Natural Transitions

Conscious, holistic approaches to end of life

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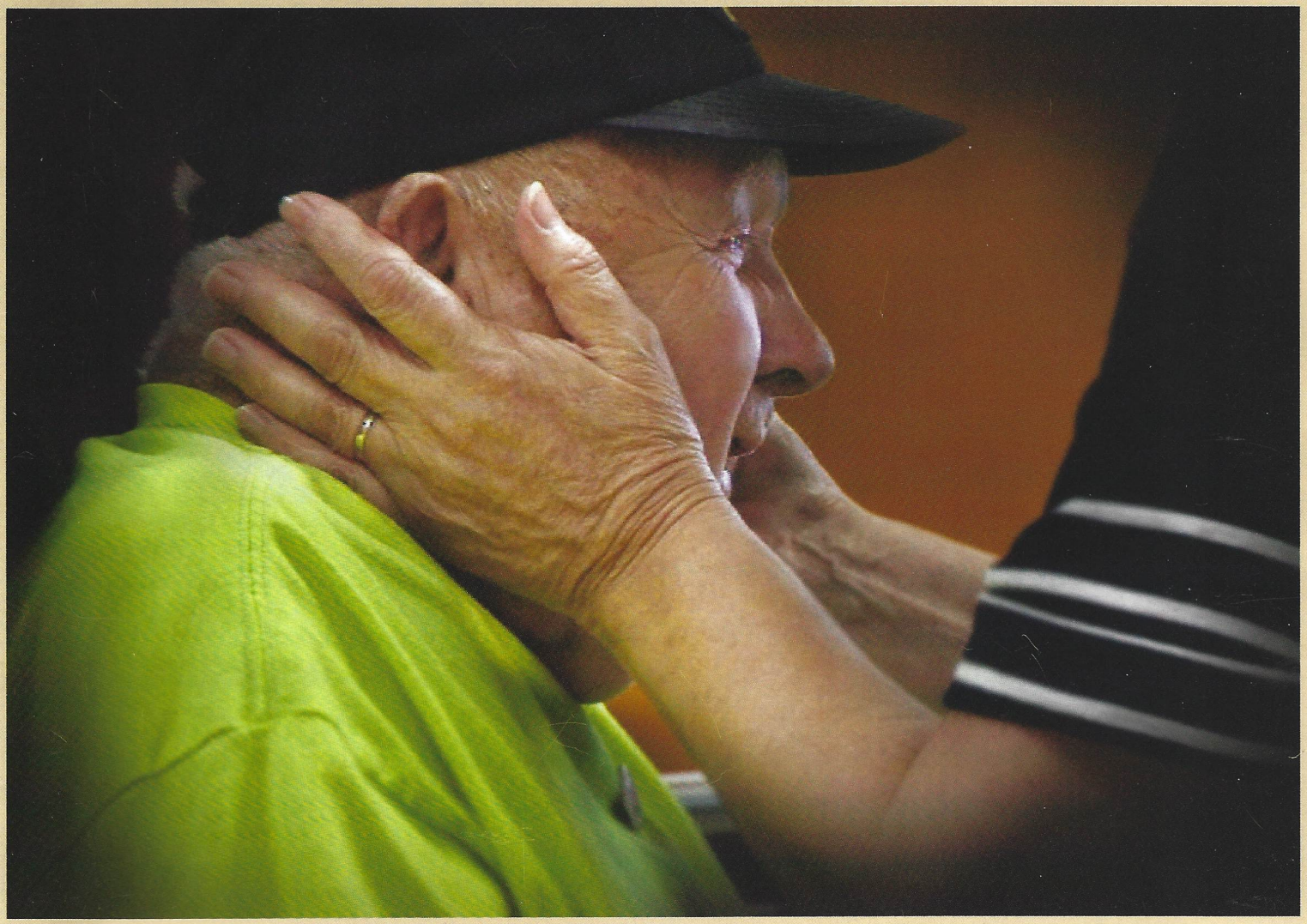


Veterans: Healing the Wounds of the Soul

Peace at Last

A VA Clinician Shares How to Bring It to Our Dying Veterans

By Deborah Grassman

Military experiences often change veterans in fundamental ways that shape, mold, destroy, and redeem the rest of their lives, including the end of their lives. The following excerpt from my book, *The Hero Within: Redeeming the Destiny We Were Born to Fulfill*, provides an overview of patients I've cared for as a nurse practitioner on a hospice unit at a Veterans Affairs (VA) Medical Center. It allows a bird's-eye view into the unique and not-so-unique needs of veterans at the end of life. You will see the context for the lessons I have learned. You will also understand the privilege that it is to care for veterans.

Mark is dying of liver failure from alcohol abuse, his skin yellow as a low-glowing lamp. He came to the hospice and palliative care unit semi-comatose; we will not get to know him except through his brother's eyes. I comment on his brother's devotion. The brother responds, "I look at Mark and know why I'm in Alcoholic's Anonymous."

Donnie is 50 years old and has lung cancer. He has been a quadriplegic since he was 27 when an automobile accident detoured his career as a professional football player. "I spent three years in despair. Then I found God and salvation," he tells me. He says he is thankful for his suffering: "I never would have found Jesus if the accident hadn't happened."

In the next room, an embittered, lonely man sits sullenly. Alcohol has estranged Zachary from his family. At 82, he is angry at his body for failing him. He has been afraid of death since he was 10 years old when a neighbor died falling through a skylight on his roof. Bitterly, he tells me, "My only solace is knowing that someday all the rest of you are going to be in this bed too." During a gathering of team members Zachary experiences the concern of four staff members who are willing to love him. "Why aren't we talking about my breathing, and the 16 pills I'm taking?" Zachary asks us.

"Because you are more than just your breathing, and we are more than just pill-givers," I reply, leaning in and daring to touch him tenderly. A tear comes; features soften for the first time.

"I can't argue with that," he says quietly.

In the room next to Zachary is Marvin. He was photographer for a general during World War II. He has been a physician, sailboat racer, and builder of piers, driveways, and roofs "made with my own hands." Marvin's wife and four children sit at his bedside, supporting his journey into the next world and supporting each other. Near death, he says little except the Lord's Prayer. There is no need for us to intervene with anything other than supportive care.

There are 1800 veterans dying every day in America.

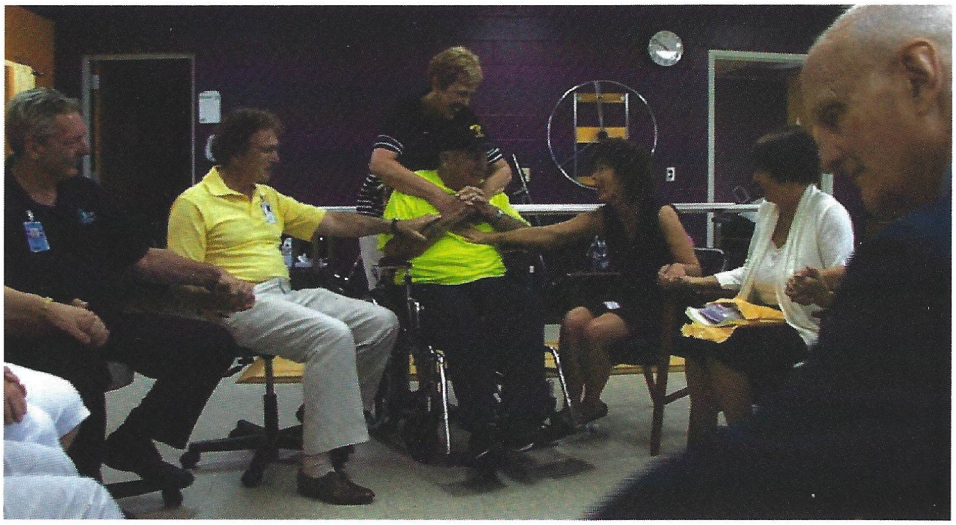
In the adjoining bed is Jim, a Viet Nam War veteran who has lived a colorful life. He is intermittently confused; sometimes he is argumentative. He has no family; a few close friends are his source of comfort. His first days on the unit were filled with agitation. He was convinced the Vietcong had put a bomb in the stereo. Nurse Suzanne responded creatively. She called the security officer and said, "I want you to inspect the stereo and declare it bomb-proof. Tell the patient you're pulling guard, so you've got his back and the perimeter is safe. Let him know that another guard will be on patrol when you leave duty." The police officer responded convincingly, and Jim's agitation subsided.

Then there's Bruce, a 67-year-old man who came for pain control. He had not wanted to come to the hospice unit "because I'm afraid I'll never get out." His anxiety and impatience during his first days with us manifested in his frequent use of the call light. Probably because he realizes he is in a safe, loving environment, his spirit is now emerging bright and full. He simply needed a little time and a little love to know that he need not fear. He has grown closer to his family as he approaches death and tells us, "I wouldn't trade these last few weeks in my life for anything."

Bruce's roommate, Richard, suffers respiratory distress from a tumor encroaching on his trachea. He awaits his daughter's arrival tomorrow from Indiana. He says his suffering will be redeemed when he can rejoin his wife who died two years ago. "That will be a happy day," he says with tears. We share his anticipated joy.

Ben has a history of drug use and actively continues with alcohol abuse. He identifies himself as a loner who has witnessed much violence. "My family doesn't care about me," he told me. We've had some difficult sessions confronting his suffering. He's going to be discharged next week, and I do not know what is going to happen with him. What I can tell you is that his brow unfurls after prayer, he plans to go to Alcoholic Anonymous meetings, and he wants to reach out to a faith community. Seeds planted and good intentions—they are not enough to withstand the ravages of alcohol. His suffering's redemption awaits a courageous decision that only he can make, every day, for the rest of his life.

The last patient, Edwin, has severe chronic obstructive pulmonary disease and is ready to die, but he worries about his wife of 54 years. His needs are increasing rapidly, but he does not acknowledge them because he does not want to worry her. "I can't hold on much longer though," Edwin says, while



making plans to hold on for his wife's sake. We talk about the advantage of letting go so he can prepare himself and his wife for his death; we talk about the damage his denial is causing them both. Edwin cries; his grieving begins.

Military Tenets that Facilitate Healthcare Provider Understanding

There are 1800 veterans dying every day in America, 25% of all dying Americans. Only 4% of these veterans die within the VA medical system. Many of the remaining 96% receive end-of-life care in community hospice programs. Hopefully, many of these community hospice providers have the requisite information about veterans to provide that care. The underlying features of veterans and their families that need to be taken into consideration include:

★ The value of stoicism, so earnestly and necessarily indoctrinated in young soldiers, might interfere with peaceful deaths for all veterans, depending on the degree to which stoicism permeated their later lives.

★ Veterans who served in dangerous-duty assignments might have their deaths complicated by traumatic memories or paralyzing guilt, depending on the extent to which they were able to integrate and heal traumatic or guilt-inducing memories.

★ A high incidence of alcohol abuse or other "flighting"-type behaviors are often used either to avoid confronting locked-up feelings or to numb traumatic memories. These factors might contribute to "unfinished business" as veterans face the end of their lives.

★ Veterans often acquire wisdom because they have reckoned with trauma, stoicism, and addiction. Understanding these three elements helps access their wisdom and has been referred to as "post-traumatic growth."

★ Veterans and their families have unique bereavement needs to consider when providing care.

Stoicism: Early Indoctrination that Continues at the End of Life

Veterans are often non-complaining, "grin-and-bear-it" types who endure their suffering silently. The few times tears or fears break through their stoic façades, they feel embarrassed, apologize, and quickly re-retreat; these walls offer protection. Unfortunately, their "fight to the bitter end" attitude sometimes means just that—fighting until a death that is, indeed, bitter. Their "attack and defend" instincts make death the enemy and dying a battle. Survival-mode mentality interferes with letting go. When backed into a corner, soldiers are not conditioned to surrender; they are conditioned to fight.

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Stoicism is necessary on the battlefield, as it is in many life situations, but the walls that stoicism erects can outlast its usefulness. The walls can be used inappropriately to block energy and emotion from self or interfere with expressing love to others. Stoicism can also contribute to veterans' underreporting their fear, emotional pain, and physical pain. Helping veterans use stoicism like a door instead of a wall can be useful. A door can be opened or closed at will and as often as they want, leaving the safety of their stoicism available to them.

Dying is a humbling experience. Control is lost, pride takes a blow, and independence is gradually taken away. Sooner or later, the wall has to crumble. "Later" means fighting to the bitter end; "sooner" means a weary soldier is finally able to surrender to hope for a peaceful death.

Many dying veterans are able to let go of control, allowing themselves to become completely human, growing in humility as they learn how to ask for help and how to become gracious receivers, discovering connection and compassion in the process. This takes courage, and it is as heroic as facing any enemy in battle.

It is important that clinicians know how to create safe emotional environments to breach stoic facades. Otherwise, dying veterans will underreport their physical and emotional pain as well as any fear they are experiencing. Although it is important to respect veterans' silence when they choose to maintain stoic fronts, it is also important to offer alternatives. The healthcare provider can help reeducate veterans by offering alternatives for them to consider, such as: "I know a lot of veterans put on a macho

front and don't want to take pain medication, but pain can consume your energy. You need your energy for other things now." Also by encouraging veterans not to confuse stoicism with courage: "Anyone can hide behind a stoic wall of silence. It takes courage to reach out to connect with others or to ask for help."

Helplessness and losing control are especially threatening; here are some examples of what a caregiver might say to elicit a helpful conversation: "Sometimes veterans tell me feeling helpless makes them angry. I imagine it's hard for a soldier to learn how to surrender, to let go," or "Some veterans tell me asking for help is humiliating. Tell me how helplessness makes you feel."

War's Aftermath: PTSD

Stoicism permeates military culture, whether a veteran served in combat or not. Combat veterans and others who have served in dangerous-duty assignments have to also cope with traumatic memories. For some, the memories crystallize into a constellation of symptoms known as Post Traumatic Stress Disorder (PTSD). The *Diagnostic and Statistical Manual* identifies six criteria that must be present for this diagnosis:

★ Exposure to a traumatic event experienced with fear, helplessness, or horror

★ The traumatic event is persistently re-experienced through one or more of the following symptoms:
- Recollections
- Bad dreams
- Flashbacks, hallucinations, or illusions
- Distress at cues that symbolize the trauma
- Physiologic responses when confronted with cues reminiscent of the trauma

★ Avoidance behaviors and emotional numbing exhibited by three or more of the following:
- Avoidance of thoughts, feelings, or conversations related to the trauma
- Avoidance of activities, places, or people that arouse recollection
- Inability to recall certain critical aspects of the trauma
- Lack of interest in significant activities formerly enjoyed
- Feelings of detachment or emotional distancing from others
- Restricted range of affect (limited emotional expression)
- Sense of a foreshortened future (inability to accomplish cherished life goals)

★ Persistent symptoms of increased arousal manifested by two or more symptoms that include:
- Difficult sleep patterns
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance (staying on guard and unable to calm down or relax)
- Exaggerated startle response to noises, being touched, etc.

★ Symptoms persist for at least one month

★ The disturbance of symptoms causes significant distress or impairment

If the veteran has received PTSD treatment, they can often say what helps them feel better. They might already have a PTSD network of friends who can provide support. Family members usually know how to respond to breakthrough episodes of PTSD because it is *familiar territory.*

Other people with PTSD have compartmentalized the *trauma, banishing it* into unconsciousness. Haunted by residual memories or corroding guilt, they might experience increased difficulty as death approaches. Others seem less affected.

When patients with PTSD are admitted to a hospice unit, they are sometimes anxious, suspicious, or angry. Leaving their home to enter an unknown hospital environment is threatening, increasing their feelings of danger. The hospital environment itself can act as a trigger with its militarized processes. Their own anticipated death can act as a PTSD trigger. PTSD, especially when combined with alcohol abuse, has often taken its toll on their relationships, leaving much unfinished business to be resolved. Sometimes they arrive at the end of their lives broken, bitterness poisoning their souls. However, it is never too late. Opportunities for growth abound when death approaches. Many veterans—even those who are bitter—avail themselves of the lessons.

Veterans might talk about past experiences with death, deaths that were often violent and mutilating. They bring these experiences with them when they are enrolled in hospice programs. To allay these fears, it can be helpful to discuss the plan for how a peaceful death can be achieved.

It can be important to eliminate as many triggers for PTSD as possible. Coming into a hospital (especially a VA hospital) can trigger past military memories of barracks, procedures, unsafe environments, past combat hospitalizations, and visiting injured

comrades. A government hospital and its employees may not be trusted by Viet Nam vets. On the other hand, a VA might be a source of comfort, belonging, security, and camaraderie, especially if the veteran previously received care there.

Loud or unexpected sounds will startle a person with PTSD, so he should not be touched without first calling his name or making sure to be within his line of sight. The use of bed alarms should be limited; they exacerbate the startle response. Restraints should also be avoided; even tight bedclothes or linens can trigger memories of being confined in prison if the veteran was a POW.

Trust plays an important role in helping veterans with PTSD because these veterans do not trust easily. They have been taught not to trust. Betray someone with PTSD once, and a clinician can become the enemy. These veterans can sniff out a phony instantly, so authenticity is important. 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 open language become important opportunities to convey trustworthiness. Additionally, people with PTSD will often test clinicians to see if they are trustworthy. Thus, dialogues about death should be conducted openly and directly when a veteran with PTSD is admitted to a hospice program. Covering up death or hospice with euphemisms might trigger suspicion. Telling someone that "hospice is for the living"—when he knows that a life-threatening illness is required in order to receive services—breeds distrust. These veterans have faced death when they were in combat. In fact, they were required to complete advanced directives and wills whenever they went into a combat zone, so they are used to open dialogue about dying. They do not like sugar-coating difficult issues; they most often prefer direct language.

People with PTSD will often "test" clinicians to see if they are trustworthy.

Many community hospices participate in NHPCO's We Honor Veterans program. This program offers resources and tools that help agencies provide services to veterans. Whether you are a hospice worker, a VA employee, hospital or nursing home staff, a veteran's family member or friend, you can make a difference. You can be an instrument of peace to heal our nation from the aftermath of war.

Deborah Grassman, an advanced registered nurse practitioner and former VA clinician, has sat bedside with thousands of veterans at end of life. She is the author of Peace at Last: Stories of Hope and Healing for Veterans and Their Families *and is founder of Opus Peace. For more information visit opuspeace.org.*

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