Veterans and End-of-Life

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Adapted from material shared by HC/ Care Services, Deborah Grassman, and the NHPCO

"War can rob men of their hopes and dreams of the future."

— Deborah Grassman

Why is it important to have Veterans care for Veterans at the end-of-life?

- Military training and the culture of stoicism can often prevent Veterans from sharing difficult experiences.
- When one Veteran talks to another, stoicism and secrecy dissolve.
- Veterans share a common language and code of conduct.
- Sharing supports life review and healing.

Veterans and their loved ones have unique needs at the end-of-life.
These needs are influenced by:

- Combat or non-combat experience
- Age
- Which war they served in
- If they were POWs
- If they have PTSD
- The branch of service and their rank
- Whether they were enlisted or drafted

The biggest influence for a Veteran at the end-of-life may be whether or not they served in combat. Additionally, the age at which the Veteran entered the military and the war era in which they served has a large affect on their perspective after the war.

War Eras

The war era in which a Veteran served and the way the Veteran views his/her military experience may impact their outlook on life, as well as death. Many Vietnam Veterans may believe the war was "lost" or all their efforts were for nothing, whereas World War II Veterans feel like heroes. There is a very different impact if a Veteran feels like a hero than if their suffering has no meaning.

WWII: Heroes

WWII was a glamorized war. There was no television footage of this war and many Veterans lied about their age to be a part of this war. When Veterans returned home from WWII, they were welcomed with parades and open arms. They were called heroes.

Cold War/Korea: Ignored

The Korean war is also known as the forgotten war. In fact, most would not even call this a war but rather refer to it as a "conflict". The sacrifices made by our Veterans during the Cold War and Korean war have been minimized, if not totally forgotten.

Vietnam: Shamed

Vietnam was a very controversial and political war. The nation was divided. Vietnam was also a very publicized war, the first in which television coverage was rampant. Guerilla warfare was first introduced during the Vietnam War and Veterans often could not identify the enemy. Veterans had to face extremely difficult experiences and make life-altering decisions at the drop of a dime.

Veterans have shared experiences of going out to retrieve bodies of American soldiers, only to find that the bodies have been "booby trapped" and explode when touched.

Gulf War, Operation Enduring Freedom, Operation Iraqi Freedom

Hospices are now seeing an increase of patients who have served in these wars. It is expected that Post-Traumatic Stress Disorder will be high amongst these soldiers, as well as other psychosocial issues not yet identified.

It is crucial to remember that women are Veterans too. Many Veterans entered the military at a very young age. Young people are very impressionable, which makes age such an important factor of a Veteran's military experience. Having fought in combat (especially if that combat included having to kill another person) also largely impacts Veterans' perspective. For women, sexual assault may be another factor greatly effecting perspectives and coping.

Post-traumatic stress disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is an anxiety disorder that can develop after exposure to one or more terrifying events that threatened or caused grave physical harm (to self or other).

This is a specific psychiatric disorder in which a cluster of symptoms occurs beyond one month after someone experiences a traumatic event.

Trauma: an experience that is emotionally, physically and/or spiritually painful, distressful or shocking and which may result in lasting mental and physical effects.

Trauma reactions are NORMAL reactions to abnormal circumstances or events such as those in war. Trauma reactions are NOT indicative of moral weakness or sin.

PTSD is a mental, emotional, social, spiritual, moral, familial, and intergenerational injury.

Diagnostic Criteria of PTSD, as described in the DSM-IV:

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

Trauma is persistently re-experienced (1 or more):

- Recollections
- Dreams
- Acting as if trauma is recurring
- Distress at cues that symbolize the trauma

Avoidance of associated trauma (3 or more)

- Avoidance of thoughts, feelings, conversations r/t trauma
- Avoidance of activities, places, or people that arouse recollection
- Inability to recall some aspects of the trauma
- Lack of interest in significant activities
- Feelings of detachment/estrangement from others (emotional amnesia/numbing)
- Restricted range of affect
- Sense of a foreshortened future

Persistent symptoms of Increased arousal (2 or more):

- Difficult sleep patterns (nightmares)
- Irritability or outbursts of anger
- Difficulty concentrating
- Hyper-vigilance (example: calling over and over or asking "where are you? Are you safe?)
- Exaggerated startle response

Several stress factors may increase a Veteran's PTSD risk, including:

- Severity
- Duration
- Proximity (role in war) – Marines and Army have higher rates of PTSD
- Some resources say that the single most influential risk is having killed another person; this greatly complicates end-of-life care
- Traumatic Brain Injury (a physical injury to the brain)

When working with families of a Veteran suffering from PTSD, it is critical to understand that PTSD is a mental, emotional, social, spiritual, moral, familial, and intergenerational injury.

Healing requires interventions that address all dimensions of suffering. PTSD does not only affect the Veteran, but it affects the entire family. Often times, Veterans suffering from PTSD also suffer from higher rates of divorce and estranged family relationships.

Behavioral and emotional reactions (common coping mechanisms) to trauma may include:

- Substance abuse
- Self-destructive and impulsive behaviors
- Uncontrollable reactive thoughts
- Inability to make healthy lifestyle choices
- Dissociate symptoms (splitting off parts of self)
- Discarding previously sustained beliefs
- Compulsive behavior patterns
- Depression, spontaneous crying, despair and hopelessness
- Anxiety, panic attacks and general fearfulness
- Compulsive and obsessive behaviors
- Feeling out of control
- Irritability, anger, and resentment
- Withdrawal from normal routine and relationships
- Emotional numbness

Combat Response Trajectories

Deborah Grassman theorizes that assimilation of combat experiences can be viewed as three trajectories. Each Veteran will process their experiences of combat in a unique manner. For some, the experience will greatly impact the rest of their life and for others there will be little notable change. Below are the three trajectory responses in her theory:

Trajectory 1: Combat Trauma Successfully Integrated

The Veteran has accepted his/her military/combat experience. The Veteran's day-to-day life is not negatively impacted by the experience. You may hear statements such as “I've faced death before in the war. I'm not afraid of death any more” or “I must have been spared for a purpose. If I didn't do that, it means my buddies died in vain.”

Some Veterans may even experience a positive, life-changing impact from combat experience. This is defined as a Post Traumatic Growth Experience. Veterans’ lives may be improved by developing new methods of:

- Relating to others
- Being open to new possibilities
- Personal strength
- Spiritual changes
- Appreciation of life

Trajectory 2: Combat Trauma APPARENTLY Integrated

This trajectory is also known as "subclinical PTSD." In this trajectory we may witness delayed onset PTSD, in which as the patient approaches the end-of-life, signs/symptoms of PTSD become apparent, where prior, the Veteran believed he/she had dealt with their military experience. As we age, our outward landscape begins to weaken and our inward landscapes get stronger; therefore, the walls Veterans have built to appear as though "everything is fine" began to fall down and the anger and fear began to emerge.

The statement "I'm fine" may be translated into "I'm freaked out, insecure, neurotic, and empty."

Indicators a Veteran may have Apparent Integration of Trauma include:

- Acting out behaviors
- Workaholic or other addictive behaviors
- "White Knuckle Syndrome": Veteran appears hollow or aloof

Trajectory 3: Combat Trauma NOT Integrated

This trajectory is also known as PTSD. The Veteran's day-to-day life is greatly impacted by his/her war experience. You may hear statements such as "Most of my brothers remained in Vietnam," "I've been fighting that war every day since I returned," or "90% of me died in that war."

Again, it is important to remember that PTSD affects the ENTIRE family. You may hearfamily make statements such as "I didn't know the person who came back." or "We've been fighting that war every day since."

PTSD increases the likelihood a Veteran will have a lack of trust and/or suspicion, and an increased anxiety and agitation. Alcohol and drug use are also common coping mechanisms for these adverse feelings. Veterans suffering from PTSD are also more likely to have unfinished business, which in return will decrease the chances of a peaceful death, if not addressed.

The three combat response trajectories are one way in which to view a Veteran's experience, although these are not utilized within the VA for diagnosing, or treating PTSD.

Additional information regarding PTSD treatment and research can be found at http://www.ptsd.va.gov/public/index.asp.

"I looked in the eyes of the dead man,
And I saw peace.
I looked into the eyes of the living,
And I saw fear."

– Vietnam Veteran Edward M.

Healing

Deborah Grassman also theorizes that in order to heal, Veterans need forgiveness. He/she may have much to be forgiven for. A Veteran may need to forgive:

- Self (for killing)
- Self (for not killing, not dying, friendly fire)
- Enemy
- Government (using/betraying them in Vietnam)
- The world (for being like it is)
- God (for allowing the world to be like it is)

Healing is a process that takes time, effort, and sometimes requires professional assistance. For some veterans, forgiveness is not enough.

Veterans with PTSD actually develop an uncontrollable learned fear response. A Veteran may not feel he/she needs forgiveness, but memories of the atrocities will continue to haunt them.

Additionally, Veterans may have significant spiritual suffering, which may include fear of retribution or retaliation that may await them in another life. A Veteran could achieve peace and forgiveness in some areas, but still be haunted in others (Schauer, Caroline, 2012).

Why Veteran volunteers are important

Military training and the culture of stoicism can often- prevent Veterans from sharing difficult experiences; however, when one Veteran talks to another, stoicism and secrecy dissolve.

Veterans share a common language and code of conduct. Sharing supports life review and healing.

Interventions

Keep in mind that hospice is more than symptom control and pain management. The goal of hospice is to heal. Veteran volunteers are in the unique position of sharing a deep understanding with Veteran patients. This unique understanding makes the possibility of a deep emotional bond possible. Veteran volunteers can provide camaraderie and walk-beside another Veteran through his/her journey at the end of life.

In trajectory #1, no special intervention is necessary, other than what would be done for all hospice patients.

In trajectories # 2 and #3, it is vital for Veteran volunteers to allow the patient the opportunity to share their experiences, feelings, and thoughts. However, it is also important to NEVER push a Veteran into sharing anything experience if he/she is not ready. In trajectory #2, t is important to be aware of the behaviors and symptoms of PTSD in order to assist the hospice team to identify delayed onset PTSD.

In order to gain a better understanding of the Veteran's emotional pain, we may ask him/her to describe their emotional pain on a scale of 0 to 10:

0=Serenity/ 10=Turmoil

Once the Veteran has identified the number, have him/her describe what that number means from in his/her perspective. Furthermore, ask the Veteran what an acceptable number is and how that would look. It is always important to understand a Veteran's pain in his/her eyes. We must never assume we understand or know what a veteran is going through or feeling. When a Veteran is sharing difficult memories/stories, the volunteer should allow him/her to share without adding statements such as "you did your best", "there was nothing else you could do".

By doing so, we are playing down or minimizing the Veteran's pain. We must be understanding and accepting of their pain, anger, shame, fear, and helplessness. Don't dismiss it with platitudes. Silence is often golden and our best approach to active listening. Acknowledge their pain!

What we can do:

- Remember their behaviors are related to trauma
- Offer statements such as, “Some Veterans tell me they experienced some horrific things in war. Did anything like that happen with you?”
- After a question about war, sit quietly
- Don't touch unexpectedly. Call their name first
- Realize that noxious stimuli can re-stimulate trauma
- Assess for environmental triggers
- Offer camaraderie
- Keep the focus on the Veteran, not you
- Remember the Veteran's experience may be different than yours
- Open the door, but never push

When volunteering with ANY Veteran:

- Make the environment emotionally safe.
- Affirm the feeling aspect of their conversation.
- Remember that stoicism might interfere with acknowledging physical, emotional or spiritual pain.

Recognize female Veterans:

- Military nurses saw trauma/mutilation
- Thank older female Veterans for paving the way
- Look for PTSD in women
- Female Veterans may have been sexually assaulted in military

If you are seeing increased signs/symptoms of PTSD, notify hospice staff. Some medications may exacerbate the symptoms of PTSD and the case manager will need to address this immediately. Do not assume behaviors are PTSD-related.

Remember:

- Non-combat Veterans may have served on dangerous assignments.
- Stateside Veterans may have been facing dangerous deployments, but were never sent
- Combat Veterans may have served in "safe" areas
- Veterans in "safe" areas may have had to witness horrific traumas as they were transported and cared for off the battlefield
- Avoid making assumptions.
- Not all people who have suffered trauma will experience PTSD.

"If Vietnam or Korean Vets speak about how Americans treated them, apologize. If Vietnam Vets speak about never being welcomed home, welcome him."

– Deborah Grassman

Suicide

Veterans are at a higher risk of suicide. Suicide is the intentional taking of one's own life. Suicide is also something you can help a patient avoid. Hospice nurses and social worker are trained to assess all patients' suicide risk; however, it is important for volunteers to be familiar with the risk of suicide, as Veterans will often share more with a Veteran volunteer than he/she ay with other hospice professionals. This subject can be controversial with several states allowing assisted suicide at the end of life. Veterans may see suicide as their way to maintain control at the end of life, but the role of hospice professionals is to address emotional, spiritual, and physical suffering and explore the option of living life as fully as possible.

Who commits suicide?

- Women attempt suicide more than men
- More men than women commit suicide
- More common with age, but teenage rate is growing
- Suicide rates vary by race, with Caucasians attempting more than African-Americans

Myths and facts about suicide

MYTH: People who talk about suicide don't commit it.
FACT: 80% of completed suicides had given definite indications of their intention

MYTH: Talking about suicide will give someone an idea to do it.
FACT: Suicidal people already have the idea. Talking about it may invite them to ask for help.

MYTH: All suicidal people are fully intent on dying. Nothing can be done about it.
FACT: 95% are undecided about it. They call for help before or after the attempt.

MYTH: Suicide is an impulsive act.
FACT: Most suicides are carefully planned and thought about for weeks.

MYTH: A person who attempts suicide will not try again.
FACT: Most people who attempt suicide have attempted to so before.

MYTH: Improvement follows a suicidal crisis.
FACT: Most suicides occur within 90 days after the beginning of "improvement". The decision to solve one's problems through suicide might offer the patient relief.

Suicide Warning Signs

Nearly 80% of those who attempt or commit suicide give some clues to their intentions. Most warning signs will present in either verbal or behavioral warnings.

Some verbal warnings that a patient may be contemplating suicide include statements such as:

- I'm going to kill myself!
- I'd be better off dead.
- I just can't go on any longer.
- You won't be seeing me around anymore.
- I'm getting out, no matter what.
- I'm going home real soon.

Some behavioral warnings that a patient may be contemplating suicide include:

- Organizing business and personal matters
- Giving away possessions
- Composing a suicide note
- Buying a gun
- Planning one's own funeral
- Obsession with death
- A sudden lift in spirits

Signs a patient may be depressed:

- Withdrawal
- Overwhelming sadness
- Lack of energy
- Irritability
- Emotional flatness or emptiness
- Changes in behavior and attitude
- Different feelings and perceptions
- Physical complaints

Patients at the greatest risk of suicide may have:

- Made a previous suicide attempt
- A family history of suicide
- Lost a friend through suicide
- Been involved with drugs or alcohol
- A history of alcoholism in the family

What to do:

- Take threats seriously
- Answer cries for help
- Contact the volunteer coordinator or other hospice on-call staff immediately.

What NOT to do:

- Do not leave the person alone
- Do not assume the person is “not the type”
- Do not keep it a secret
- Do not act shocked
- Do not argue or reason
- Do not analyze
- Do not shock or challenge

Additional resources

Care of Veterans at End of Life: War and Peace. Deborah Grassman, February 2012. Presented at Hospice of Central Iowa Institute, Des Moines, Iowa.

The Wounds of the Past: Post-Traumatic Stress and Aging. A. Klink, March 2012. Amedisys Hospice, Durham North Carolina.

Veterans’ Needs at the End-of-Life. T. Wade, 2011. IHPCA Fall Conference, Ames, Iowa.