

ELNEC- For Veterans

END-OF-LIFE NURSING EDUCATION CONSORTIUM

Palliative Care For Veterans

FACULTY GUIDE

Module 4 Cultural and Spiritual Considerations in Palliative Care

The End-of-Life Nursing Education Consortium (ELNEC – For Veterans train-the-trainer program and curriculum was developed by the National ELNEC Project Team, a partnership between the City of Hope (Betty R. Ferrell, PhD, RN, MA, FPCN, FAAN, Principal Investigator) in collaboration with the American Association of Colleges of Nursing with updates undertaken by Carma Erickson-Hurt, DNP, LCDR, USN, RET. Curriculum development and national ELNEC-For Veterans train-the-trainer courses were generously funded by the US Department of Veterans Affairs (original courses and ongoing updates spanning 2009-2023).

Module 4: Cultural and Spiritual Considerations in Palliative Care Faculty Outline

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End-of-Life Nursing Education Consortium

Palliative Care For Veterans

Module 4: Cultural and Spiritual Considerations in Palliative Care

But I fear they do not know us. I fear they do not comprehend the full weight of the burden we carry or the price we pay when we return from battle. This is important, because a people uninformed about what they are asking the military to endure is a people inevitably unable to fully grasp the scope of the responsibilities our Constitution levies upon them... We must help them understand, our fellow citizens who so desperately want to help us.

Admiral Michael Mullen, Chairman of the Joint Chiefs of Staff, 2011

- The 21st century brings heightened awareness of how beliefs, values, religion, sexual orientation, language, and other cultural and socioeconomic factors influence health promotion and behaviors. Assessing patient and family cultural values, practices and beliefs is a vital component of palliative care.
- The nurse plays a key role in understanding and providing culturally sensitive palliative care to each individual patient.

TEACHING TIP

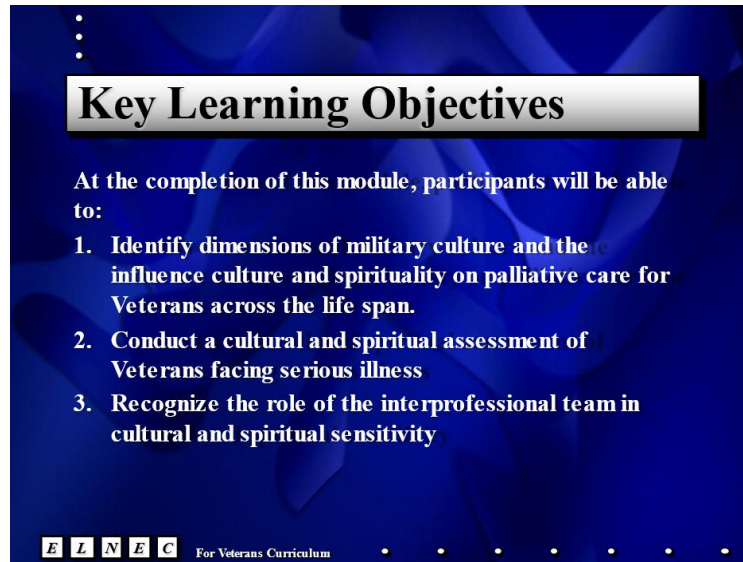
Have participants conduct a military cultural self assessment prior to presentation. The assessment is in module one of TRAIN program by the Department of Defense (DOD) link: <https://deploymentpsych.org/military-culture-course-modules>

Encourage them to try one of the implicit bias tests from Project Implicit:
<https://implicit.harvard.edu/implicit/education.html>

This module is divided into two sections:

- Section I: Cultural Considerations
- Section II: Spiritual Considerations

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Key Learning Objectives

At the completion of this module, participants will be able to:


1. Identify dimensions of military culture and the influence of culture and spirituality on palliative care for Veterans across the life span.
2. Conduct a cultural and spiritual assessment of Veterans facing serious illness
3. Recognize the role of the interprofessional team in cultural and spiritual sensitivity

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Military Culture



Unique American Subculture

- Branch of Service
- Rank
- Service type
- Occupational specialty
- Deployments
- Era of service

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- This module reviews dimensions of culture, which influence care in advanced disease. The assessment of culture is essential to understanding the person and patient-centered care. Cultural understanding is essential to adequate communication and in providing cultural and spiritual competent care to all Veterans and their families. Several factors exist:
 - Culturally competent care includes recognition of multiple factors, i.e. ethnicity, gender, sexual orientation and military experiences.
 - Cultural factors significantly influence quality of life and communication with Veterans and families at the end of life.
 - Culturally competent care is best provided through an interdisciplinary team approach.
- Military members, veterans, and their families belong to a unique American subculture (Isserman & Martin, 2021). Each branch of the Armed Forces has its own sub-culture, including titles, language, norms and traditions that makes them distinct from one another (Hamaoka et al, 2014). There are many subcultures within the military culture itself. For example:
 - Branch of service: (e.g., Army, Navy, Air Force, Marines, Coast Guard). Each has its own instilled values that influence culture.
 - Rank: (Officer, Warrant Officer, Enlisted)
 - Service Type: (Active Duty, Reserves, National Guard)
 - Occupational Specialty
 - Deployments: (type, combat, location, frequency)
- The era of service has its own unique culture, which can influence the outcome of a veteran's experience. For example, WWII Veterans are more likely to have had areas of safe haven than Vietnam Veterans, who were often in immediate physical

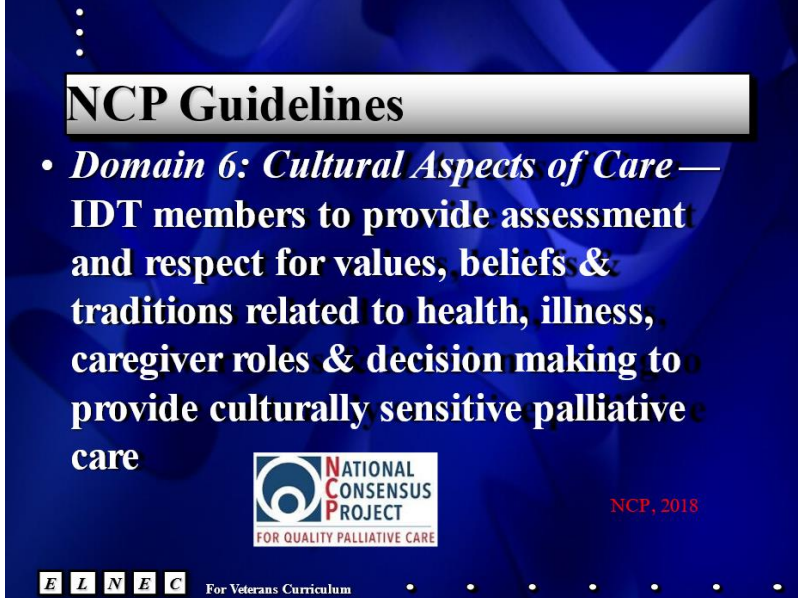
danger. This resulted in a higher incidence of stress-related disorders. Korean Veterans were often told not to discuss their military service and are sometimes overlooked in the discussion regarding the needs of Veterans. Iraq and Afghanistan Veterans may have served multiple deployments in combat areas. So asking and understanding the military history of Veterans is important (NHPCO, n.d).

- Military deployments can be defining experiences in the lives of Veterans, whether they were to war zones, or to third-world countries in need of humanitarian aid. Learning to empathically and therapeutically ask about these experiences is fundamental to military cultural competence (TRAIN, 2018).

TEACHING TIP

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Slide 4



The slide features a dark blue background with a subtle pattern of white dots. At the top, a white box contains the title "NCP Guidelines". Below this, a bullet point describes Domain 6. At the bottom, there is a logo for the National Consensus Project and the text "NCP, 2018".

NCP Guidelines

- **Domain 6: Cultural Aspects of Care**— IDT members to provide assessment and respect for values, beliefs & traditions related to health, illness, caregiver roles & decision making to provide culturally sensitive palliative care

 NATIONAL
CONSENSUS
PROJECT
FOR QUALITY PALLIATIVE CARE

NCP, 2018

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- National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care (NCP, 2018):

Domain 6: Cultural Aspects of Care

- *Global:* The interprofessional team delivers care that respects patient and family cultural beliefs, values, traditional practices, language, and communication preferences and builds upon the unique strengths of the patient and family. Members of the interprofessional team work to increase awareness of their own biases and seek opportunities to learn about the provision of culturally sensitive care. The care team ensures that its environment, policies, procedures, and practices are culturally respectful.
- *Communication and Language:* The interprofessional team ensures that patient and family preferred language and style of communication are supported and facilitated in all interactions.
- *Screening and Assessment:* The interprofessional team uses evidence-based practices when screening and assessing patient and family cultural preferences regarding health care practices, customs, beliefs and values, level of health literacy, and preferred language.
- *Treatment:* A culturally sensitive plan of care is developed and discussed with the patient and /or family. This plan reflects the degree to which patients and families wish to be included as partners in decision-making regarding their care. When hosting meetings to discuss and develop the plan, the interprofessional team ensures that patient's and family's linguistic needs are met.

Culture Defined

- System of shared symbols
- Provides security, integrity, belonging
- Constantly evolving
- Making meaning out of illness
- Beyond race or ethnicity
- Influences response to illness
- Variations



Cormack et al., 2019; Mazanec & Panke, 2016

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Slide 6



- Cultural humility (first identified by Tervalon & Murray-Garcia in 1998) is an “other-centered” approach that incorporates (Rosa & Morin, 2017):
 - Self-reflection and lifelong learning in order to accept, understand, and incorporate differing beliefs and health practices
 - Patient-focused interviewing and care that replaces power imbalances seen in paternalistic provider-patient dyads
 - Community-based care and advocacy that leads to mutually beneficial partnerships for both providers and recipients of health care services
- Foronda et al. (2016) identified five key attributes of cultural humility:
 - Openness: “...possessing an attitude that is willing to explore new ideas
 - Egoless: “...require[s] humbleness or throwing away ego
 - Supportive interactions: “...intersections of existence among individuals that result in positive human exchanges
 - Self-awareness: “...being aware of one’s strengths, limitations, values, beliefs, behavior, and appearance to others
 - Self-reflection and critique: “... a critical process of reflection on one’s thoughts, feelings, and actions

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**Striving to Understand Culture:
A Process**

- **All terms & definitions about culturally appropriate care involve self-awareness and an openness and respectfulness for each other**
 - Cultural humility
 - Cultural competence
 - Cultural sensitivity
- **Striving to understand the importance of culture in healthcare is a process, not an end-point**

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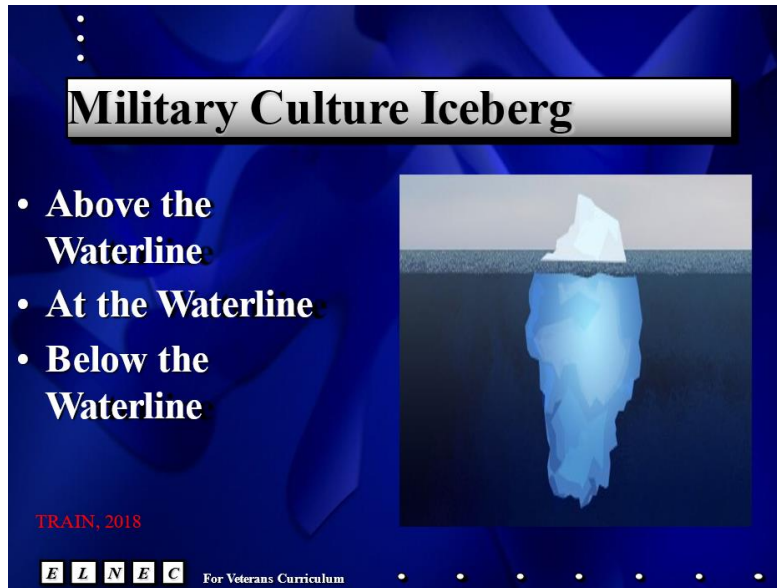
- Striving to understand and respectfully engage with other cultures is a process.
- Being sensitive to other cultures is a major step in cultural humility (Foronda, 2020). This is absolutely necessary in palliative care, as in any other clinical arena.
- We must go into each new encounter with a mind that is open, knowing that our own individual and professional perspectives are but one of many in the larger community we are serving. Our goal should be to create a shared understanding (Mazanec & Panke, 2016, Cormack, Mazanec & Panke, 2019).
- We must be willing to learn self-reflect in order to provide care that respects and honors other's culture.
- Cultural safety: an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and the experience of learning together (Curtis et al., 2019).
- Cultural effectiveness: "To be culturally effective/competent doesn't mean you are an authority in the values and beliefs of every culture. What it means is that you hold a deep respect for cultural differences and are eager to learn, and willing to accept, that there are many ways of viewing the world." –Okokun O. Udo [<https://xculture.org/cultural-competency-programs/about-cultural-competency>; <https://www.lacrosseconsortium.org/content/cultural-competencies>] (accessed June 23, 2022).
- Cultural arrogance: feeling our ideas, thoughts, and our unique ways of viewing or understanding the world are superior to others; may be endemic in US health care practice and education; antithetical to humility.
- Cultural distress: patients may experience this when they do not receive culturally congruent care; a negative response rooted in a cultural conflict in which the patient lacks control over

the environment and the practices taking place in the patient-provider encounter. Cultural distress may manifest in both physiological and behavioral pathways through the simultaneous experience of stressors related to

- The disease or illness state
- The sense of otherness related to the structure of society

The power imbalance with the patient-provider relationship (DeWilde & Burton, 2017).

Slide 8



- What is military culture? The iceberg has been used to describe various race and ethnic cultures, and fits for military culture as well. It is said that 90% of culture is hidden below the waterline. Some of what identifies men and women as members of the military is readily apparent, above the waterline.
- **Above the Waterline:** Above the waterline are aspects of a culture that are explicit, visible, and easily taught. Some of what identifies men and women as members of the military are readily apparent or above the waterline: **uniforms, medals, salutes, ranks, hats, tshirts, wall hangings and plaques in the home and ceremonies.**
- **At the Waterline:** At the waterline is a transition zone where the observer has to be more alert, the area where implicit understanding becomes talked about and where ethos is codified into creed. This level of military culture includes the **Service creeds, the core values, and the oath of office.**
- **Below the Waterline:** Some of what identifies Service members and Veterans as belonging to the military culture is not readily apparent and exists below the waterline. This level includes the hidden aspects of culture are not taught directly: **discipline, teamwork, self-sacrifice, fighting spirit, loyalty, warrior values, warrior beliefs, warrior ethos.** (TRAIN, 2018)

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Armed Forces Subcultures


Branch	Title	Job
Army	Soldier	The largest and oldest service in the U.S. military, the Army provides the ground forces that protect the United States
Air Force	Airman	The Air Force provides a rapid, flexible, and lethal air and space capability that can deliver forces anywhere in the world within hours
Navy	Sailor	On, above, and below water, the Navy is America's forward deployed force and is the major deterrent to aggression around the world
Marine Corps	Marine	As a component of the Department of the Navy, the Marine Corps maintain amphibious and ground units for contingency and combat operations
Coast Guard	Coastie or Coast Guardsman	The Coast Guard provides law and maritime safety enforcement, marine and environmental protection and military naval support
National Guard (comprised of Air National Guard and Army National Guard)	Soldier	A versatile force supporting combat missions, domestic emergencies, humanitarian efforts, homeland security operations and other missions.
Space Force (established in 2019)	Guardians	Responsible for organizing, training, and equipping Guardians to conduct global space operations that enhance the way our joint and coalition forces fight, while also offering decision makers military options to achieve national objectives.

Adapted from U.S. Department of Defense, *in Our Force* <https://www.defense.gov/About/OurForces/> and Elliot, 2021

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- Military service is not only an occupation, but also a unique and all-encompassing lifestyle to which service members become identified with to varying degrees (McCaslin et al., 2021)
- The diversity within this military/veteran subculture is reflected in the unique military missions and lifestyle differences within as well as across the various service components and various US military branches (i.e., the Air Force, Army, Navy, Marine Corps, Coast Guard, and newly created Space Force). Each service has its own mission and rank structure. As an example of service specific diversity members of the Marine Corps are more likely to be younger and serving in some type of direct combat specialty that requires significant physical capacities, while members of the Air Force are more likely to be older, many with college degrees, and mostly trained in some type of technical skill. The Army and Navy are the largest branches, and they reflect the widest array of occupational specialties required to support their varied and numerous missions. While there is great diversity among the various sectors of our armed forces, there are implicit cultural values and beliefs shared within and across all components and service branches. For example, the concept of *service before self*, (a core military value that stresses integrity and requires service members to place their duty responsibilities before their own personal interests and desires).
- Many of these core values are ingrained early in military service and remain with military members and become part of their identity even after transitioning from military service to veteran status. (Isserman & Martin, 2021)

Cultural Demographics of Veterans

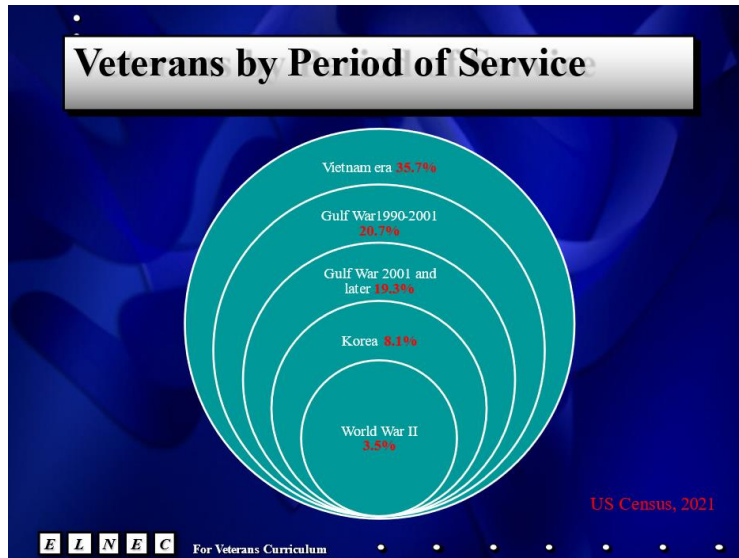


- Population decreasing (12 million in 2045)
- 63.1% white
- 16.1% Hispanic/Latino
- 12.2% Black/African American
- 5.8% Asian
- 4.7 % some other race alone
- 4% two or more races
- 0.8% American Indian or Alaskan Native
- 0.2% Native Hawaii or other Pacific Islander
- Veteran population is younger

ELNEC For Veterans Curriculum US Census, 2021

- This slide illustrates some of the cultural demographics of Veterans.
- The 2020 census revealed the following regarding Veterans and race. 63.1% are White alone (non-Hispanic or Latino), 16.1 % are Hispanic or Latino, 12.2% are Black or African American alone, 5.8% are Asian alone, 4.7% some other race alone, 4% two or more races, 0.8% are American Indian or Alaskan Native alone, 0.2 % are Native Hawaiian or other Asian Pacific Islander alone, (US Census, 2021)
- The Veteran population is projected to decrease from 20.8 million in 2015 to 12.0 million in 2045 (NCVAS, 2019). Over this time, the proportion of minorities among all Veterans will increase from 23 percent to 34 percent (NCVAS, 2019).
https://www.va.gov/vetdata/docs/QuickFacts/2017_Veterans_Profile_Fact_Sheet.PDF
- Age of Veterans (US Census, 2021)
 - 29.9% are 18-34
 - 33.1% are 35-54
 - 16.7% are 55-64
 - 11.8% are 65-74
 - 8.5% are 75 and older


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The following data from the 2020 Census reflects the era of the current Veteran population.

- Gulf War (9/2001 or later) veterans 19.3%
- Gulf War (8/1990 to 8/2001) veterans 20.7%
- Vietnam era veterans 35.7 %
- Korean War veterans 8.1%
- World War II veterans 3.5 %

Cultural Demographics: Different Wars



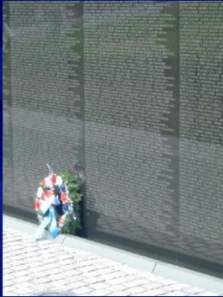
- **World War II: 1941 -1945**
 - Enthusiastically supported by Americans
 - Veterans came home as heroes
- **Korean Conflict: 1950 -1953**
 - Never officially declared a war
 - “Forgotten war”, Veterans’ trauma minimized/neglected
- **Cold War: “Atomic Veterans ”**
 - Considered 1945 till 1990s
 - Veterans exposed to radiation

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- During WWII, many Service members deployed to war zones almost continuously over months and years, while Vietnam-era deployments tended to be for a single 12-month period. Since the beginning of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND), military service has been characterized by repeated deployments to war-zones, each for a period of 6-18 months. At the same time, increasing numbers of military deployments have been in support of potentially stressful humanitarian and peacekeeping missions other than war (TRAIN, 2018). Although characteristics are discussed by war era it is important to not assume that just because your patient is a Veteran that he/she identifies with all aspects of military culture to the same degree as other Veterans.
- **World War (WW) II: 1941-1945**
 - Many soldiers lied about their age and joined the military service when they were 16 years old.
 - Without television, Americans could be shielded from the war’s brutality, and hence it could be glamorized.
 - Soldiers felt camaraderie and were in the war until it finished. Troops came home together after the war.
 - Enthusiastically supported by Americans.
- **Korean Conflict: 1950-1953**
 - Not officially declared a war, but rather a “conflict.” Has been called “The forgotten war”
 - Americans in the 1950’s were happy with post-World War II feats and they wanted to forget about war and configure ways of growing prosperously.

- Being shaded by the WW II generation and the upheaval caused by Vietnam, Korea War Veterans became even more “invisible” (Elliott, 2017)
- **Cold War:** “Atomic Veterans”
 - Considered end of WWII in 1945 until the collapse of the Soviet Union in the 1990’s.
 - Major fear was nuclear war.

**Cultural Demographics:
Different Wars (continued)**



- **Vietnam War (largest group of veterans)**
 - Veterans were not welcomed home
 - Anti-war protests
 - Tragedy of war: toxic exposures (AGENT ORANGE)

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- There is no single profile of the Vietnam Veteran
- **Vietnam War: 1964-1975**
 - It was the first war in which the US failed to meet its objectives.
 - It was the first time America failed to welcome its Veterans back as heroes. Many Veterans were attacked personally by their fellow countrymen, who opposed the war. This situation magnified the stress associated with their combat experiences.
 - There was a lack of unit cohesiveness as many soldiers were sent to Vietnam as individuals and left when their year's tour was completed. They often traveled to and from Vietnam by air, being an active combatant one day and a Veteran returning to a hostile civilian environment the next. They reported being spat upon as they disembarked at the airport and being uncomfortable wearing their uniform in public. (We Honor Veterans, 2022)
 - Following the war, Veterans experienced many readjustment problems and adverse health effects, many of which are attributed to Agent Orange.
 - The draft forced many into the military; some of whom were opposed to the war.
 - Due to factors including the Vietnam War itself, Veterans' receptions back home, lack of support services available for them, and frustrations with the U.S. Department of Veterans Affairs (VA), skepticism for healthcare and end-of-life services is common among Vietnam Veterans (NHPCO, 2019)
 - Many Vietnam Veterans were exposed to Agent Orange during their service, as over 19 million gallons of various herbicidal

combinations were used between 1961 and 1971. Agent Orange was the most widely used of the herbicide combinations that was sprayed. VA has recognized that certain cancer and other diseases have been associated with exposure to Agent Orange. Other diseases include acute and subacute neuropathies, Parkinson's Disease, Hodgkin's Lymphoma, chronic B-cell leukemias, multiple myeloma, etc. For further information about Public Health and Diseases Associated with Agent Orange, go to

<http://www.publichealth.va.gov/exposures/agentorange/diseases.asp>

- Despite their shared experiences, Vietnam Veterans' needs as they enter hospice care and their attitudes about the war vary dramatically. Some Vietnam Veterans are proud of their service and they've made it an outward part of their identity. They want to talk about it. They appreciate being honored for their service in a variety of ways. Others do not talk about their service and do not want it to be part of their story (NHPCO, 2019)

Note:

- For more info on compensation associated with Agent Orange exposure go to: VA's Guide on Agent Orange Claims, http://www.benefits.va.gov/compensation/claims-postservice-agent_orange.asp
- "VA assumes that certain diseases can be related to a Veteran's qualifying military service. VA has recognized certain cancers and other health problems as presumptive diseases associated with exposure to Agent Orange or other herbicides during military service and Veterans and their survivors may be eligible for benefits for these diseases," <http://www.publichealth.va.gov/exposures/agentorange/conditions/index.asp#sthash.FyE9WtYB.dpuf>

**Cultural Demographics:
Different Wars (continued)**

- **Gulf War**
 - Greeted home as heroes
 - Concerns about toxic agents
- **Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)– Operation New Dawn (OND)**
 - Longer and multiple deployments
 - Environmental and traumatic injuries

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- **Gulf War Desert Shield/Desert Storm: 1990-1991 (or Desert Shield/Desert Storm or Persian War)**
 - Multi-symptom based medical/psychiatric conditions reported (i.e. fibromyalgia, chronic fatigue syndrome, memory loss, chemical sensitivity, PTSD, anxiety, depression). In addition, there was exacerbation of asthma, secondary to oil-well fire/smoke.
 - The link between military service and ALS was first discovered in two research studies published in 2003 (ALS Association, n. d.)
- **Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF); effective September 2001, now referred to as Operation New Dawn (OND):** Military personnel were deployed in response to the September 11, 2001 terrorist attacks on the World Trade Center and the Pentagon. Since October, 2001, over 1.7 million US troops have been deployed for OEF/OIF/OND.
 - Long and multiple deployments to Afghanistan and Iraq have taken significant psychological tolls, evidenced by increasing incidence of suicide and suicide attempts.
 - Veterans experienced environmental hazards and combat injuries.

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**Cultural Demographics:
Women Veterans**

- **Veterans (VA, 2019)**
 - 10% of Veteran population
 - Fastest growing group in the Veteran population
- **I Am Not Invisible (IANI) campaign**
- **More challenging to identify women Veterans**
- **Women Veteran Program Managers at all VAFacilities**

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Start by playing the video “She Wore These”

https://www.youtube.com/watch?v=F_MxASC8UHU&ab_channel=VeteransHealthAdministration

- According to the VA (2019a)
 - The total Veteran population as of Sept. 30, 2019, was 19,209,704. The population of women Veterans numbered 1,920,965 (approximately 10%). States with the largest number of women Veterans were Texas, Florida, California, Virginia and Georgia.
 - ten percent of our Veteran population consists of women and is the fastest-growing group in the Veteran population.
- Women continue to face significant barriers and challenges in accessing necessary health care and other services, while experiencing a lack of recognition (CWV, 2022). The I Am Not Invisible (IANI) campaign began in February 2017 as a way to increase visibility of women Veterans, who are often invisible both as Service members and Veterans. The IANI Campaign 2.0 kicked off in December 2020 to enhance the visibility of women as Veterans and to change the culture of gender-based harassment by strategically placing images of women Veterans in VA medical facilities in order to facilitate women Veterans feeling welcome in their own spaces.
- Once the uniform is removed, there is no apparent indication that a woman is a Veteran. Frequently women are far from the quintessential image that springs to mind when one thinks of a “U.S. military Veteran” (Ward, 2022). Many veterans wear hats with insignia stating branch or service, but this practice is much more common among men than women. It isn’t uncommon to hear about a woman

Veteran who was challenged about parking in a “Reserved for Veteran” spot or not being thanked for her service on Veterans Day (Ward, 2022).

- Every VA Medical Center nationwide has a Women Veterans Program Manager to advise and advocate for women Veterans and help coordinate all the services they may need, from primary care to specialized care for chronic conditions or reproductive health.

Exercise - Stop and Consider:

- Do you ask women if they are Veterans?
- What type of diseases do you see most frequently with women Veterans?
- Are women Veterans cared for differently than male Veterans? If so, how?
- Is there a history of sexual trauma? If so, is there a need for evaluation, counseling, treatment? How might this affect their palliative care plan of care?

Resources:

Short videos Stories of Service:

<https://www.womenshealth.va.gov/WOMENSHEALTH/materials-and-resources/videos.asp>

Examples:

Vivian Greeno:

https://www.youtube.com/watch?v=QbcVgcFzQYY&ab_channel=VeteransHealthAdministration

Brigadere General Wilma Vaught, Vietnam Veteran:

https://www.youtube.com/watch?v=k6S3jRrh4uk&ab_channel=VeteransHealthAdministration

Lenell Kittlitz, US Coast Guard:

https://www.youtube.com/watch?v=sdAs107MXgg&ab_channel=VeteransHealthAdministration

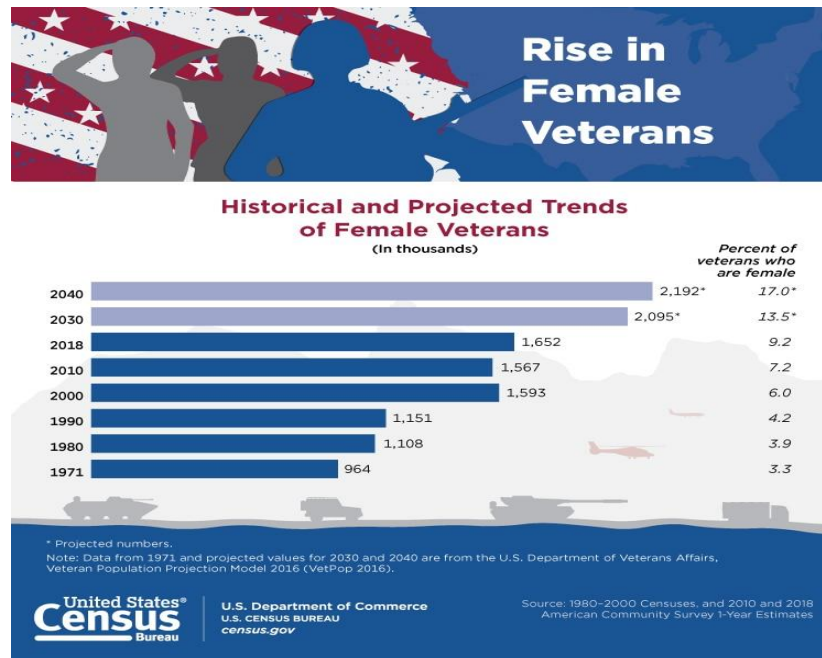
Amy Otzel, Operation Iraqi Freedom:

https://www.youtube.com/watch?v=YXmwrSF7i3g&ab_channel=VeteransHealthAdministration

She Wears the Boots: A Podcast for Women Veterans is a website dedicated to providing education on various services the VA offers for women. <https://www.spreaker.com/show/she-wears-the-boots-a-podcast-for-women>

A short video describing healthcare for women at the VA: <https://www.womenshealth.va.gov/>

Slide 16



- This slide describes the growing numbers of women Veterans.

Slide 17

LGBTQ Veterans

- **Prior to 1982 criminalized and discharged**
- **1993 Don't Ask Don't Tell**
- **2011 openly gay, lesbian and bisexual people allowed to serve in military**
- **Family structure**
- **VA Facility LGBTQ coordinators**

Healthcare
→ **for the Veteran you are**
Proudly serving lesbian, gay, bisexual, transgender,
and queer/questioning Veterans. (LGBTQ+)

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- **Lesbian, Gay Bisexual & Transgender (LGBT) Veterans**
- The history of LGBT Veterans is an important aspect of understanding their unique military experience. It wasn't until 1982 that the military enacted a policy explicitly banning gay men and lesbians from their ranks. Before 1982 same-sex relations were criminalized and cause for discharge. In 1993, the "Don't Ask, Don't Tell" (DADT) policy went into effect allowing closeted LGBTQ people to serve in the military. Under the policy, service members would not be asked about their sexual orientation but would be discharged for disclosing it. (Military One Source, 2021). Although the DADT policy was intended to assist the LGBT service members, it created a communication barrier to openly discuss their needs. for The DADT policy was repealed by Congress in 2011, allowing openly gay, lesbian and bisexual people to serve in the military.
- The decades of discrimination, criminalization, violence, social stigma, and unequal treatment under both military policies and the law have fueled the invisibility of this population and have made many reluctant to engage with the healthcare system (Hinrichs & Donaldson, 2017). Veteran LGBTQ individuals may have concerns that that disclosure of their sexual orientation or gender identity may put them at risk for disrespectful comments or sub-par treatment in healthcare settings; therefore, healthcare providers must be culturally sensitive, and ensure all patients feel welcome presenting as their authentic selves (Mark et al., 2019)
- An important consideration for older LGBT Veterans at end-of-life is their family structure and availability of caregivers. When compared with younger Veterans for whom sexual diversity may be seen as more commonplace, older Veterans may have experienced substantial discrimination across their life course with regard to their sexuality. These experiences could predispose some to feeling less comfortable disclosing information to healthcare providers. (Hinrichs & Christie, 2019). Each

Veteran's experience is unique and may be dependent on the policies in place during the time the Veteran served.

- Each VA facility has a LGBTQ coordinator.

Consider:

- Watch the trailer for the Oregon Department of Veterans Affairs (ODVA) film Breaking the Silence: An oral history of Oregon's LGBTQ Veterans and Service members at <https://bts.oregondva.com/>
- The entire 51 minute film can be viewed at: <https://bts.oregondva.com/watch-the-film/>

**Cultural Demographics:
Poor and Homeless Veterans**

- VA efforts between 2009-2020 have led to nearly a 50% decrease in Veteran homelessness
- California, Hawaii and Oregon have the highest rates of homelessness among Veterans
- Causes for homelessness
- Programs to assist Veterans
- Helping Veterans access the VA

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- It is a challenge to identify homeless Veterans who are terminally ill and bring them into the VA system early enough that they can benefit from hospice/palliative care. Nurses can play a strategic role in identifying terminally ill Veterans who are at high risk for being homeless and assuring that they are provided with compassionate and dignified care.
- VA efforts between 2009 and 2020 has led to nearly 50% decrease in Veteran homelessness. California, Hawaii, and Oregon had the highest rates of homelessness among all veterans. (HUD, 2021)
- There are several causes of so many Veterans being homeless:
 - A shortage of affordable housing
 - Low salary
 - Limited access to health care
 - Mental Illnesses
 - On-going effects of PTSD
 - Substance abuse
 - Lack of family/friend support
- Some homeless Veterans are not comfortable in “facilities.” For some, they want to die as they lived-homeless. For these Veterans, it is important to connect them with community hospices that can provide care “under the bridge” or “on the street.”
- Every VAMC has a homeless Veteran services coordinator who is responsible for providing outreach and services for homeless or at-risk Veterans.
- The VA has been very proactive in ending Veteran homelessness. One issue is determining Veteran eligibility for VA services. The Status Query and Response Exchange System (SQUARES) is a VA web application that provides VA employees and external homeless service organizations with reliable, detailed information about

Veteran eligibility. Users submit identity attributes for homeless individuals (name, date of birth, social security number, gender) and SQUARES returns information regarding their Veteran status and eligibility for homeless programs. The tool facilitates quick and simple access to care for homeless and at-risk for more on this program :

https://www.youtube.com/watch?v=KTDw4Lh7Kso&ab_channel=U.S.Dept.ofVeteransAffairs

- Veterans who are homeless or at imminent risk of homelessness are strongly encouraged to contact the National Call Center for Homeless Veterans at (877) 4AID-VET (877-424-3838) for assistance. If Veterans do not have access to a phone or the internet, only then are they to visit their closest VA medical center without calling in advance.
- For those working in non-VA facilities: Do you have Veterans who may be better served in a VA-facility? Many Veterans state that attempting to “get into the VA system” is confusing and a lengthy process. The very first step in obtaining access to VA benefits is completing an application for enrollment (Erickson-Hurt, McGuirk & Long, 2017)
- The most convenient way for Veterans to apply for benefits is to use an advocate. Veteran advocacy groups are known as Veteran Service Organizations (VSOs) and they usually have a Veteran’s Advocate Service Officer who is trained and may represent and support Veterans on issues related to their Veteran status and applications for benefits (Erickson-Hurt, McGuirk & Long, 2017). There are many VSOs, but some of the most well known include the Veterans of Foreign Wars (VFW) <http://www.vfw.org> , Disabled American Veterans (DAV) <http://www.dav.org>, American Veterans (AMVETS) <https://amvets.org/>, American Legion <https://www.legion.org> , Vietnam Veterans of American (VVA) <https://vva.org>

Providing Palliative Care for Poor and Homeless

- **Goal: stable housing**
- **Expect that trust is earned over time**
- **Appreciate their unique story**
- **Recognize/address maladaptive behaviors**
- **Person-centered care is essential**

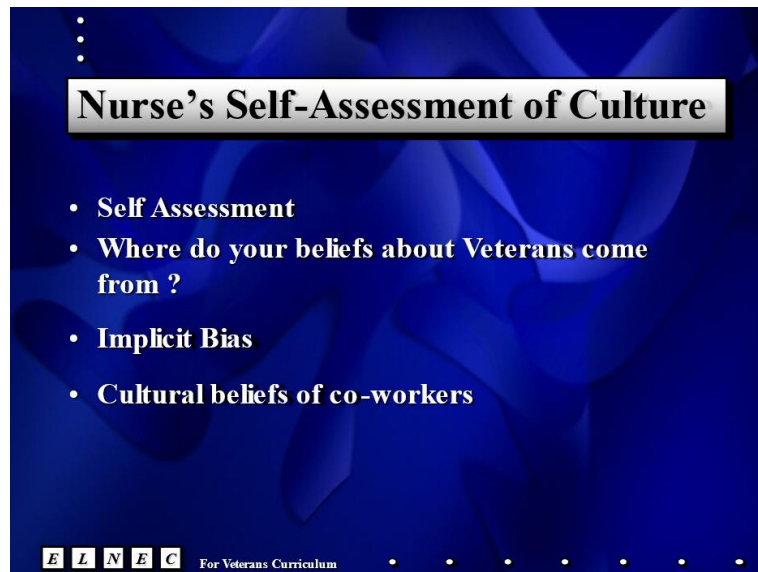
Hughes, 2015

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- Ideally, all patients receiving palliative care would have stable housing. The poor and homeless live on the street and exist on very little. They can be seen as disenfranchised as many are mentally ill and have substance abuse problems. All of these factors can make providing excellent palliative care to this population very challenging.
- It may take a long time to build trust with these patients.
- No matter what they look like, what they smell like, what they say, or feelings that they may stir in us, it is important that we respect this person as a human being, deserving of care that we can provide.
- Listen and appreciate their unique story as it may influence their response to being ill and dying.

Exercise - Stop and Consider:

- Do you care for homeless Veterans?
- How does your institution reach-out to homeless Veterans?
- What needs to be done to overcome barriers to reach homeless Veterans who have life-threatening illnesses and need palliative care?
- How does this culture of homelessness interfere with excellent palliative care?
- Every VA has a homeless Veteran services coordinator who is responsible for providing outreach and services for homeless or at-risk Veterans. Do you know who this coordinator is in your area?



- A starting point in striving towards culturally sensitive care of patients is self-assessment. It is important to recognize our own culture and how that effects our interactions, decisions, language, and behavior (Ellis Fletcher, 2015).
- Each one of us has our own culture based on our heritage and life experience that influences our interests, emotions, biases and how we view the world.
- Consider Where your Beliefs come from?
 - **Personal experience:** This can be a great asset especially if your experience was similar to the Veterans, but because all experiences are unique, your own Veteran experience could also be an obstacle if you do not appreciate differences. What Veterans most appreciate is not that you also served, but that you show respect for their experiences as well as their personal viewpoint.
 - **Friends/family:** some families view service as positive or negative and this can be powerful motivators for family member to join the military. The term used for children of military personnel is a “brat” many use this term in a positive tone saying “I was a Navy brat.” Increasingly fewer Americans have a personal relationship with a Service member or Veteran as the percentage of the total U. S. population serving in the Armed Forces during the post 9/11 conflicts is 0.5%, the lowest percentage in American history (TRAIN, 2018) this is
 - **Patients:** Experiences with previous patients can influence your beliefs and expectations
 - **Media, Movies, Books:** News reports, TV shows, Movies and books involving Veterans and their families tend to paint a dramatic, intense, and vivid image to illicit emotional and intellectual reactions from consumers of media.

Stop and consider: *how has media informed your ideas about military service and Veterans?*

- Understanding our own definition of culture helps uncover areas to assess in another.
 - All healthcare providers should complete a cultural self-assessment including assessing one's view of other cultural groups before completing a patient or family assessment (Cormack et al., 2019).
 - In addition to our understanding of culture, we all hold attitudes or stereotypes that are unconscious and based upon experiences and learned association. This is called "implicit bias." For example, we may hold negative stereotypes about others based on age, gender orientation, weight, race or religion without conscious realization.
 - A free test of your own attitudes and beliefs can be found at: <https://implicit.harvard.edu/implicit/takeatest.html> [accessed June 23, 2022].
 - Also, assess the cultural beliefs of co-workers. There is increasing cultural diversity among healthcare professionals, and one should not assume that the team members providing care for individuals with serious illness hold common beliefs.
- Consider taking the self-assessments found within the Military Culture Training for Health Care Professionals: Self-Awareness and Military Ethos online course <https://www.train.org/main/course/1056248/> [accessed July 2, 2022)

Examples of Implicit Bias: Look Inward

- Do you ask all females if they are a Veteran?
- Do you make assumptions when you see someone with a “Vietnam Veteran” hat on?
- Do you assume a woman present with a man are husband and wife? Do you assume the man is the Veteran?
- Do you assume two women present are sisters?
- Do you assume someone joined the military because they had no other options?
- Do you think you can tell someone’s sexual identity based on your experience?

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- Stop and think about these questions and your responses to them:
 - Take an honest look at your personal assumptions and biases
 - Do you ask all females if they are a Veteran?
 - Do you make assumptions when you see someone with a “Vietnam Veteran” hat on?
 - Do you assume a woman present with a man are husband and wife? Do you assume the man is the Veteran?
 - Do you assume two women present are sisters?
 - Do you assume someone joined the military because they had no other options?
 - Do you think you can tell someone’s sexual identity based on your experience?
- Have you thought of these assumptions before?
- Implicit bias is formed from ages 2-5. The attitudes that are formed affect our understanding, actions, and decisions.
- Implicit biases that are detrimental can be unlearned.

STOP & CONSIDER: What are your biases that may impact your delivery of culturally sensitive care?

Consider watching video on health equity stories to share:

<http://link.brightcove.com/services/player/bcpid4521574267001?bckey=AQ~~,AAACmABW4 k~,u3UC4vmaozkRbnTOHzovpplgn0QYiIND&bctid=4790043174001>

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Components of Cultural Assessment

- **Veteran, family & community**
 - Birthplace
 - Ethnic identity
 - Race
 - Family/kinship
 - Social life/networks
 - Community
 - Decision-making
 - Language and communication

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The slide features a blue background with a white title box at the top. Below the title is a bulleted list of components. To the right of the list is a photograph of a group of approximately ten people, including several veterans in military uniforms and some in wheelchairs, sitting together in a room. At the bottom of the slide, the acronym 'ELNEC' is displayed in a stylized font, followed by the text 'For Veterans Curriculum'.

COMPONENTS OF CULTURAL ASSESSMENT (Cormack et al., 2019)

There are numerous components to include in a cultural assessment and many tools available to help nurses complete this assessment. As you do an assessment keep in mind how social determinants of health impact the patient's and family's ability to access and engage in palliative care.

- Social determinants of health that should be considered for health equity include (CDC, 2020):
 - Health and healthcare
 - Education
 - Social and community contact
 - Economic stability
 - Neighborhood & environment

Key components of a cultural assessment include:

- Country of origin; current residence:
 - Where was the Veteran/family, caregivers born? (Non US citizens can join the US military, and many use the military as a route to naturalized citizenship. Veterans may marry foreign nationals when stationed overseas, for example, Korea, Japan, Germany)
 - If an immigrant, how long has the person lived in this country?
 - How old was the person when they came to this country?
 - What is the person's ethnic affiliation and how strong is the ethnic identity?
 - Do they live in an ethnic community? Is the community a source of support?

- Ethnicity
 - Ethnicity refers to complex interactions of dynamics involved in individual functioning and family/group behaviors, beliefs, and values, and provides a sense of commonality with others.
 - Ethnic identity is based on rich cultural heritage, and social belief systems reflected in how we respond to life transitions; ways of communication; behavior; illness beliefs; and how major life decisions are made.

Race-

In the U.S., racial categories for the 2020 Census reflect the social definition of race in this country <https://www.census.gov/topics/population/race/about.html>:

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or other Pacific Islander
- Some other race

Please NOTE: ONLY for the 2000 Census, two or more races was an option and is claimed to be the fastest-growing racial group between 2016 and 2060 (Johnson, 2020).

Healthcare providers need to be mindful of ethnicity and race because of the significant disparities in healthcare and end-of-life care that exist among certain groups and the issues of racism that are present in our society.

Major support people: Family members, friends, spiritual leader(s)/clergy/community, others

- Decision-making (Cormack et al., 2019; Mazanec & Panke, 2016):
 - How does the patient's culture affect decisions regarding his/her medical treatment?
 - How does the patient make decisions: alone or along with the family? Or does a designated family member make decisions for the patient?
 - Are there important community leaders or spiritual leaders/clergy involvement?

Languages/communication

- Primary and secondary languages/dialects
- Educational literacy including oral skills, reading ability, and educational level
- Health literacy including past history with health care
- Is it appropriate to share thoughts/feelings?
- Non-verbal communication: touch, eye contact, timing
- Hearing and/or vision disability

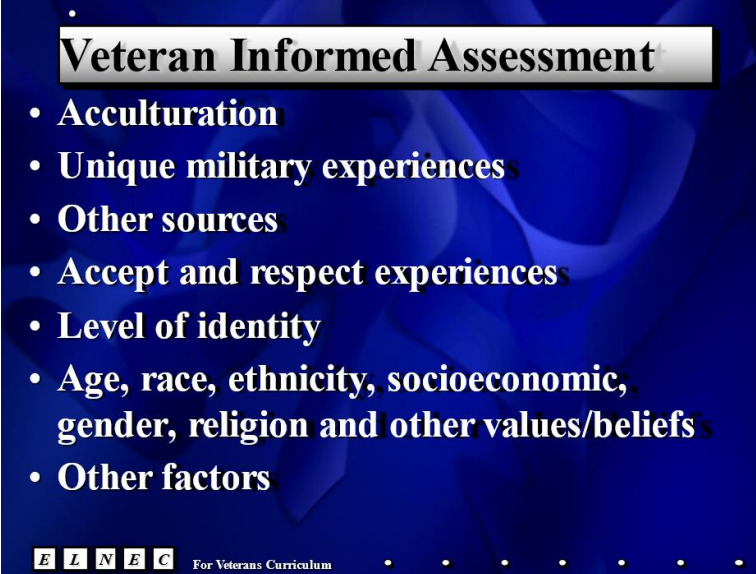
Slide 23



- Religion and spirituality (Ferrell 2016; Puchalski & Ferrell, 2010): Religion is a system of faith and worship. “Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred” (Puchalski et al., 2009). Some patients and families find comfort in the rituals associated with their beliefs. One example of a spiritual assessment is represented by the acronym FICA: Faith, Importance, Community, and Address (Refer to spiritual section for further information).
- Nutrition: Meaning of food, restrictions, and religious observances.
- Economic situation: Impact on illness, services needed, availability of medications, and is income adequate to meet the needs of the patient and family?
- Gender identity, gender preference and sexual orientation : Be respectful of each person’s gender identity, gender expression and sexual orientation along with their definition of “family” (Acquaviva, 2017; Cormack et al., 2019).
 - Gender identity: one’s sense of oneself as male, female, or an alternative gender
 - Gender expression: an individual’s presentation, including appearance, voice, behavior and chosen name/pronoun; these may not conform to the person’s gender identity
 - Sexual orientation: the sex of those to whom one is romantically and sexually attracted

- Differing ability: Respect and understand the rights of all people to be involved in decision-making about their healthcare and find the appropriate accommodations to ensure that they understand what they are hearing, seeing, and reading (Mazanec & Panke, 2016).
- Health and illness beliefs and practices (Rosa, 2019)
 - What are the customs and beliefs around such transitions as birth, illness, and death?
 - What are the Veteran's and family's past experiences regarding death and bereavement?
 - How much does the Veteran and family wish to know about the disease and prognosis?
 - What are Veteran's and family's beliefs about pain and suffering?
 - Complimentary [non-traditional] therapies (i.e. folk remedies, herbal medications, other practitioners - sometimes used in combinations). Veterans may be hesitant to inform healthcare providers of these therapies for fear they will not be taken seriously; often mistakenly translated into "compliance" problem.
 - Care of the body
 - Organ donation: For many, organ donation is not allowed or considered because of either personal or religious beliefs.

REMEMBER: A person self-identifying as a member of ethnic, religious, or demographic community does not mean they value the entire cultural perspective of the community they identify with.

A presentation slide with a dark blue background and a white title box at the top. The title is "Veteran Informed Assessment". Below the title is a bulleted list of seven items. At the bottom left of the slide is the logo "ELNEC For Veterans Curriculum" and a series of dots.

Veteran Informed Assessment

- **Acculturation**
- **Unique military experiences**
- **Other sources**
- **Accept and respect experiences**
- **Level of identity**
- **Age, race, ethnicity, socioeconomic, gender, religion and other values/beliefs**
- **Other factors**

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- **Informed Assessment (TRAIN, 2018)**
- Recognize and accept that individuals from military backgrounds may have varying degrees of acculturation into the military and/or veteran culture.
- Make every effort to ask about patient's unique military experiences before making comments or assumptions about their experiences, values, or goals.
- If possible, attempt to gather information from other sources about your patient's particular experiences in the military (i.e., the unique ramifications of their particular job, their branch of service, their years in the service, and locations of service).
- Accept and respect that an individual's unique experiences, including background, length of time in service, and quality of experience while serving may have significant influence on that individual's level of identification with military culture and ethos.
- Make efforts to determine the patient's level of identity with military culture and ethos.
- Accept and respect that age, race, ethnicity, socioeconomic, and gender, religion, and other values and beliefs may have significant influence on military cultural identity.
- Make efforts to discover other factors that factor into the patient's self-identification (i.e., ethnicity, gender, age, location of upbringing, family tree, religion, values, and beliefs)

Slide 25

Cultural Considerations of Communication

- Safe space
- Conversation style
- Personal space
- Eye contact
- Touch
- View of healthcare professionals
- Learning styles
- Use of interpreters

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Safe space

- Create an environment that is welcoming and fosters trust
- Be open to Veteran's preferences as to how to proceed

Conversational style

Assess whether the Veteran wishes to speak for him/herself or have a family member or other make decisions and serve as spokesperson.

Verify correct pronunciation of name

Ask Veterans how they would like to be greeted (e.g., first or last name; pronoun choice?)

A Veteran's silence may denote respect or mean "no" (Cormack et al., 2019).

Personal space

How close is appropriate? Observe the Veterans' reactions to posturing and space.

- Eye contact
 - Observe the Veteran's reaction to eye contact.
 - Avoiding eye contact in some cultures is seen as a sign of respect, not indifference.

- Touch

The acceptance of touch as a communication method is variable.

It may vary between genders by cultural norms

Use empathy to determine the Veteran's comfort with space and touch.


- View of healthcare professionals:
 - Some cultures/ groups of Veterans have past negative history with the health care system and may be mistrustful.

- Some cultures/Veterans approach healthcare professionals with respect and may be afraid to question their physician or other healthcare professionals.
 - Other cultures may respect the health care professionals but are not afraid to be confrontational and question the team regarding various issues.
- Auditory versus visual learning styles
 - Supplement oral communication with visual teaching materials.
 - Question Veterans/family members on whether they would like materials in English or another language and whether they prefer written materials or audiotapes/videotapes.
 - Narrative interviews – Listen to their stories and watch for cues regarding what is appropriate.
 - Use of interpreters (Dahlin & Wittenberg, 2019).
 - Avoid the use of family members as interpreters, if possible.
It may be taboo for younger members to address issues of an older family member, or there may be gender issues.
- Family members may edit what is being said, based on what is culturally acceptable.
May violate HIPPA laws.
- For more information on translation service, refer to these two organizations:
National Council on Interpreting in Healthcare (NCIHC – <https://www.ncihc.org/>)
and Diversity Rx; Improving Health Care for a Diverse World
(<http://www.diversityrx.org/>) [Websites last accessed June 23, 2022].

Slide 26

Role of the Family

- **Who is considered family?**
- **Who are the caregivers?**
- **Who makes decisions?**
- **Who is included in discussions?**
- **Is full disclosure to the family/Veteran acceptable?**



Blackford & Street, 2016; Mazanek & Panke, 2015

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- Family is more than a sum of individuals.
 - A social system in which members have ties to each other, are interdependent, have some common history, and share some goals.
 - Whoever is identified as family by the Veteran. Asking who is their “chosen family” as well as their “family of origin” is all inclusive.
 - Are any of these “family members” providing care?
- Various cultures have “rules” or “an understanding” that certain members of the family are to make decisions, certain members are to be in on discussions related to care, and certain members are responsible for determining whether full disclosure is appropriate.
 - Always ask Veterans to decide which family member is to be the surrogate, who may be present during discussions, and if they prefer full disclosure
- Ascertaining patient’s desire for disclosure (Koffman & Calanzani, 2021):
 - What do you want to know about your condition?
 - Whom should we talk to about your treatments and outcomes?
 - Whom do you want to know about your condition?
 - Whom do you want to make healthcare decisions for you?
- Questions to think about include:
 - Who makes decisions in the family? Who is the spokesperson? Is it the Veteran or a family member? Is it a family decision?
 - Who should be included in discussions? This is also a matter of respecting confidentiality. Professionals may ask the family to select

one person to serve as the key contact for information. Avoid HIPPA violations.

- Is full disclosure acceptable? (e.g., Does the Veteran want full disclosure about their diagnosis or prognosis to family/caregivers? (Mazanec & Panke, 2016).
- Disclosure of diagnosis and/or prognosis (Mazanec & Panke, 2016).
 - Certain diagnoses, for example cancer, as well as terminal prognosis, may not be told to the Veteran, as the family beliefs/culture is that the family believes that the Veteran will give up hope, experience increased suffering, and may, in fact, die sooner -- or in some cases complete suicide.
 - Conflict may arise when healthcare providers insist on full disclosure to the Veteran, particularly when the family is not included in this decision.
 - If a Veteran is asked and *chooses* to designate a family member to make decisions and receive all information, then the Veteran's rights have been respected.

Cultural Considerations: Disparities in Palliative & End-of-Life Care

- **Impact on families with chronic illness**
- **Access to medications for pain and symptom management**
- **Gender issues**
- **Access/utilization to hospice & palliative care services**
- **Racial/ethnic disparities**

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- There are many health equity issues related to cultural disparities in serious illness.
- Impact on families when a family member has a chronic illness:
- Increased risks on families
 - Single parent
 - Blended families
 - Reversal of roles [i.e., child taking care of parent]
 - Balancing home and work roles not always successful
 - Facing family stress and crisis, when a family member becomes ill with a chronic illness
 - Families are increasingly responsible for providing care of a patient at home.
 - Greater stress on the emotional and physical health of these caregivers.
 - Less access to resources or interventions to assist family caregiver to be informed.
- Cultural disparities impact access to medication and treatments for pain and symptom management. Consider both the economic factors and the social factors (environment/area and availability).
- Gender issues: There is a growing body of literature that indicates women are more likely than men to be undertreated for their pain.
- Education/knowledge regarding access and utilization to hospice and palliative care services, as well as resources available (both financial and availability).

When Cultures Clash

- **Clashes occur**
- **Assess your reactions, values and bias**
- **Never lie**
- **Offer information**
- **Use cultural guides**

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- Despite best efforts, clashes between people will occur. The key is to continue attempts to understand each perspective and take time to understand your own reactions. The three most common sources of cultural conflict are between (Mazanec & Panke, 2016):
 - Veterans and their family members
 - Healthcare team members
 - Healthcare team members, Veterans, families
- Failure to take the Veteran's/family's culture seriously means we choose to place our own values over those of differing backgrounds. For example, assuming a Chinese woman would not want to be told her diagnosis because she is Chinese is stereotyping. Insisting that she be told and disregarding her rights is akin to cultural imperialism (Andrews et al., 2019).
- Suggestions to address cultural conflicts (Koffman & Calanzani, 2021; Mazanec & Panke, 2016):
 - Assess your own reactions, potential bias. Be aware of your own ethical values.
 - Never deliberately lie to the Veteran or family.
 - Offer to make information available to the Veteran but allow the Veteran to decline.
 - Use cultural guides to facilitate communication when indicated.

STOP & CONSIDER:

- In the past month, have you experienced a “culture clash”? If so, what caused it?
- What were ways that could have been considered to avoid the clash?
- Was the clash resolved? If so, how?

Suggested Video: 15 things Veterans want you to know

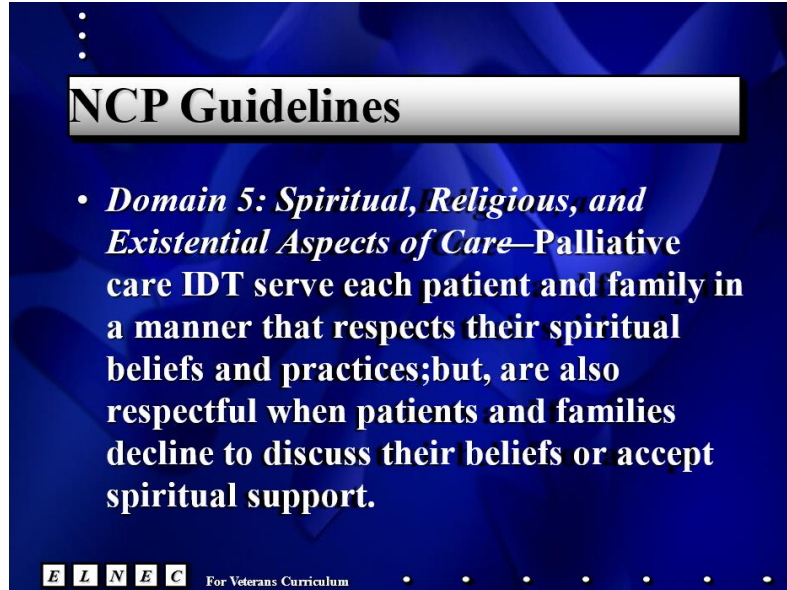
https://www.youtube.com/watch?v=V0E7wbLmu8A&ab_channel=PsychArmor

- Other suggestions:
 - A recommended resource that explores how cultures clash in healthcare is the book, *The Spirit Catches You and You Fall Down* (Fadiman, 1997). The author consulted psychiatrist and medical anthropologist Arthur Kleinman on how to elicit a family member’s or patient’s explanatory model regarding an illness, and how to improve interaction and understanding overall:
 - What do you call the problem?
 - What do you think has caused the problem?
 - Why do you think it started when it did?
 - What do you think the sickness does? How does it work?
 - How severe is the sickness? Will it have a short or long course?
 - What kind of treatment do you think the Veteran should receive? What are the most important results you hope he/she receives from this treatment?
 - What are the chief problems the sickness has caused?
 - What do you fear most about the sickness?

Slide 29

**Part II: Spiritual
Considerations in Palliative
Care**

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NCP Guidelines

- ***Domain 5: Spiritual, Religious, and Existential Aspects of Care***—Palliative care IDT serve each patient and family in a manner that respects their spiritual beliefs and practices;but, are also respectful when patients and families decline to discuss their beliefs or accept spiritual support.

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- *Domain 5: Spiritual, Religious and Existential Aspects of Care* (NCP,2018)
 - *Global:* Patient and family spiritual beliefs and practices are assessed and respected. Palliative care professionals acknowledge their own spirituality as part of their professional role and are provided with education and support to address each patient’s and family’s spirituality.
 - *Screening and Assessment:* The spiritual assessment process has three distinct components – spiritual screening, spiritual history, and a full spiritual assessment. The spiritual screening is conducted with every patient and family to identify spiritual needs and/or distress. The history and assessment identify the spiritual background, preferences, and related beliefs, values, rituals, and practices of the patient and family. Symptoms, such as spiritual distress and spiritual strengths and resources, are identified and documented.
 - *Treatment:* The IDT addresses the spiritual needs of the patient and family.
 - *Ongoing Care:* Patient and family spiritual care needs can change as the goals of care change or patients move across settings of care.

Spirituality and Religion

- **Spirituality**
 - Meaning-making
 - Need for purpose, forgiveness, love, hope, relatedness and religious faith
- **Religion**
 - “Organized”
 - Institutional beliefs



Taylor, 2019a

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- It is estimated that approximately 75% of patients state they have experienced at least one religious/spiritual (R/S) (Taylor, 2019a).
- Caring for the spirit allows us to better care for the physical, psychological, and social needs of Veterans.
 - When assessing the spiritual needs of a Veteran, it involves more than just asking what religion he or she is.
- **Spirituality** can be quite valued for those who do not consider themselves “religious.”
 - It is spirituality that gives life meaning and purpose.
 - It provides a means to forgive and to ask for forgiveness, to love, to hope.
 - This ethereal phenomenon allows for “transcendence”—to rise above whatever circumstance comes our way.
- **Religion** is more “organized” and tends to be categorized as denominations (i.e., Catholic, Protestant, Jewish, Muslim, Buddhist, etc.) (Taylor, 2019b).
- Nurses must work closely with available chaplaincy or spiritual care services and make referrals as congruent to the Veteran and family wishes.

For more information on specific religious beliefs and practices regarding illness, healing, and end of life as well as recommendations for ways & words to comfort:

Taylor, E.J. (2019). *Fast facts about religion for nurses*. Springer Publishing Co.

REMEMBER: The Joint Commission for hospitals accreditation now mandates that all patients be assessed for their spiritual beliefs and practices (The Joint Commission, 2022; Taylor, 2019a).

Slide 32

FICA: An Example of a Spiritual Assessment

- **F = Faith**
- **I = Important**
- **C = Community**
- **A = Address**

Puchalski, 2015

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- There are several examples of spiritual assessments, but this is simple and short and one that you can use in everyday conversations with Veterans and their families (Puchalski, 2015).
 - **F = Faith:** Does the patient have a faith belief? What gives his/her life meaning?
 - **I = Importance or Influence:** How important is your faith to you? How does your faith influence your life?
 - **C = Community:** Do you belong to a faith community? If yes, in what ways does this provide support to you?
 - **A = Address:** How would you like for the team to integrate issues of spirituality into your care?
- Stop & Consider:** How do you start the conversation regarding spiritual aspects of the Veterans' humanity? Evidence shows that Veterans must feel trust with their caregiver(s) to share these existential-type experiences. How do you develop a trusting relationship, so they can feel comfortable sharing these types of thoughts/experiences?

Examples of Nonreligious Spirituality Questions

- “You’ve gone through so much lately. Where do you get your inner strength and courage to keep going?”
- “As you think about the future, what worries you most?”
- “What comforts are the most satisfying for you now?”
- “What are you hoping for now?” Taylor 2019a

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- Questions that can encourage conversation about life’s meaning without focusing on religion:
 - help draw on inner strength and resiliency
 - start a conversation about spiritual concerns
 - help the Veteran identify that there is always hope

Spirituality in Veterans

- **Moral injury**
- “[My faith] is what got me through this and why I am still here.”
- “I was Methodist and went to church almost every Sunday. Being deployed over there, I don’t believe in that anymore.... I just didn’t see how, you know, how God could allow that to happen.” (Berkel et al, 2019)

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- Moral injury is a complex phenomenon characterized by spiritual, psychological, and moral distress caused by actions or acts of omission inconsistent with an individual’s moral and ethical values.
- Positive spiritual coping improves veterans’ lives in the context of post-traumatic stress, suicide, depression, anger/aggression, and anxiety and improve their quality of life (Smith-MacDonald et al., 2017) (Moral injury is discussed in more detail in bereavement module)
- The experience of serious illness coupled with past traumatic military service may increase R/S concerns
- In a qualitative study of recently deployed female veterans Berkel et al. (2019) found diversity of religious and spiritual identities and beliefs.
- Military experience may be a risk factor for spiritual wounds because war routinely involves paradoxical situations in which acts of aggression and compassion exist side by side. Veterans might therefore face a variety of R/S struggles that are uniquely related to serving in the armed forces. For example, veterans may struggle to make meaning out of trauma experienced during combat, blame God for abandoning them during the toughest of times, or have questions about their religious faith following their return to civilian life. Veterans might feel guilt regarding actions taken during wartime that were not in line with their moral code outside the context of war
- A study of Veterans with PTSD symptoms and depression found that 80% identified as religious or spiritual, with 15–20% of those Veterans reporting that religion or spirituality was an important aspect that needed to be addressed as part of their mental health care (Currier et al., 2018).

Resources:

- The VA has Veterans specific resources at <https://www.va.gov/WHOLEHEALTH/circle-of-health/spirit-soul.asp>

- Additionally make the connection website has videos, support and links for help at <https://www.maketheconnection.net/events/spirituality/>

Questions/Statements That Prompt Intervention

- **“What have I done to deserve this?”**
- **”I pray, but I’m still sick.”**
- **”I feel like all hope is gone.”**
- **“What did my life mean?”**
- **“I used to believe in God, but now I’m not so sure.”**

Rosa, 2019

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- These patient questions/statements indicate spiritual concerns or existential distress and need further exploration:
- The nurse should encourage the Veteran to discuss these questions/statements further by asking, “Can you tell me more about that?” and remaining fully present during the conversation.
- The nurse should work with the interprofessional team, in particular the spiritual care member/chaplain, to conduct a deeper assessment into spiritual needs.
- Spiritual interventions should be planned by the team to meet these needs.

Spiritual Care Interventions

- **Being present**
- **Deep/involved listening**
- **Bearing witness**
- **Putting compassion into action**
- **Evolving human-centered care [compassionate and empathetic care]**



Rosa, 2019; Rosa & Estes, 2016

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- Examples of spiritual care interventions are (Rosa, 2019):
 - Providing presence.
 - Deep listening.
 - Bearing witness.
 - Putting compassion into action.
- These interventions can assist in:
 - Reconciliation.
 - Self-worth.
 - Resolving guilt.
 - Forgiveness.
 - Stronger relationship with God/Higher Being.
- In order to generously tend to spirit, we recognize the Veteran as an evolving human experience. Rosa & Estes (2016) define *evolving human-centered care* as “compassionate and empathic care that responds, attends, and conforms to the human as a living, breathing, evolving experience; human as a fluctuating phenomenological being of engagement; human as history, as story, and as narrative; human as presence, emergence, and possibility; human as fellow sojourner; human as caring-healing; and human as LOVE” (p. 336)
- Understand and respect the Veteran’s culture.

NOTE: *Spirituality and Practice*: multifaith and interspiritual website, which has a spiritual toolkit at:

<https://www.spiritualityandpractice.com/practices/features/view/27713/spiritual-practice-toolkit>

Conclusion

- **Culture is a major influence during palliative and end-of-life care**
- **Many dimensions of culture**
- **Self-assessment of culture**
- **Culturally and spiritually sensitive care**
- **Interdisciplinary care**

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- Recognize that culture influences all aspects of life, especially during illness, the dying process, death, and bereavement (Mazanec & Panke, 2016).
- Self-assessment is the first step in culturally sensitive care: How do your own values/beliefs influence your attitudes or behavior towards others? Nurses must become aware of their own cultural beliefs and values and how these influence their behaviors and attitudes about others.
- Gain basic knowledge of the cultures common in your community. Get to know community and spiritual leaders and involve them in the care team when necessary. Increase awareness of the range of perspectives and issues that might arise along the course of an illness.
- Most importantly, obtain information from individual assessments, and complete assessments early. Seek to understand; never assume.
- Spirituality is an equally important component of quality of life along with the physical, psychological and social domains. All nurses should assess for spiritual needs and concerns and provide appropriate interventions.
- Culturally sensitive care is best provided through an interprofessional approach. Social workers, psychologists, psychiatric, mental health advanced practice nurses, and chaplains offer tremendous support in cultural assessment.

- Every clinical encounter is cross-cultural, so the healthcare provider must be flexible, sincere, and ethical in their interactions.
- Veteran- and family-centered care is the goal. There are no one-size-fits-all templates for care of Veterans with life-limiting illness. Effective care depends on the heightened sensitivity and awareness of social, cultural, psychological, and spiritual issues throughout the illness.