

Post-Traumatic Stress Disorder and Soul Injury: The Aftermath of War that Complicate Peaceful Dying

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Military experiences change veterans in fundamental ways that shape, mold, destroy, and redeem the rest of their lives, including the end of their lives. This article addresses the confluence of issues faced by veterans who are living with Post-Traumatic Stress Disorder at the end of life. It provides lessons that inform geriatric healthcare delivery for veterans and their families, including how to respond to an overlooked, unassessed wound, now named 'soul injury', and distinguishes soul injury from moral injury.

Key words: soul injury, moral injury, Post-Traumatic Stress Disorder (PTSD), veteran, hospice, end of life, death, dying

In many ways, veterans face the end of life the same as civilians; however, there are some fundamental differences in the ways they experience death. Traumatic memories are harder to suppress at the end of life, causing unbidden recollections to surface. Later-life Post-Traumatic Stress Disorder (PTSD) manifests much like childhood PTSD, as the original trauma is acted out. A dying person might listen and speak metaphorically. If the metaphorical image relates to war, it might precipitate a flashback. For example, a World War II prisoner of war (POW) admitted to the VA for end-of-life care became agitated when bathed in a tub, shouting "Get me out of here. You're all a bunch of Hitlers." His wife later reported that the Nazis had dug holes in the ground to interrogate prisoners and since then, the vet could never be in enclosed spaces, including bathtubs. If a veteran experiences helplessness while dying, the helpless feeling might act as a trigger for the helplessness of the original trauma, which might result in agitation that does not respond to usual anti-anxiety medications. Personal death may act as a trigger for past deaths experienced by the veteran, including deaths on the battlefield.¹

Post-Traumatic Stress Disorder (PTSD): Special Considerations at the End of Life

Increasing dependency often accompanies the dying process. This can become especially problematic for veterans because they have been trained to be strong, in control, and independent. Although interventions to maintain a sense of control should be provided, it is also important to initiate dialogue about *losing* control so the veteran can make peace with the losses. A health provider might say, "Sometimes veterans say that feeling helpless makes them angry. It's often hard for a soldier to learn how to surrender, to let go," or "Some veterans say that asking for help is humiliating. How does helplessness makes you feel?"

Loss of control can be especially difficult for veterans with PTSD. Helplessness is a common emotional reaction to trauma.² Helplessness and loss of control experienced in the original trauma play a crucial role in how veterans with PTSD sometimes face death. Their helplessness during the original trauma can subsequently incite overly-controlling behaviors throughout their lifetime in order to ward off experiencing helpless again. As illness progresses, veterans may lose independence

and control over their bodies, environment, and ability to exert their will. This acts as a trigger for the original helplessness they felt when traumatized which may cause anxiety and, if close to death, agitation. The agitation might not respond to benzodiazepine-type medications.³ In fact, anti-anxiety medications sometimes cause a paradoxical reaction (instead of decreasing anxiety, it increases anxiety). A chain reaction might be initiated in which the medication causes loss of control, which increases feelings of helplessness, which acts as a trigger for the original helplessness, which causes them to fight even harder to counteract the effect of the medication so they can regain control, which is manifested as agitation.

In addition to these shifts in behavior, language changes at the end of life. As a person dies, their conscious mind starts receding and the unconscious starts expanding.⁴ The language of the unconscious is symbols. Commonly, dying people start speaking in symbolic travel metaphors: "Help me pack my bags. I'm going on a trip." Dying people often *hear* metaphorically as well. For example, a World War II veteran was admitted to an inpatient hospice facility. Unrolling an air mattress onto the bed, one nurse said to another: "Okay. We can blow it up now." The veteran became agitated for several hours, repeatedly shouting: "Where's the bomb? Get me out of here." (If this same conversation had occurred just a few weeks earlier while his conscious mind was more intact, he probably would not have reacted; his conscious mind would have provided the appropriate context.) Although the DSM has not yet made note of it, dying people often express PTSD as children do; they act it out.⁵

Trust plays an important role in helping veterans with PTSD. They do not trust easily. They have been taught *not* to trust. Fail to keep your word once with someone who has PTSD, and a clinician can become the enemy. Authenticity is especially important as the clinician engages with the veteran. In a hospice program, trust may need to be gained quickly because the veteran may not have long to live; time to build a trusting relationship is simply a luxury that is not always available. The clinician's movements, tone of voice, and language become important opportunities to convey trustworthiness. Additionally, people with PTSD will often "test" clinicians to see if they are trustworthy. Dialogues about death should be done openly and directly. Veterans have faced death before when they were in combat. In fact, they were required to complete advance directives *whenever* they went into a combat zone. Clinicians should not use indirect phrases to try to make death more palatable. (However, family members may be more tolerant of euphemisms, as are veterans without PTSD.) For example, one veteran declined hospice services. Follow-up with the veteran revealed the reason: "I told them that I knew that hospice was for dying people and the nurse said, 'No. Hospice is for the living. Funeral homes are for the dying.' Right then, I knew I couldn't trust her. Send me someone who can play it straight with me."⁶

Triggers and flashbacks are issues that may further complicate peaceful dying. The veteran's own anticipated death can act as a PTSD trigger. If they are admitted to a hospice unit, they might become anxious, suspicious, or angry. Leaving their home to enter an unknown institutional environment can be perceived as threatening, which may increase their feelings of danger. When a Vietnam vet was admitted to an inpatient hospice unit, he became agitated because "Vietcong are under my bed." The hospice nurse showed him that there were no Vietcong under the bed, reassuring him that he was safe. As soon as she left the room, however, the Vietcong returned. The mattress was then placed on the floor and the veteran's flashback eased. Another patient became agitated thinking he was in a POW camp again. Medications and psychological measures failed to give him relief. Once it was determined that he had urinary retention and a catheter was inserted,

he “returned” from the POW camp in only minutes – a reminder that any noxious stimuli (like a full bladder) might trigger noxious wartime memories.

Veterans with dementia also need special consideration. Traumatic memories are encoded and stored differently than non-traumatic memories. Traumatic memories often emerge in involuntary fragments unconsciously triggered by internal or external reminders of the original trauma.⁷ Dementia compounds the problem with short-term memory loss and inability to appropriately contextualize situations. For example, a Korean War veteran became agitated watching the news about the Iraq war. “Don’t let them draft me again. Don’t let them draft me,” he desperately pleaded with his wife. When the hospice team arrived, he poignantly added: “I’ve killed enough people. I can’t do it anymore.” Assurances that he would not be drafted again only provided temporary relief that he soon forgot. A large card was made with his name and “Not eligible for the Draft” printed on it. Clutching the card and re-reading it provided the assurance he needed.

Stoicism is a component of military culture that tends to long outlast military service. Stoicism is defined as indifference to pleasure or pain.⁸ Stoicism is important, even essential, on a battlefield. However, stoicism can contribute to veterans underreporting their fear, emotional and physical pain, as well as reluctance to ask for help. This can be especially frustrating for family members who are trying to provide care. The healthcare provider can help reeducate veterans by offering alternatives for them to consider. The provider could say, “I know a lot of veterans put on a brave front and don’t want to take pain medication, but pain can consume your energy. You need your energy for other things now.” Encourage veterans not to confuse stoicism with courage by saying, “It takes courage to reach out to connect with others or to ask for help.”

Moral Injury: A Sub-Category of Soul Injury

Facing the end of life offers a natural life-review process that might precipitate the revelation of psychological trauma sustained throughout a lifetime of experiences. A *soul injury* is a penetrating wound that separates a person from their authentic self, corrupting their identity, and affecting their sense of personhood.⁹ Soul injury is a spectrum of wounds that range from traumatic to insidious. “Traumatic soul injury” might accompany PTSD in veterans if the trauma changed how they perceive themselves. For example, a combat veteran’s action or non-action harms a comrade, he subsequently feels ashamed, and he no longer feels like a person of worth. Less apparent is “insidious soul injury” which occurs more gradually and becomes chronic before it becomes obvious. For example, a veteran has an unfair military administrative action taken against him or is labeled as “weak” when unable to maintain a stoic façade. Over time, this might cause the veteran to feel defective or inadequate – hallmarks of soul injury. Unmourned loss, unforgiven guilt or shame, and diminished self-compassion often keep the soul injury alive throughout a lifetime.

The concept of soul injury applies to veterans and non-veterans, traumatized and non-traumatized, alike. Soul injury can be experienced by victims of sexual assault, crime, accidents, natural disasters, bullying, abuse, and neglect; people who have experienced heartache, loss of personal health or a loved one’s health, death of a loved one, or betrayal by a significant other; minorities and marginalized members of a society, culture, or group; and veterans, first responders, and civilians living in war-ravaged countries.¹⁰

Moral injury is a specialized subcategory of soul injury that is primarily associated with combat veterans. It is especially relevant for veterans as they prepare for the end of life. The term originated

with Veterans Affairs (VA) psychiatrist, Jonathan Shay. Shay sought a name that could describe the moral damage experienced by veterans during dangerous military assignments. He believed that much of the distress that veterans suffer represents an inner conflict between their moral beliefs and their actions during military service, such as killing children. He called this ethical conflict moral injury.¹¹ The term has subsequently been adopted by both the VA and the Department of Defense: “Events are considered morally injurious if they transgress deeply held moral beliefs and expectations.”¹²

At the core of a moral injury is often the inability to forgive one’s self for letting others die or for killing others. This caption captures the dilemma:

*Hoping and wishing
you can settle
this whole thing in your mind
about this war
resolving it within yourself
before the time of atonement comes,
weeping and crying at the end of your life.*¹³

Experiencing or witnessing violence can be disturbing for anyone; but the difference with veterans is that they also *committed* violence. That is a deeper level of traumatization, as this case example depicts:

Jim, a World War II vet, was weak with a cancer that would take his life in a few days. After I introduced myself and we spoke quietly for several minutes about hospice care, I asked him if there was anything from the war that might still be troubling him. He said there was, but he was too ashamed to say it out loud. Motioning me to come down close to him, he whispered, “Do you have any idea how many men I’ve killed?”

I shook my head, remaining silent, steadily meeting his gaze with my own. He continued.

“Do you have any idea how many throats I’ve slit?”

Again I shook my head. The image was grim, and I felt my eyes begin to tear. Jim was tearful too. We sat silently together, sharing his suffering. No words needed to be said. This was a sacred moment that words would only corrupt.

After several minutes, I asked, “Would it be meaningful if I said a prayer asking for forgiveness?”

He nodded. I did the Anchoring Heart Technique, placing my hand on his chest, anchoring his flighty, anxious energy with the security of my relaxed palm.¹⁴ My prayer, like any praying I do with patients, reflected no particular religion. “Dear God: This man comes before you acknowledging the pain he has caused others. He has killed; he has maimed. He hurts with the pain of knowing he did this. He hurts with the pain of humanity. He comes before you now asking for forgiveness. He needs your mercy to restore his integrity. He comes before you saying ‘forgive me for the wrongs I have committed.’ Dear God, help him feel your saving grace. Restore this man to wholeness so he can come home to you soon. Amen.”

Jim kept his eyes closed for a moment, tears streaming down from beyond unopened lids. Then he opened his eyes and smiled gratefully; his new sense of peace was almost palpable. It was a reminder to me of just how heavy guilt weighs.¹⁵

Soul Injury Interventions

Whereas PTSD affects a person's brain (especially the amygdala, the part of the brain that reacts to real or perceived threats), a soul injury affects a person's sense of being. Soul injury interventions, including the subcategory of moral injury, focus on learning how to mourn losses, forgive self and others, and cultivate love and compassion. These interventions are not routinely taught in healthcare or trauma curricula. However, providing these interventions at the end of life when soul injuries tend to surface can have a dramatic impact on a dying person's quality of life, as well as their family. It is essential that clinicians know how to create a safe emotional environment that allows soul injuries to surface. This includes not dismissing or minimizing guilt with well-intentioned platitudes such as: "You were following orders" or "You were being a good soldier; we have our freedom because of you." Instead, create a safe emotional environment so guilt and shame can be revealed *if the veteran so chooses*. However, this needs to be done cautiously. At no time, should the clinician overtly, covertly, or subtly convey that the veteran "needs to forgive," for example, saying, "You need to forgive _____ so you can have peace." This can actually add another layer of damage by causing additional guilt about inability to forgive themselves or others. Rather, the clinician should simply offer the consideration of forgiveness and invite the veteran to stay open to its possibility. "Now is a time to look back over your life. Is there anything that might still be troubling you? Anything about the war that might still haunt you?" Then, sit quietly. These are not the kind of answers that can be hurried.

A tool has been preliminarily developed to screen for soul injuries.¹⁶ Some agencies have developed a team of chaplains and social workers who can then follow up with assessment and intervention.

Fallen Comrade Ceremony

Ceremonies are an effective way to respond to soul injuries, even long after they occur. Native Americans have long recognized the soul injury of war and designed rituals that help warriors "decontaminate" their hostile energy before reintegrating into the tribal community.¹⁷ The ceremony acknowledges the hardships, provides information about how to face the challenges, and integrates the experience symbolically. Well-designed ceremonies are effective because they access the *unconscious*; they access the deepest levels of the soul.

Opus Peace, an organization dedicated to tending to soul injuries, has developed ceremonies that respond to the hardships incurred by veterans and their families. The Fallen Comrade ceremony originated when Opus Peace was providing consultation services for a long-term care facility to assist staff in caring for the unique needs of aging veterans. One veteran was asked, "Is there anything from the war that might still be troubling you now?" The veteran started crying, saying, "My brother and I both went to Vietnam, but I was the only one who came back." Then, he added, "I didn't even get to go to his funeral." A memorial service was subsequently provided for him, as well as all the veterans at the facility who held similar losses. Unmourned loss and unforgiven guilt were finally liberated and the result was visibly evident.¹⁸

The Fallen Comrade ceremony is carefully designed to provide a safe sanctuary where losses are acknowledged, honored, mourned, and redeemed. Such losses might include the loss of comrades

who died in battle, loss of physical and mental health, or the loss of their pre-war self. The ceremony is usually held in a long-term care facility since many of the residents are nearing the end of life, although veterans from the community are also invited to attend. Family members are encouraged to attend because they are secondarily impacted by their loved one's trauma plus they are the ones providing needed support on a regular basis. Civilians and staff are encouraged to attend so they can learn how to provide care that supports the unique needs of veterans. Opus Peace affiliates are now providing Fallen Comrade ceremonies throughout the nation so the wounds that veterans sustained in the public's name can be healed *together*.

Conclusion

Media images of soldiers dying on a battlefield are familiar to most Americans. Less familiar are the 1800 veterans who are dying every day, years after they leave service.¹⁹ Healthcare providers need to become sensitized to how military service influences veterans in ways that can sometimes complicate peaceful dying. Stoicism, PTSD, and *Soul Injury* are a few of the issues that health care professionals need to consider when intervening with veterans. Responding to the unique needs of this underserved population helps to ensure that the men and women who served our country will receive the honor they earned.

Posttraumatic Stress Disorder

- A. Exposure to actual or threatened death, serious injury, or sexual violence in at least one of the following ways:
 - 1. Direct experience
 - 2. In-person witnessing of others being traumatized
 - 3. Learning about a loved one's traumatic event
- B. At least one intrusive symptom that began after the trauma:
 - 1. Recurrent, intrusive memories of the trauma
 - 2. Distressing dreams related to the trauma
 - 3. Dissociative reactions (ex: flashbacks)
 - 4. Psychological distress to cues that trigger traumatic memories
 - 5. Physiological reactions caused by traumatic memories
- C. Avoidance of stimuli associated with the trauma as evidenced by at least one of the following:
 - 1. Avoiding memories, thoughts, or feelings associated with the trauma
 - 2. Avoiding external reminders of the trauma (people, places, activities, etc.)
- D. Adverse changes in cognitions and mood related to the trauma, as evidenced by at least two of the following:
 - 1. Inability to remember an important aspect of the trauma
 - 2. Exaggerated negative beliefs about self and others
 - 3. Distorted beliefs that cause blame of self or others
 - 4. Persistent negative emotional state
 - 5. Marked disinterest in significant activities
 - 6. Feelings of detachment or estrangement from others
 - 7. Inability to experience positive emotions
- E. Marked reactivity associated with the trauma, as evidenced by at least two of the following:
 - 1. Irritable and angry outbursts
 - 2. Reckless or self-destructive behavior
 - 3. Hypervigilance
 - 4. Exaggerated startle reflex
 - 5. Difficulty concentrating
 - 6. Sleep disturbances
- F. Duration of the symptoms last at least one month
- G. Symptoms cause significant functional impairment
- H. Symptoms cannot be attributed to the effects of a substance or medical condition

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