

Serving the Bereavement Needs of Veterans and Their Families

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Veterans and their families need the same things non-veterans and their families need when a loss is experienced: comfort, sympathy, emotional support of friends and family, knowledge, coping skills, time, and healing. But the military culture can create special grief needs as well.

Stoicism, while a needed quality for an operative military, can be a hindrance in grief. Stoicism may cause grief to be hidden by a silent or angry facade, cavalier humor, an attitude of bravado, or an “I’m fine” wall of denial. Stoicism not only affects veterans, it can affect whole family systems. One woman spoke of her friend who was married to a career Marine. She described the woman’s stoicism: “She is as much a Marine as he is. When her mother died, she was expected to grieve quickly and return to normal functioning in short order. She did.” Twenty years later, however, her mother’s death was reactivated when her husband died. This time, she was given permission and encouragement to grieve and to take the time she needed to grieve both of these losses. She did.

In addition to stoicism, “career-military” family systems may present special considerations. The family may have lived in numerous places for short periods of time, and this impacts family in several different ways. For example, at one veteran’s deathbed, his adult daughter identified for the first time where her bitterness for her father had begun: “It was the five different first grades I went to.” Since this veteran was dying in a Veterans Administration (VA) hospice and the staff had been trained in veteran-specific issues, his daughter made this discovery as part of her anticipatory grief. She had the opportunity to work through this issue and the wall it had created before her father died. The

clinician acknowledged the patriotism and sacrifice that her entire family had made, which allowed the daughter to change her relationship to her past. This change helped her let go of some of her anger and open up to her father in a new way. Her grief after his death was facilitated by acknowledging the ways that this early loss affected her life and her perception of her father, which helped her deal with those losses prior to her father's death.

Another issue which may arise with career-military families is that when there is a death or major loss, the family may find themselves far away from their family and support system. Because military families have not established roots, there may not be a network of support that facilitates effective grieving. On the other hand, because of these frequent moves, families of veterans may readily reach out for support because they have learned how to ask for help and form new bonds quickly. A Greek war bride from WWII cried at her husband's death bed: "I have no family, what am I going to do?" The staff anticipated the possibility of complicated grief due to lack of support. An hour later, however, she was found in the hospice kitchen, with five lifelong friends from the Officers' Wives Club. It was every bit a supportive family, just a different kind. Conversely a young Vietnamese wife who barely spoke English said: "We did everything together. We are each other's world." This veteran's isolation excluded everyone except his wife, leaving her unprepared for his death. She was at high risk for complications of grief and required extensive support to find her way materially and emotionally after his death.

Consider a third young American bride living in Germany while her husband served in Afghanistan. He was due to return in time for the birth of their first child. Unfortunately, the young woman went into labor early and their child was delivered stillborn. She was far from home, family, and anything familiar as she struggled with her overwhelming grief. Her husband returned to her as soon as possible, which in this case was a week later. He was grieving the loss of their child, feeling like he deserted his platoon and struggling with symptoms of Posttraumatic Stress Disorder (PTSD). She was grieving the loss of their baby, the loss of innocence as she saw the changes in her husband, and experiencing changes in her body. This couple required intensive support as they faced their changed world. Their return to home was delayed due to legal issues related to transporting their child's remains from one country to another so the priority was to assist their parents to travel to them. This whole family system may need extensive support due to the complexity of the situation.

In her book, *Peace at Last: Stories of Hope and Healing for Veterans and Their Families*, Deborah Grassman (2009) explores the impact of military service on veterans at the end of life. She offers insight into some of the possible effects of combat on veterans and their families. Providing the book for family members to read helps them better understand the military influence on their loved one, their family, and themselves. This enhanced understanding can facilitate peaceful life closure and more effective grief recovery.

Veterans may gain a deeper appreciation of life by surviving combat and recognizing each day as a gift. Others may superficially integrate their experiences and carry on with their pre-war lives after returning from war. A third group may be changed by their combat experience and be unable to effectively cope. These latter two groups' coping styles may adversely affect the family. Veterans in the last category may have struggled for years with bouts of depression, anger, nightmares, or from being overly protective or controlling. The veteran may have coped by using drugs and alcohol, or might have isolated himself in order to feel safe. Families living in this environment may have been abandoned, abused, or developed dysfunctional coping mechanisms to deal with these behaviors. This kind of lifestyle might precipitate divorce, creating multiple families by the time the veteran comes to the end of life. A common saying among Vietnam vets that overly simplifies this issue is, "Most veterans with PTSD have been married three times." There may be three different sets of children at a veteran's death bed. Perhaps their first family was abandoned when the veteran first returned home from war and he was unable to reconnect with them. These children may be angry. When the veteran remarried and started a second family, these children may have lived with abuse, drugs and alcohol, and developed dysfunctional coping mechanisms. After a second divorce, the veteran may have gotten into an addiction recovery program, as well as received help for his PTSD. A third marriage is often to someone who already has children. These children may reap the benefit of the veteran's recovery and think their stepfather is very special. Imagine this veteran's death bed with all of these family members present. Providing support for all of these family members with a wide range of forgiveness, estrangement, and anger issues creates a highly charged environment for needed therapeutic work. Clinicians should strive to keep their hearts open to all of these different family members and recognize each of the particular losses and relationships with this veteran, in order to help facilitate some resolution. The past cannot be changed, but

new understanding can help to change their relationships to the past.

When there are multiple families, judgments about one another are often passed. Guilt, shame, and blame are often the fuel that has been used to avoid the pain of the underlying loss of healthy relationships. This can negatively impact decisions that need to be made as the veteran is approaching the end of life. For example, the person who is legally able to make the decisions for the veteran may be someone from whom the veteran has been estranged. The current significant others of the veteran may find themselves disenfranchised at the time of the death, funeral, and burial. Another common contention after the death of a veteran with this kind of multiple-family constellation is: “Who gets the flag?” There is one flag provided for each veteran, yet there may be more than one person who feels that they deserve it. In these situations, it can be helpful to work with the VA’s office of Decedent Affairs, also known as Details Clerk, to arrange for the provision of more than one flag.

Presentation of the flag in a respectful manner is of the utmost importance. Because many families today choose cremation, there may or may not be a funeral or memorial. In these cases there is not a formal presentation of the tri-corner flag to the next of kin. One VA nurse saw a family leaving the hospice unit after their loved one’s death with a flag in a small rectangular box. He was upset by this “indignity” and called the team together to find a way to correct it. The solution was found when the Korean War Veterans Service Organization (VSO) agreed to use this need as an opportunity. The VSO provided education to a local Boy Scout troop about proper flag etiquette and flag folding. The Boy Scouts now meet bi-monthly with the VSO to fold flags. Together, they have maintained a supply of folded flags for that VA facility. The flag is now formally presented in a dignified way to the family by the Decedent Affairs Clerk.

Other family members might have anger or bitterness about their veteran not getting a medal, service-connected disability, or pension. These feelings can interfere with effective grieving: “Dad was wounded in combat and he never received his Purple Heart. They lost his records.” This veteran and his entire family had chafed over this injustice for many years. After his father’s death, one son doggedly pursued his father’s records until the Purple Heart was awarded posthumously. This act helped the family begin to move through their grief. In a similar situation in which the Purple Heart could not be obtained, a VA hospice nurse practitioner made a “purple heart,” ceremonially pinning it on the veteran while citing the heroic deeds that he had done. The bereaved

family survey subsequently identified this act as extremely meaningful.

If PTSD is identified for the first time as a veteran is dying, the impact on family needs to be factored into their bereavement needs. Some family members feel relief: “I’m so glad to know it has a name. I knew something was wrong but I didn’t know what. Now this makes sense.” Other family members might feel guilty: “I wish I would’ve realized this sooner, I would have _____ (listened more carefully, gotten him help, been more patient and understanding, etc.)” (NHPCO VAC, 2012).

If the veteran had PTSD, physical or mental disability, or long-term illness prior to the death, the family member may be exhausted from providing care; they may not have the energy to grieve. In her book *Chronic Sorrow: A Living Loss*, Louise Roos (2002) writes about “significant losses with no foreseeable end” in the context of children with disabilities. Veterans and their families may share a similar experience. This may lead to frequent periods of sadness with no stable periods to allow time for grief and adjustment.

The family may have financial concerns near the end of life. For example, if the family has been supported by the veteran’s disability check, they may want extensive futile care because they do not know how they will survive without the veteran’s check. They may have provided care for the veteran for years and thus been unable to maintain work outside the home. It is important for the clinician to acknowledge the reality of this practical consideration and recognize that the family’s questions about money may not indicate a lack of love, but instead may be a first step in providing the practical groundwork for their future welfare and their ability to grieve. Providing social work services can help the family with financial strategies and resources. The veteran may also be concerned about the financial plight of their family after he or she dies. This concern might cause the veteran to fight death so the disability check continues. One veteran lived for 40 years as a quadriplegic in a VA nursing home. He said, “My job is to stay alive as long as I can so my wife will have the money to raise our kids.” When he died, his family spoke of “growing up at the VA,” and there were as many staff mourners as family at the memorial service. Many such families have provided care and support for their loved one for years with little or no recognition. Acknowledgment of their patriotism and a word of gratitude for the sacrifices they have made may bring tears to their eyes. Those tears often represent the internal healing that is taking place. One VA recognizes the family members who have been caring for veterans by pinning

them with a small patriotic angel dressed in red, white, and blue. The family is thanked for their sacrifices and service to America by providing care and support to their veteran. A small card is given to them so they will remember the meaning behind the pinning. The card reads: “Caregivers are important too! Because we know you have also paid a price for our freedom, we honor you with this pin. It’s our way of acknowledging the many ways you’ve been impacted by the military and also the many ways you have provided care to our veteran. We are grateful.”

Caregivers are 93% female. Most caregivers are spouses (72%) and parents(12%) (National Alliance for Caregiving, 2012). Today, there are more services for family caregivers than ever before. All VA medical centers now have Caregiver Support Coordinators at all VA medical centers (Johnson, 2012). They are experts on caregiver issues and are knowledgeable about VA and non-VA resources. They manage a menu of options to support veterans including in-home care service, respite care, needed equipment, home and automobile modification, peer support, and caregiver support groups. The VA also runs an interactive website for caregivers (www.caregiver.va.gov). The Primary Family Caregiver Benefits include a stipend (post-9/11) paid directly to the caregiver, which is centrally funded and managed. The caregiver may be eligible for health insurance through CHAMPVA (a health benefits program through VA), travel, lodging and mental health services through VA or by contract. This kind of support allows veterans and their families to have more time and energy for their bereavement and emotional needs.

In addition to needing support when a veteran is facing illness and death, family members may also need help in understanding a veteran’s response to loss. A veteran’s inability to grieve someone’s death might be due to their fear of unresolved grief from comrades who died in combat, and this fear can sometimes cause the veteran to detach from grief. This was true for a veteran and father of four whose youngest son was killed in a hit-and-run motor vehicle accident. The veteran went through the formalities of identifying the body, arranging the funeral, and receiving the outpouring of support from his community; yet he remained impassive throughout the process. His wife and family were appalled at his lack of emotion. When the veteran came in for counseling, he reported being in Vietnam 40 years earlier and being on a convoy. One of the trucks in the convoy hit a young Vietnamese boy. It was a dangerous area and they were under orders not to stop. This veteran was

devastated by seeing this innocent boy left presumably dead and unattended. When his own son died in a similar manner, he could not allow himself to feel the grief for his own son until he had acknowledged the loss and grief of the parents of the Vietnamese boy. The latter was the focus of the bereavement intervention.

Another young soldier serving in Iraq was notified of his grandfather's death; the Red Cross was prepared to bring him home for the funeral. The soldier declined to leave his troop, and the family was very upset with his decision. The bereavement counselor discussed with the family their son's need for stoicism so he could face war every day. If he came home for the funeral, he may have felt that he had deserted his troop. He could also be opening himself up to an emotional bungee jump, bouncing from his feelings of his grandfather's loss which could also trigger grief over deaths he was seeing in war, only to have to go right back into war two weeks later. Thus, the bereavement intervention did not focus on trying to convince the grandson of the need to return home, but rather on helping the family choose to validate the young soldier's choice. Intervention also focused on planning a family gathering when the young soldier was home again and emotionally able to participate in working through his grief for both his grandfather and his fallen comrades.

SUPPORTING VETERAN GRIEF

As part of a focus on comprehensive care, the VA identifies unresolved bereavement needs of veterans when they are being treated for physical and mental health issues, homelessness, substance abuse, and PTSD. These needs can best be addressed by a clinician who has been sensitized to the special needs of veterans. In 2003, *Wounded Warriors: Their Last Battle*, a PowerPoint presentation developed by Deborah Grassman, was produced by the National Hospice and Palliative Care Organization (NHPCO) and distributed widely throughout both the hospice and VA communities. Her presentation sensitizes clinicians, veterans, and their families to issues that may otherwise be overlooked or misunderstood. The same stoicism that allows veterans to be the helpers of the world may prevent them from reaching out for help or support. Messages of "big boys and girls don't cry" were learned as children and reinforced in the military. This message needs to be reframed by clinicians. When a veteran is talking about the pain of loss and attempting to hold back the tears, they can be reminded of the courage it takes to allow their feelings

to show. It may be helpful to sit beside rather than in front of the veteran to allow emotional privacy. Alternatively, the clinician might bow their head and sit quietly when tears escape from behind a stoic wall. Clinicians can let veterans know that tears are a normal reaction to pain and are welcome. One counselor has a picture of a face with a beautiful tear running down it. The picture is referenced with veterans who struggle to externalize tears, and acts as a reminder of the beauty of grief expressed. Another counselor has a prescription pad and “prescribes” crying in the shower, in the car, or wherever the veteran feels safe. Some veterans are more comfortable with humor and respond well to being told that the counselor gets a bonus if they cry. Everyone grieves in their own way, so there are not always tears. The gender differences between men and women have been studied for years and many men are more likely to express their grief by doing something active, such as planting a tree, building a memorial, or organizing a fundraiser for a needy veteran family. Tears may or may not be part of their grief journey (Doka and Martin, 2010; Golden, 2010).

In caring for veterans with PTSD, it is important to know that they may not trust easily. Initial efforts by clinicians need to focus on gaining their trust. This can make something as simple as scheduling an appointment difficult. For example, when a veteran is identified for bereavement counseling, a telephone call is used to make contact. Not unusually, there is no answer and a message is left encouraging a call back. When this is unsuccessful, a second call is made and again a message is left. If the call is not returned, a condolence note is mailed to the home. Persistence often pays off at this point and the veteran may reconnoiter and peek into the bereavement office a few times. If the counselor passes muster and seems trustworthy, the veteran will schedule an appointment to address his or her grief issues. A basic premise of passing muster is the clinician’s understanding that “we serve those who first served us.” Veterans need to know that clinicians are aware that veterans are trained warriors; they need to know that clinicians value their service and recognize that freedom is not free.

These issues may also be apparent when a veteran is diagnosed with a terminal disease. The veteran may not want anyone “to see me weak.” They may go so far as to say, “When I can’t take care of myself, I’ll just go off into the woods to die.” One such veteran received interventions during his several admissions to the hospital during his illness. The clinician’s interventions

focused on encouraging him to be a gracious receiver. He was educated about Dame Cicely Saunders, founder of the modern hospice movement around the world, and what she said at a conference a few years before her death. Using a wheelchair for ambulation, she stated, “I used to think that being a giver was the most important thing. Now that I need help myself, I realize that being a gracious receiver is the most important thing.” He was encouraged to see how helpful his gracious receiving could be for him and for his comrades.

As his illness progressed, he was able to make healthier decisions about his care. The veteran allowed his friends in the “Vietnam Brotherhood” to participate in his care and ultimately his death. Many of these men had only witnessed violent or mutilating deaths in the past. In combat there was no time to mourn the deaths of comrades. This veteran made a courageous choice to allow the brotherhood to come together as a group to grieve while they provided care and support to their dying comrade. They were dressed in their Vietnam Brotherhood jackets; many had long hair, ponytails, and tattoos. Although their tough exteriors were intimidating, they provided tender physical comfort by repositioning the veteran, giving him drinks of water and food, and even participating in circles of prayer. By relying on their camaraderie and overcoming their fear of vulnerability, they created a dignified death for their friend and a new concept about death for themselves.

The Commander of a local chapter of the Korean War Veterans Service Organization (VSO) was asked about the impact of combat on the members. His eyes clouded over: “We all have PTSD to some degree. It’s just a matter of what we do with it.” He spoke of some members who self-medicated with alcohol, but of many others who channeled their pain into contributing to the community. Honor guards are one of the services this chapter provides. They are frequently at the local VA cemetery to honor their newly fallen comrades by providing military honors, an interment ceremony, and the presentation of the flag to the next of kin. He acknowledged that when he participates in these events, he is attending to his own bereavement needs by honoring the buddies he lost in service so long ago.

As many as 30,000 veterans live in State Veteran Homes and there are many other long-term care facilities caring for veterans. These settings can provide an opportunity to address unresolved grief from fallen comrades decades earlier.

One State Veterans Home in Ohio provides such a service. The team of clinicians prepares a sacred space in the front of a large meeting room. A long table holds the American flag and other patriotic symbols. Veterans are encouraged to think in advance about a fallen comrade they might want to honor during the ceremony. As they gather, patriotic music plays and the lights are lowered to accent the importance of the occasion. At the entrance, there are small rocks for each veteran to select and take with them to their seats. The ceremony is opened by the chaplain with a prayer of remembrance for all those who had died, as well as those who are still in the beds next to them. The social worker does a guided imagery with the veterans, taking them into those deep parts of themselves where they store their feelings. Then soothing music is played as they are invited to write the name of the person they wish to honor on the rock they are holding. Some of the veterans request additional rocks because the ceremony causes other unresolved losses to the surface. The tasks of dying healed (Forgive me, I forgive you, I love you, Thank you, Goodbye), from Ira Byock's book *Dying Well* (1997), may be read to offer the option of completing any unfinished business. The veterans are encouraged to say in their hearts whatever they need to say to the person. Then one by one, each veteran carries his or her rock forward, placing it on the sacred space. Staff caregivers are also encouraged to participate and include those veterans they've cared for whom they wish to remember. A closing blessing offers hope for the future. The veterans are told that these rocks would remain in the sacred space for one month; the veterans would be later invited back to transport the rocks to an outdoor area of remembrance that would remain accessible to them. Singing of patriotic songs closes the ceremony. At each ceremony, there are many tears as these veterans allow themselves to confront their losses and begin moving through them.

The value of rituals cannot be underestimated, especially because ritual has been a successful aspect of military culture throughout the years. An effective ritual consists of three stages: separation, transition, and integration. The separation phase acknowledges the problem. In the above example, this was done with the chaplain's prayer and the guided imagery; both validated the loss that each veteran experienced. The transition phase focuses on educating participants in how to proceed with this change and loss. In the ceremony with the rocks, this was done by the bereavement counselor who spoke about the value of grief, encouraging them to re-think their stoic stances. The value

of completing “unfinished business” with Byock’s five tasks was provided. The last phase, integration, was accomplished by encouraging the veterans to let go of what was and open up to a new normal. This was done by physically placing their rocks in the sacred place, knowing that their comrade’s memories would continue with them. The integrative process would continue as the veterans would visit the outdoor area of remembrance whenever they wanted.

Throughout the United States, there are memorials and ceremonies taking place nearly every day. These can be healing to both veterans and their families. Most VA Medical Centers offer memorial services honoring the veterans who died in their facility annually. These services should be formatted in a ritualized ceremony that acknowledges and promotes effective grieving and the ceremony should have a military context. Many VAs provide bereavement ceremonies or events to provide support for the veterans and their families for Memorial Day, Veterans Day, Fourth of July, and other holidays. Including veterans and their families in these events can be very helpful with their grief.

Active-duty deaths

The military culture influences both veterans and their families. They may face issues that do not impact the general population. This is also true of veterans and families of loved ones dying on active duty; however, hospice services are not provided to families prior to an active military death. Bereavement care to the surviving family members should follow the above guidelines coupled with standard bereavement guidelines that focus on sudden and violent death.

There are two organizations that are uniquely equipped to provide bereavement counseling and support to active duty personnel, their families, and extended families: Vet Centers and Tragedy Assistance Program for Survivors (TAPS). Vet Centers provide individual, group, and family counseling to all veterans who served in any combat zone. Services are also available for their family members. TAPS is a national non-profit organization that offers extensive peer-to-peer support and education about traumatic death and the active duty military’s specific grief needs. Some hospices partner with these agencies to provide services. Other hospices partner with the Red Cross to offer bereavement services for active military deaths. Hospice staff receive specialized training in order to perform this task.

CONCLUSION

Supporting veterans in grief and loss is essential, but servicemen and women's military training can hamper this process. Stoic grief sometimes postpones reacting and responding to losses. When the stoic facade begins to crumble, losses accumulated over a lifetime may surface. Families of veterans may also have special needs in grief. The fallout of war often infiltrates families and causes scars and divisions which require special attention. Clinicians need to continue to learn how to better serve those who first served us.

Editor's Note: The contents of this paper do not represent the views of the Department of Veterans Affairs or the United States Government.

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