate context.

Trust plays an important role in helping veterans with PTSD. They do not trust easily. They have been taught *not* to trust. Fail to keep your word once with someone who has PTSD, and a clinician

can become the enemy. Authenticity is especially important as the clinician engages with the dying veteran. In a hospice program, trust may need to be gained quickly because the veteran may not have long to live; time to build a trusting relationship is simply a luxury that is not always available. The clinician's movements, tone of voice, and language become important opportunities to convey trustworthiness. Additionally, people with PTSD will often "test" clinicians to see if they are trustworthy. Dialogues about death should be done openly and directly. Veterans may have faced death before when they were in combat. In fact, they were required to complete advance directives *whenever* they went into a combat zone. Clinicians should not use indirect phrases to try to make death more palatable. One veteran declined hospice services. Follow-up with the veteran revealed the reason: "I told them that I knew that hospice was for dying people and the nurse said, 'No. Hospice is for the living. Funeral homes are for the dying.' Right then, I knew I couldn't trust her. Send me someone who can play it straight with me."

Triggers and flashbacks are issues that may further complicate peaceful dying. The veteran's own anticipated death can act as a PTSD trigger. If they are admitted to a hospice unit, they might become anxious, suspicious, or angry; leaving their home to enter an unknown institutional environment can be perceived as threatening, which may increase their feelings of danger. A World War II prisoner of war (POW) admitted to the Veterans Affairs (VA) hospital for end-of-life care became agitated when bathed in a tub, shouting "Get me out of here. You're all Hitlers." His wife later reported that the Nazis had dug holes in the ground to interrogate prisoners; since then, the vet could never be in enclosed spaces, including bathtubs.

Veterans with dementia also need special consideration. Traumatic memories are encoded and stored differently than nontraumatic memories (2014). Traumatic memories often emerge in involuntary fragments unconsciously triggered by internal or external reminders of the original trauma. Dementia compounds the problem with short-term memory loss and inability to appropriately contextualize situations. A Korean War veteran became agitated watching the news about the Iraq war. "Don't let them draft me again. Don't let them draft me," he desperately pleaded with his wife. When the hospice team arrived, he poignantly added: "I've killed enough people. I can't do it anymore." Assurances that he would not be drafted again only

provided temporary relief that he soon forgot. A large card was made with his name and "Not eligible for the draft" printed on it. Clutching the card and re-reading it provided the assurance he needed.

A Different Kind of Wound: *Soul Injury*

Whereas PTSD affects a person's brain (especially the amygdala, the part of the brain that reacts to real or perceived threats), a Soul Injury affects a person's sense of being. At the heart of a Soul Injury is usually guilt and shame. Guilt takes many forms.

Although some veterans feel guilty about the killing they had to do, others feel guilty for not killing: "They had to take me off the front lines. I was such a coward."

Some noncombat veterans feel guilty because they don't feel that their sacrifice was enough. One veteran was a talented trumpeter assigned to the Navy band, playing as ships left harbor for Vietnam: "Here I was with this cushy job playing an instrument I loved to play. It wasn't fair."

Military nurses and medics can also experience guilt about the life-and-death decisions they made. One nurse said she was not afraid of hell: "I've already been there. I have to live every day with the faces of those soldiers who didn't have a chance during mass casualties. The doctor left it up to me, a 21-year-old nurse, to decide which ones got surgery and which ones were left to die."

Survivor's guilt is common and can interfere with the ability to enjoy life. One World War II veteran said, "When I landed on the beach, there were all these dead bodies. The sand underneath them was pink with their blood." Then he tearfully added, "They didn't get to have grandkids the way I did. It's not fair that I should have this enjoyment when they can't."

Some Vietnam veterans struggle with forgiving the government for what they and many others see as using and betraying them. Korean and Vietnam veterans might have to forgive the American public for ignoring or scorning them. Soldiers may have to forgive the world for being unfair and for having cruelty and war in it; they have to forgive God for allowing the world to be like it is with war in it.

Clinical Interventions to Support Those Facing Soul Injury

Interventions that address Soul Injury (including moral injury, which is the internal suffering that results from taking actions against one's own moral code), focus on learning how to mourn losses, forgive

self and others, and cultivate love and compassion. Providing these interventions at the end of life when Soul Injuries tend to surface can have a dramatic impact on a dying person's quality of life, as well as on their family.

It is essential that clinicians know how to create a safe emotional environment that allows Soul Injuries to surface. Some agencies who work with veterans have developed a team of chaplains and social workers who can then follow up with assessment and intervention.

Creating safe emotional environments includes not dismissing or minimizing guilt with well-intentioned platitudes such as: "You were following orders" or "You were being a good soldier; we have our freedom because of you." Instead, create a safe emotional environment so guilt and shame can be revealed if the veteran so chooses. However, this needs to be done cautiously. At no time should the clinician overtly, covertly, or subtly convey that the veteran "needs to forgive" in order to find peace. This type of sentiment can actually add another layer of damage by causing additional guilt about the inability to forgive themselves or others. The clinician should simply offer the consideration of forgiveness and invite the veteran to stay open to its possibility: "Now is a time to look back over your life. Is there anything that might still be troubling you? Anything about the war that might still haunt you?" Then, sit quietly. These are the kind of answers that can't be hurried.

Conclusion

Media images of soldiers dying on a battlefield are familiar to most Americans. Less familiar are the 1800 veterans who are dying every day, years after they leave service. Health care providers need to become sensitized to how military service influences veterans in ways that can sometimes complicate peaceful dying. Stoicism, PTSD, and Soul Injury are a few of the issues that need to be considered when intervening with veterans. Responding to the unique needs of this underserved population helps to ensure that the men and women who served our country will receive the honor they earned.

—Deborah Grassman

REFERENCES

American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*, pp. 271-280. Washington, DC: American Psychiatric Association Publishing.

Grassman, D. (2009). *Peace at last: Stories of hope and healing for veterans and their families.* St. Petersburg, FL: Vandemere Press.

Grassman, D. (2013). The military milieu: A grin and bear it culture. In K.J. Doka & A.S. Tucci (Eds.), *Improving care for veterans facing illness and death*, pp. 3-16. Washington, DC: Hospice Foundation of America.

Grassman, D. (2015). Special patient populations: Veterans. In B. Ferrell, N. Coyle, & J. Paice (Eds.), *Oxford Textbook of Palliative Nursing*, 4th ed., pp. 671-679. New York, NY: Oxford University Press.

Grassman, D. (2015, June 22). Help PTSD sufferers heal from 'soul injury.' *Boston Globe.* Retrieved from https://www.bostonglobe.com/opinion/2015/06/21/too-many-suffer-too-long-with-soul-injury/KjaS0gXx2vykS4WdtwUf0L/story.html

Grassman, D. (2017). *Anchoring heart technique.* Opus Peace. Retrieved from www.opuspeace.org

Grassman, D. (2017). *Healing the trauma of Soul Injury.* Opus Peace. Retrieved from http://www.soulinjury.org

Grassman, D. (2017). *Soul Injury screening tool.* Opus Peace. Retrieved from www.opuspeace.org/Survey

Grassman, D., & Shreve, S. (2013). Veteran care at the end of life: Their last battle. In J. Amara & A. Hendricks (Eds.), *Military Health Care*, pp. 287-311. New York, NY: Routledge.

Shay, J. (1994). *Achilles in Vietnam.* New York, NY: Scribner.

Tick, E. (2005). *War and the soul.* Wheaton, IL: Quest Books.

U.S. Department of Veterans Affairs (2016). *Moral injury in the context of war.* Washington, DC: National Center for PTSD.

Van der Kolk, B. (2014). *The body keeps the score.* New York, NY: Viking Press.

VHA Directive (2003). *Palliative care consult teams.* Washington, DC: Department of Veterans Affairs.