Ministry to Veterans: Unique experiences, unique challenges

NACC embraces new, official role in ministry to veterans – by David Lichter, Executive Director

Memories of discipline define the veteran experience – by John Paul Stangle

Prayer ritual helps cancer-stricken vet resolve moral injury – by Rev. Alejandro De Jesus

Military sexual trauma may scar veterans’ lives - by Rev. Alejandro De Jesus

Horses and dogs help re-integrate veterans into society – by Maggie Finley

Chaplains offer safe space to veterans with PTSD and addiction – by Anne Millington

Dying veteran confronts moral injury as ALS worsens – by Natalie O’Loughlin

Hospitals honor veterans’ service in life and death – by Connie Foster

Social workers help meet veterans’ inner and outer needs – by Jodie Ellis-Hart

VA medical center offers hope and healing across generations – by Susan D. Decker

Honoring the health care needs of our nation’s veterans – by Sr. Georgeann Roudebush
NACC embraces new, official role in ministry to veterans

By David Lichter
Executive Director

This issue is devoted to caring for our military veterans. Some quality articles provide a glimpse at the pastoral care provided to them and their families. We are grateful to the contributors. However, there is another Catholic association whose mission is to serve these veterans, the National Conference of Veterans Affairs Catholic Chaplains (NCVACC).

In 1984, over fifty Catholic VA chaplains sought to organize to provide mutual support for Catholic priests serving in the chaplain service of the Department of Veteran Affairs. The NCVACC remains the Catholic organization for communication with the Archdiocese for the Military Services, USA, and has a national episcopal advisor. They provide ongoing training, certification, and professional development for all phases of Veterans Affairs pastoral care. Their standards and procedures for certification for chaplaincy were first approved in 1988 by what was then United States Conference of Catholic Bishops’ Commission on Certification and Accreditation. They also worked closely with us, the NACC, to ensure their certification standards and procedures aligned with those of our strategic partners, as well as the added Catholic standards that the NACC included in 2007 for the approval by the USCCB/CCA and in 2014 for approval of the USCCB Subcommittee on Certification of Ecclesiastic Ministry and Service (SCEMS).

Given our close partnership and certification alignment, and with the encouragement of the SCEMS, the NCVACC and NACC leadership have been in dialogue over the past couple years with the intent of having the NACC assume the board certification of the NCVACC members. Since the NCVACC already had the same qualifications and competencies as the NACC, with added competencies for veteran affairs, this partnership was a relatively easy decision.

In April 2019, the NCVACC leaders announced that the NACC will assume the certification and renewal of certification of its members. An NCVACC member who seeks to become board certified or renew his board certification would become an NACC member and be certified or renew his certification as a member of NACC. The NACC would offer a BCC-VA specialty certification for those NCVACC members, adding the distinctive VA-specific competencies to our existing qualifications and competencies. This partnership is effective starting January 2020.

We are grateful to the NCVACC leaders, the leaders of our NACC Certification and Competencies Commissions, and our Board of Directors for their discernment and decision-making, as well as to the SCEMS for its encouragement and support. We welcome our NCVACC colleagues as they become members of the NACC and work with us to advocate for the profession of spiritual care and educate, certify, and support chaplains and all members who continue the healing ministry of Jesus in the name of the Church.
Memories of discipline define the veteran experience

By John Paul Stangle

I grew up in a military family and neighborhood. Both my parents were Army-Air Force and then Air Force officers. Most of our neighbors were military families. The neighbor kids were military kids. We were all normal in each other’s eyes. But is it normal for a mother to say, “When I say, ‘march’, you march!” or, “When I say ‘jump’, you jump”? For us kids, that was normal. So was the statement, “If you get a spanking at school, you’ll get two when you get home.” Kids were not asked; they were commanded. We were, in fact, a mini-reflection of boot camp.

For me, actual Navy boot camp wasn’t too different from normal home life. It was just an intensified few months of being controlled and hassled. It was my initiation into eventually becoming a Vietnam-era hospital corpsman who worked as an EMT and in nursing, emergency rooms, and medical laboratories. But keep in mind – home boot camp may not be the experience of all the kids on the block. To some, entering into the military can be a shock and even an unbearable experience.

All veterans have gone through boot camp of one sort or another. It serves as a sort of trial, a trying out, a test of receiving discipline. Discipline, it turns out, is what defines a veteran. Veterans learn to take orders and to follow them and give them. Things are done a certain way, and this certain way is not an option. Veterans may not all like the discipline, but they have all experienced it, lived it, and perhaps hated it.

Whoever needs to deal with veterans can be greatly aided by knowing about military discipline. Most veterans tend to follow orders, be polite, and respect authority. A smaller group rebel and despise orders, are brash and crude, and dismiss or reject authority. However, in either case, all veterans know what discipline means, as they have all experienced it in the military. A helper or provider who has not been in the military may be somewhat discounted and minimized; the converse is true if one has been in the military. This is just something to keep in mind. One could argue that the kind of discipline I’m talking about is not limited to just veterans – many have experienced it in home settings, athletic and school musical programs, job situations, etc. But vets remember being under 24-hour discipline, and for this they claim a certain uniqueness of experience.

Veterans have many resources available that are not accessible to others. However, many vets do not, cannot, or just won’t access that help. This includes housing, job opportunities, education, and medical care including nursing homes and counseling. The main port for access to help a vet is the Department of Veterans Affairs, whose website, www.va.gov, provides 24/7 crisis lines at www.veteranscrisisline.net. Also, all states have their own departments of veterans affairs that can be accessed for consultation and advice. Besides these, many veterans groups are available, such as the congressionally chartered American Legion and AMVETS organizations. Both groups help vets access help. And of course all other social service and help programs available to citizens – and non-citizens – are available to veterans.

John Stangle, BCC, is a chaplain advanced (mental health) emeritus in Angel Fire, NM.
Prayer ritual helps cancer-stricken vet resolve moral injury

By Rev. Alejandro De Jesus

While there are around 19.6 million veterans in the country today, only 9.15 million are currently enrolled in the VA healthcare system. A little over 10 percent of the total veteran population are women. The women veteran population is more racially diverse than the men’s, with higher educational levels but lower median incomes, and higher poverty incidence with lower rates of health insurance coverage. This brings us to our story.

Jane joined the Marine Corps in her early twenties in 2003, just as the nation was preparing for Operation Iraqi Freedom. She recalled that it was the best time of her life, as she could prove that women can achieve anything, given the chance. As a staff sergeant, she saw action in ground combat where she participated in various assaults on civilian villages suspected of hiding armed insurgents.

In one of those assaults, her squad leader ordered them “to shoot and eliminate all moving things.” In the midst of the shooting in darkness, she heard screams of women and children. After seeing bodies of men, the elderly, women and children strewn on the ground, she later said to herself, “I’m sure I killed some of them!” This happened more than once in her six months of deployment.

Back in a base in Texas, Jane began having nightmares, loss of appetite, agitation, excessive guilt and decreased energy. She could not escape the memories of those bodies, especially unarmed civilians and children. She was also diagnosed with partial loss of hearing due to bomb blasts.

Similar to the psychological trauma of post-traumatic stress disorder but deeper in terms of moral expectations and spiritual distress, moral injury has been identified as a mental health concern that requires special attention. Jonathan Shay, the pioneer researcher on the topic, noted that the experience of feeling betrayed, transgressed or violated in one’s moral and even religious world by a person in authority in a “high stakes situation” cuts a very deep spiritual wound (see https://www.law.upenn.edu/live/files/4602-moralinjuryshayexcerpt.pdf). The theologian Martin E. Marty portrays it as an “assault on the soul” (https://divinity.uchicago.edu/sightings/articles/moral-injury).

Among the many instances that eventually lead to moral injury, the following experiences were more prevalent: (a) harm, especially unintended harm, to women, children and the elderly; (b) disproportionate violence to combat enemies but especially to unarmed civilians; (c) violence within the ranks, such as military sexual violence; and (d) issues of betrayal by officers or leaders to subordinates. (https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp)
Rita Nakashima Brock, co-author of *Soul Repair: Recovering from Moral Injury after War*, expressly noted that “moral injury is not a disorder” but rather a “normal response to extremity” (https://www.texasobserver.org/combating-moral-injury/). That is the reason, she added, why treatment or therapy may not be a sufficient help. Instead, patients need a process to experience forgiveness and spiritual reconnection. So, what must chaplains do to help veterans in the end-of-life stage, while at the same time suffering from PTSD and moral injury?

In Jane’s case, she was eventually diagnosed officially with PTSD, and later with moral injury. Throughout this period, she never married, had three bad relationships, and never had children. She claimed no religious preferences but acknowledged growing up in her mother’s Baptist tradition. At age 33, she was diagnosed with advanced colon cancer, which had also metastasized to the liver and kidneys. When she first heard the sad news, Jane remarked to the team that she rightfully deserved to die as punishment for her sins.

Members of the palliative care and hospice teams made sure that the transition to hospice was smooth. Providers tried to medically respond to her recurring PTSD symptoms, especially her discomfort at night and sleep disturbance. The psychologist and the chaplain worked together to address her other emotional and spiritual anxieties.

The room had to be free from loud noises, while aromatherapy and music were made available, as she requested. Restraints were disallowed. Devastation and despair are twin consequences of moral injury, and chaplaincy intervention must take these into consideration. The female chaplain on a number of visits applied the listening technique not only to validate traumatic events but to allow for healing and forgiveness to surface. The chaplain guided Jane through a series of prayers for forgiveness, using the language of confession as a means.

In one of the prayer rituals, Jane invited the nurses and staff to join them. On a table covered in white cloth, Jane and the chaplain made paper flowers of blue and pink, representing the lives lost in the battle, especially the children. On top of each paper flower was a small votive candle. Quoting Scripture passages of forgiveness and pleas for mercy,\(^1\) the chaplain helped Jane through intermittent prayers for those who suffered and died at her hands. As she evoked each prayer intention, Jane dipped the bottom of the lighted candle at the bowl of water at the center of the table, then lit the votive candles, one at a time. The lighting of the votive candles was interrupted with Jane’s weeping. At the end of the ritual, everyone joined in an appropriate song.

\(^1\) Psalm 51.9: *Hide your face from my sins and blot out all my iniquities.* Isaiah 55.6-7: *Seek the LORD while he may be found; call upon him while he is near; let the wicked forsake his way, and the unrighteous man his thoughts; let him return to the LORD, that he may have compassion on him, and to our God, for he will abundantly pardon.* Matthew 11.28-30: *Come to me, all who labor and are heavy laden, and I will give you rest. Take my yoke upon you, and learn from me, for I am gentle and lowly in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light.*
In many similar rituals and prayer sessions, Jane was able to express remorse, regret and self-forgiveness. While not consistently religious, Jane had moral expectations and standards that formed part of her character. Dr. Harold Koenig, one of the top proponents of using religion in patient treatment, notes² that when these expectations and standards are transgressed, the person experiences deep feelings of shame and guilt, which later connect with feelings of unforgiveness or being punished by a Supreme Being. Chaplaincy, therefore, must integrate this into its spiritual care, especially at end of life, to accompany the veteran through the journey towards forgiveness and peace.

Alejandro De Jesus, PhD, BCC, is certified in the NACC, NCVACC, and NAVAC and has specialty certification in hospice and palliative care and in mental health. This article is adapted from a talk at the Fourth Annual Integrative Medicine and Mental Health Conference at UCLA on March 9, 2019.

Military sexual trauma may scar veterans’ lives

By Rev. Alejandro De Jesus

Pedro was a Hispanic Navy mechanic in his early twenties, working as an assistant in the ship’s air-conditioning and refrigeration equipment area during the Vietnam War in the early 1970s. On his first voyage, after almost two months at sea, he was sexually assaulted by six shipmates. He was tied to a table face down and naked, while his rapists took turns penetrating him. His screams of pain were muted by the noise of huge machines and air-conditioning equipment.

Pedro lay sick and in pain for days. His supervisor, after hearing from him what transpired, even threatened Pedro with reprisal if he squealed. Pedro began to isolate himself from the rest of the crew, often in deep thought or shock, often jumpy and on edge especially when he worked alone. He entertained a lot of suspicion and felt deep anger and resentment. These were all telltale signs of military sexual trauma, abbreviated as MST (www.mentalhealth.va.gov/mentalhealth/msthome/index.asp).

Combat exposure is a general term that refers to events with potentially traumatic effects on military personnel on active duty. This may include witnessing death and injury, being involved in vehicular accidents, or handling human remains. By 2004, after over a decade of continuous investigations and dialogue, MST was added as a “duty-related hazard” in a similar category as combat exposure (see ajph.aphapublications.org/doi/10.2105/AJPH.2006.092999).

One out of four servicewomen, and one out of a hundred men, report they have experienced MST. While the percentage is lower for men, they are numerically more, simply because of the much higher male population in the military. Also, other data reveal that only 6% of women and 1% of men report it. Both sexual contact and sexual harassment fall under the concept of MST, which includes inappropriate sexual jokes and lewd comments, unwanted physical contact that makes one uncomfortable, repeated sexual advances as well as quid pro quo exchange for sex (https://www.mentalhealth.va.gov/docs/mst/MST_General_Brochure_2016_English_508.pdf).

Soon after his rape, Pedro was discharged dishonorably due to incidents including a fist fight in the ship, insubordination, and not following safety instructions. For the next thirty years, Pedro intermittently got into trouble with the law, abused alcohol, drugs and marijuana, and once attempted suicide. In between these events, he was married and divorced twice, while also having two children with his first wife.

Sometime around 2010, with the help of a nonprofit lawyers’ group, he was able to secure a court decision to overturn his dishonorable discharge and receive benefits for MST and other mental health problems. He went through a 28-day rehab treatment program, then another 90-day long-term rehab that included support to gain and maintain work.

Then, in his 60s, Pedro was diagnosed with liver cancer, metastasizing into his other organs. As a palliative patient, all the symptoms of MST resurfaced with a vengeance, especially his depression, extreme range of emotions and combative ness, as well as the inability to trust and the tendency to isolate himself from family and friends as well as from the staff. Pedro had initial difficulty relating and believing in his medical team. The chaplain likewise faced the
difficulty of regaining Pedro’s trust in God, whom he blamed for his fate. Is this what he deserved after cherishing his faith when he was a kid?

The chaplain spent many visits listening to Pedro, slowly allowing him to share what he could while assuring him of compassionate support. The chaplain likewise applied the HOPE method (see www.aafp.org/afp/2001/0101/p81.html). First, the chaplain asked Pedro to identify his sources of **Hope**, meaning, comfort, strength, peace and love. From where did he draw his internal support, and what sustained him during those desperate moments? Pedro realized that at his lowest point, he would turn to his guitar and start to sing, and that would provide him some respite and even calm from his struggles.

Next, the chaplain asked what **Organized** religion Pedro recognized, or what aspects of his religion or spiritual community did he find helpful? Pedro loved his second wife’s stubborn reliance on God and church attendance. That, he shared with the chaplain, introduced him back to participating in her local church, and the memories of those years with the church choir gave him the resolve to find God again in his life, as he was then grappling with dying.

Questions about his **Personal** practices of spirituality similarly indicated to Pedro that he had spiritual insight, that his simple practices of bedtime prayers and occasional church visits and attendance emanated from his deep personal spirituality. This touched on a sensitive part of many veterans’ lives: support systems, family, and friends. Is there a need to reconnect or reunite with any loved one? Is closure a desired goal, and how does the veteran feel about doing it? Would he like the chaplain and other providers to make that possible for him?

Accepting the limitations and burdens of his condition, Pedro realized the **Effects** of faith on his struggle to find meaning with death and dying. He had come to terms with the tragedies and disappointments that littered his life by laying no blame on God or anyone, least of all himself. Part of his spiritual care plan was to be able to rewrite his life’s story, which is to say to stop viewing his life from the angle of darkness, bitterness and despair, and to see it from the perspective of light, forgiveness and joyful expectation.

**Alejandro De Jesus, PhD, BCC, is certified in the NACC, NCVACC, and NAVAC and has specialty certification in hospice and palliative care and in mental health. This article is adapted from a talk at the Fourth Annual Integrative Medicine and Mental Health Conference at UCLA on March 9, 2019.**
Horses and dogs help re-integrate veterans into society

By Maggie Finley

Among the alternative modalities available to active duty, retired and even incarcerated military personnel are programs utilizing companion dogs or therapeutic horses to treat post-traumatic stress disorder and traumatic brain injury. As the name implies, companion dogs live with vets and are trained beyond the scope of touch to relieve anxiety, often lending actual physical support. They perform a number of specific tasks: retrieving medication, turning on lights, aiding hearing-impaired people or waking a warrior from flashbacks or night terrors. Horses, too, are proving helpful to warriors who self-report having grown weary, distrustful of or otherwise disinterested in more traditional forms of therapy.

Personnel with a history of multiple tours often run out of options and hit bottom, having lost faith in themselves and in leadership. Some who are “sick and tired of being sick and tired” fortunately find themselves exposed to the idea of horsemanship. Stats from the Department of Veterans Affairs record that nearly 70% of these persons opt out of getting any help at all, tending to isolate themselves in their homes, since they are “mentally fragile and tend to back away from what is new and scary,” according to Debbi Fisher at Hope for Heroes. However, many who begin working with therapeutic animals find their way back from the brink of despair — giving them not only “something to get up for” but also reducing their dependence on prescribed medications.

Anecdotally, veterans respond favorably to this non-probative form of therapy. Wary of questions about their sometimes gruesome experiences of service and combat, veterans are likely to value and better respond to “non-verbal, non-labeling and non-judgmental” presence — similar to what chaplains provide in their work.

In Washington state, two animal-assistance programs showing significant success in their work with warriors are Brigadoon Dogs’ veteran program in Bellingham and Hope for Heroes Equine Therapy Consulting in Yelm. Service dogs and horses are specially trained over time to help warriors normalize situations: to relieve hypervigilance, regain independence and self-confidence, communicate in a positive and effective way as well as identify and give them coping strategies for managing flashbacks and emotions — ultimately, offering them future hope. Each program expresses as much in aspirational mottos: “Changing lives one partnership at a time” and “I will restore health to you, and your wounds I will heal” (Jeremiah 30:17), respectively. Both programs originated in direct response to the needs of Washington’s Joint Base Lewis-McChord. Both are non-profit organizations, relying on fundraising for viability, offering their services to warriors at no cost, convinced “they have more than paid the price with their service,” as Debbi says.

Denise Costanten, the founding executive director of Brigadoon Dogs (www.brigadoondogs.org) says her late husband, Leon, a retired Army special ops lieutenant colonel, encouraged her to make Brigadoon a reality. Although Brigadoon’s service dogs are accessed by other client populations, her work with veterans began in 2011 when she accepted the Lewis-McChord base commander’s invitation to evaluate dogs. He had concerns about vets adopting rescues that were neither suited to nor properly trained for manageable companionship. Denise helped veteran clients and existing dogs to meet Assistance Dog International standards, and the prison program for incarcerated veterans began in 2012. Vets under supervision have total responsibility for the care and training of dogs to be
placed with other veterans. For inmates, it is a source of pride to give back to their own. Denise manages and consults four programs concurrently inside minimum security prisons, and in spring 2020, she will begin the first program of this kind for incarcerated women. Denise continues to be inspired by her work, since it’s really about relationship building. It’s not unusual for warriors “to stay in touch for years – at the very least, during the life of the dog.”

At Hope for Heroes (www.hope4heroesconsulting.org), Debbi Fisher’s passion for training active-duty service members and veterans to work with horses also comes from her awareness of mental health crisis within her own military community. She became a Gold Star widow in 2006. Today she has a son in the Marine Corps and a daughter serving as an Air Force pilot. In finding what she believes she was meant to do, she watched as “God opened some doors and closed others.” Finally, she discovered not only a new outlet as a certified therapeutic horsemanship instructor, but also met her husband, Bob Woelk. Bob is business manager and PR specialist, promoting the program through community outreach. Besides being the lead trainer, Debbi consults onsite, via telephone and Skype with other horsemanship programs from around the globe. She continues to identify study subjects and gather data for her research projects with Baylor University.

Hope’s barn sits within view of Mount Rainier, providing a quiet and peaceful environment, where 11 school horses are housed, accommodating 40-50 referrals from the Army’s Warrior Transition Battalion and the Air Force’s Medical Flight Unit. Participants commit to 90-minute leadership sessions twice weekly for eight weeks. While the reduction in the PTSD score shows “clinical meaningful change” after that time, Debbi and Bob have observed remarkable changes in the affect, energy and bearing of participants formerly on suicide watch after as little as four to six weeks.

“Core to the program are grooming and groundwork,” Debbi says. “That’s all that’s really needed to help warriors, while to eventually get on the horse is icing!” Debbi and Bob acknowledge that it’s within the very nature of horses to “heal invisible wounds.” Horses are uniquely suited to this work because of their innate ability to mirror, which is hard-wired into their instinct for survival. Mirroring gives the handler instant biofeedback. Handlers can see and adjust their anxiety because when the horse is calm, the handler calms and vice versa. “Horse and handler are set up for success, while ending on a high note through positive reinforcement helps establish the handler as the horse’s leader. The subtle, non-verbal communication between horse and handler elicits confidence and self-esteem.

Debbi finds genuine joy in witnessing the ripple effect and its implications for transformation – improving and restoring the handler’s life. And those ripples may spread further, as pending legislation in Congress may make equine therapy eligible for grants aimed at preventing suicide among veterans.

_Maggie Finley, BCC, is a retired chaplain from Providence Hospice of Seattle._
Chaplains offer safe space to veterans with PTSD and addiction

By Anne Millington

For veterans suffering from post-traumatic stress disorder, life is punctuated regularly by intrusive memories of past combat. The past bleeds painfully into the present in flashbacks, anxiety, nightmares, depression, and more. In order to soothe their symptoms, veterans often reach for alcohol, drugs or other addictive substances, and the combination of PTSD and substance use may well worsen both conditions.

As chaplains we may often encounter veterans suffering from PTSD, and I recall one veteran’s comment, “Every time I hear fireworks or other loud noises I’m right back in Vietnam, hearing that rapid fire again.” For this veteran and others, everyday existence can feel straddled in the often painful space between life and death. In her book *Spirit and Trauma: A Theology of Remaining*, trauma expert and theologian Shelly Rambo notes that veterans suffering in the time warp of PTSD inhabit a place much like Holy Saturday, the day between Good Friday and Easter, the middle day between death and life where “death haunts life and life bears death within it.” As chaplains, through both our pastoral skills and our faith, we can accompany veterans living in this frightening Holy Saturday space, witnessing to God’s resurrecting love amidst the echoes of death and creating space for God’s healing.

Many traumatized veterans feel a steadfast bond between past and present, since, according to Rambo, “in the aftermath of death, the nature of life is bound to that death as witness.” In the words of a Vietnam veteran, “Again and again I see the faces of fresh young Marines arriving at my platoon. In the morning groups of them would arrive and head out, never to return that evening … all of these bright young men killed each day in combat.” Although this particular veteran built a successful career and had a family after his return to civilian life, he remains haunted by frightening flashbacks of those young Marines’ faces. Moreover, as Laurie Calhoun wrote in *The Independent Review*, PTSD symptoms may be worse for veterans of controversial missions such as the Vietnam War and the Iraq War than for World War II or other wars the public strongly supported (www.jstor.org/stable/24563155?seq=1). As a Vietnam veteran struggling with PTSD once told me, “I heard Lyndon Johnson say on the radio, ‘I don’t want any more men killed in Vietnam.’ So my men and I took him at his word and hid in the jungle. So many had already died, and for what?”

It is well documented that veterans often turn to alcohol and other addictive substances to numb the troubling and painful symptoms of PTSD. According to the U.S. Department of Veterans’ Affairs, substance abuse occurs in roughly a third of veterans with PTSD, and 60 to 80 of Vietnam veterans seeking PTSD treatment have alcohol use problems as well (www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp). Even more troubling, veterans often binge drink in order to mask strong PTSD symptoms. As one veteran told me, “After coming home from the war I dealt with the trauma by binge drinking, and when I start binge drinking I completely black out. I have no memory of arriving at this hospital, in this hospital bed. I don’t remember anything since being at the bar last night.” Sometimes a
veteran’s substance problem begins while still overseas, as available alcohol, drugs or prescription medications provide psychological relief from the harsh realities of deployment. While a veteran may seek drugs and alcohol to avoid bad memories, that step can make PTSD symptoms last longer. Because PTSD and alcohol- and substance-use problems tend to exacerbate one another, effective recovery requires treating PTSD and drug and alcohol problems concurrently.

As chaplains, we offer unique witness to God’s love by our ability to join veterans in their Holy Saturday journey between life and death, offering them a supportive and safe place to share their experiences. These safe places can be very rare, as veterans often refrain from speaking about their traumatic experiences to a civilian world that may not relate. As one veteran of both the Korean and the Vietnam wars reflected, “I never speak of my experiences. They all live inside me and stay inside me.”

Because we are trained as chaplains to accept people where they are and as they are, we can provide an open-minded, open-hearted space for veterans to share all that they suffer in silence. Moreover, because we have training in keeping people emotionally and spiritually safe, the space we provide veterans is not only open but also sturdy, a space where veterans at risk of re-traumatization are “spotted” and supported as necessary. This open and safe space becomes a true life-giving space, a space where Rambo imagines God’s love as revealed on Easter moving back through nonlinear time to breathe new life into the death present on Holy Saturday. For Rambo, these spaces offer an experience of resurrection, where resurrection is “not so much about life overcoming death, as it is about life resurrecting amid the ongoingness of death.”

As we bear witness to God’s resurrecting presence alongside veterans suffering from PTSD and addiction, we can observe carefully how that presence highlights additional paths towards healing. Additional paths are likely to include both continued pastoral visits and efforts to connect veterans more strongly to community resources such as VA services and treatment programs, and recovery groups such as Alcoholics Anonymous and Narcotics Anonymous. Local VA medical centers, for example, provide modern PTSD treatments including cognitive processing therapy, prolonged exposure therapy, eye movement desensitization and reprocessing, and medication. VA medical centers also offer resources to treat alcohol- and substance-use disorders both separately and concurrently with PTSD treatment. Here in Boston, the Archdiocesan Addiction Recovery Pastoral Support Services supports those suffering from addictions, and other dioceses may offer similar resources.

In order to support veterans suffering from PTSD and addiction, we chaplains are called to accompany these veterans in their weary world that Shelly Rambo designates Holy Saturday, that middle place between Good Friday and Easter where death has occurred and new life is not certain. In this world, present consciousness is perennially interrupted by past traumatic experiences.

---

1 Calhoun, 250.
2 Calhoun, 247.
memory, by flashbacks, nightmares and panic attacks. In this world, false relief sought in alcohol and other addictive substances serves only to make traumatic symptoms worse. As chaplains we can bring true relief, however, as we join veterans in this Holy Saturday space. Through our witness, veterans can feel less isolated and more held as God’s Love gently loosens shackles of traumatic memory and points to additional paths of healing support. Veterans thus may experience a resurrection story within the middle space of Holy Saturday, which Rambo notes “is not a story of rising out of the depths, but a transformation of the depths themselves.”

Anne Millington, BCC, is a chaplain at Beth Israel Deaconess Hospital-Milton in Milton, MA.
Dying veteran confronts moral injury as ALS worsens

By Natalie O’Loughlin

The biblical story of the lost sheep⁴ always reminds me of veterans. First, veterans would never leave one of their own behind. Secondly, God is searching out the lost for a relationship in this parable. Sadly though, many veterans worry about how God sees them. In hospice care, they often say, “I wonder if God will forgive me,” or “I’m afraid God cannot forgive me for what I have done.”

Many veterans have trust issues because of physical, emotional and spiritual harm done to them, a frequent consequence of moral injury. The Department of Veterans Affairs defines this condition as “the damage done to one’s conscience or moral compass when the person perpetrates, witnesses, or fails to prevent acts that transgress one’s own moral beliefs, values, or ethical codes of conduct.”

Moral injury causes one to question their very identity and the meaning of their life. Sufferers feel they are not worthy of being loved. The feeling of not believing that you can be loved by anyone, including God, must be a very empty, lonely and fearful place. Love is the foundation we need to say, “This is who I am.” As Matthew 7:24 says, we need to hear God so we can have a foundation built on rock. If one does not feel able to be loved by God, where is their foundation? The combination of war and disease has a way of crumbling foundations.

I have seen veterans on the hospice unit afraid to die because of the moral injuries they have suffered — now that their lifespan has a definite time frame, they have a true fear of God, and the shame that has been part of their lives comes to the very forefront. One veteran in particular struggled with the idea of who God was, and how God handed out punishment. This Vietnam veteran, diagnosed with ALS (Lou Gehrig’s disease), had kept himself in excellent physical shape and worked in the government and law enforcement after his honorable discharged from the Marines. He was highly respected and well educated. When he came into the VA for hospice, he was angry at everyone, including God. I worked with him for three months as his disease progressed rapidly.

When I first walked into his room, I wasn’t sure what would happen. The man told me he had no religion but believed in “some God,” and he voiced his anger. “How could God do this to me? I have been a good man. I did the right things for my family. What kind of God would do this to a good person? I fought the war I was asked to fight.” He had space to be angry and space to lament, and I sat with him in his anger. After all, chaplains do not have the answers and I was not there to fix anything.

In that small hospice room, we delved into what God looked like for this veteran. Eventually, I posed a thought to him: “What if God did not do this to you but is walking with you in this disease?” He stopped and looked at me and said, “I never thought of God walking with me.” I let him sit with that. Over time, we talked about a God of love. We were able to explore what love looks like, and the trust we built also allowed him to reveal broken relationships with his children. War tends to disrupt family relationships. Moral injury causes a veteran to have
trouble with relationships when trying to integrate back into society, especially those closest to him or her. A veteran does not want to traumatize family by speaking the horrors of war to them.

My patient and I took baby steps. We talked about how Vietnam veterans came home from the war and were treated with disrespect and seldom thanked. We talked about how war changes people and you are “never the same.” We talked about ALS and what it was doing to him physically, emotionally and spiritually. We spoke of the meaning of his life, past, present and future. We talked about his life, traumas, troubles, family, friends and how God has been with him through all of this. He was able to see himself as a lost sheep. The sheep God went after.

Over the course of these conversations, the veteran’s disease grew worse. His voice became weak, and it was difficult for him to breathe. He was not able to reach for a drink of water, and I had to be aware of when he needed one. Some days he had good days, and other days were bad and I could not visit.

It was very difficult to sit and watch this horrible disease take the life of a proud Marine. It was difficult to sit and hear parts of horrific stories and the questions of the aftermath. But I was amazed at the beauty of God’s work in his life. I was amazed at the healing power of God in the midst of ALS, in the midst of questioning the meaning of one’s life journey. The lost are looking to be safe, looking for someone to trust and wanting to be truly loved. God loves his sheep. God also helps to rebuild foundations.

Veterans are strong, resilient men and women who have endured much. Let’s thank all our brothers and sisters who have paid a great price, so we are able to live with all our freedoms.

Natalie O’Loughlin is a chaplain at UPMC Magee-Women’s Hospital in Pittsburgh.

¹ https://www.biblegateway.com/passage/?search=luke+15%3A1-7&version=NABRE
Hospitals honor veterans’ service in life and death

By Connie Foster

Having grown up in the Vietnam era, I always had mixed emotions about that conflict. Then later, one of my older sisters married a Vietnam veteran who suffered flashbacks from the war and committed suicide, leaving behind three young boys. In nursing school, I spent time at a VA center during my psychiatric rotation. I saw the struggles those men went through but didn’t know what to do to thank them for their service. Through the years, however, I met many men who served in the armed forces.

In November 2011, my hospital started an initiative to honor those patients. The We Honor Veterans program (www.wehonorveterans.org) through the NHPCO (www.nhpco.org) provided the inspiration for our ongoing recognition program and our hospital-wide and community education programs. Some statistics regarding our veterans:

- One in every four deaths is a veteran, as of 2012.
- Approximately half of veterans receive healthcare in the community, not through the VA system.
- We are currently caring for three war eras of veterans who are approaching end of life: WWII, Korea and Vietnam. This does not account for our current service men and women and the veterans of more recent conflicts. Each has a different experience and a different story that impacts quality of life and end of life.
- An estimated 390 Vietnam veterans die each day.
- 250,000 of 697,000 1991 Gulf War veterans have chronic, multisystem illness, as of 2019.

Our hospital recognition program officially started on Veterans Day 2011. Two of our veteran patients that were in our hospital that day were thanked for their service to our country. One of our employees, who himself is a veteran, presented the patients with a flag pin and thanked them on behalf of our country and our hospital. We now routinely thank our veteran patients with a flag-pinning ceremony, and patients and their families have expressed gratitude for this program. Every effort is made to have one of our veteran employees present the flag pin to the patient. Our flag pins are donated by our local American Legion posts.

Initially we had difficulty identifying our patients who served in the armed forces, but we now have a question about veteran status as part of our registration process. The recognition program soon spread to our sister hospitals. In the Great Lakes Region of Bon Secours Mercy Health (BSMH), specifically in the Toledo rural area, our chaplains now daily receive a report of patients in the hospital who are also veterans. Our social workers routinely ask patients about their VA status. Once identified, the chaplain contacts a hospital employee who also served in the armed forces. That employee and other available staff present the flag pin to the patient or family recognizing their service.
If a veteran dies in our hospital, we perform a flag ceremony in their honor. (We also perform the ceremony for patients who served in police or fire departments or were elected officials.) Typically, a chaplain is attending to the family during this time. The chaplain contacts two employees who are also veterans to assist with the flag ceremony. After the patient is placed on the funeral cart and the body is secured, they drape an American flag over the cart. Then all available hospital employees line the hallway to honor the patient and flag. The hospital employee veterans accompany the body to the hearse with the funeral home representative and the family, passing the employees who are lining the hallways. The flag is then refolded after the patient leaves the hospital and stored in the chaplain’s office.

Recently, we have been able to provide red, white, and blue blankets to our veteran patients who are in hospice or going home with hospice. The blankets are made and donated by various volunteers. The family may place the blanket on the patient.

Our veteran employees are also recognized for their service to our country. Yearly since 2012, BSMH Willard Hospital has presented a different flag pin with a certificate/card to our employees to thank them for their service. This past year our BSMH Toledo-area facilities honored all employees who are also veterans with a flag pin.

By recognizing the unique needs of our veterans, we can learn how to accompany and guide them and their families through their life stories. Each veteran has his or her own unique story. Some were never thanked for their service, but it’s never too late.

Connie Foster, RN, CHPN, is palliative care coordinator at Bon Secours Mercy Health Tiffin and Willard in Ohio.
Social workers help meet veterans’ inner and outer needs

By Jodie Ellis-Hart

“No one is put on this earth to take another human life.” (male Vietnam veteran)

“I feel like I’m in a constant fight between war mentality and being a human. I couldn’t be a human for two years, and it’s hard to get that humanness back. It feels weak wanting to.” (male Iraq veteran)

“When you’re in a war zone you turn into an animal. I had to turn off my emotions. You become an asshole, but you still follow the chain of command. I’m realizing that I need to start thinking differently.” (female Iraq veteran who returned from her deployment in 2007.)

“I came to the realization that I may have to kill a child when I knew that, someday, I wanted to be a mother, to have a child.” (female Afghanistan veteran)

These are some of the thoughts shared with me within the past few months alone in the course of my work as a licensed clinical social worker, providing outpatient mental health services to veterans.

Veterans who struggle with such moral injuries and inner conflict need someone to listen to them. They need someone who they know without uncertainty that they can trust. Like healthcare chaplains, I provide a safe place for them to share their innermost struggles: memories of their experiences, actions they may or may not have taken, atrocities witnessed, conflicting thoughts and feelings about their experiences, and stories they may not feel safe sharing with their own spouse of decades.

My role is that of a mental health provider, but I always hope that social workers in other roles are equally mindful, patient, aware and compassionate listeners. A VA clinic has numerous resources to help with our patients’ varying psychosocial issues, including primary care social workers assigned to each of our primary clinics. All veterans enrolled in primary care are typically scheduled to meet with a primary care social worker, who does a full psychosocial assessment and will provide the veteran with information and refer them to the appropriate services if needed.

We have a team of primary care/mental health integration providers who are assigned to each clinic and are available for “warm handoffs” and scheduled appointments if a patient needs brief mental health services. These providers are usually available to meet with the veteran within 30 minutes for a mental health assessment – which makes follow-up much more likely than telling someone they have to wait several weeks.

We increasingly offer more alternative healing and whole health options to our veterans, such as yoga, Brazilian jiu-jitsu, aromatherapy and Zentangle classes, numerous recovery groups and equine therapy (referred out). And we have recreation and art therapists who offer an array of
different classes and socializing opportunities to veterans, such as biking, art classes, and social skills building.

Our VA supportive housing team assists veterans in need of housing and/or at risk of homelessness. They act as case managers in helping veterans find and maintain appropriate housing. The Community Resource and Referral Center is a facility for homeless veterans to come in to shower, do their laundry, use computers, and get other assistance. The VA main hospital houses two clothing rooms, a men’s and women’s, for veterans in need of clothing, and we quite often have available gift cards for gas, Goodwill, Walmart, grocery stores and restaurants.

Upward Bound is a program that assists veterans with schooling needs, and we have many programs that assist veterans with job-related issues, including creating a resume, finding and maintaining employment, and a Compensated Work Therapy program which provides a supported employment counselor for veterans with a chronic mental health diagnosis.

But even with all the resources available, it’s a matter of veterans coming in, getting a thorough assessment, and being willing to use the services available to them. I have seen a number of veterans go from homelessness and unemployment to being able to independently provide for themselves via VA eligible resources.

So many veterans have lost so much: their youth, innocence, belief in humanity, belief in their government, faith, belief in God and/or religion. We need to help them identify and mourn what they’ve lost and help them transform their grief, if they’re willing to go there, and if we are very good, compassionate companions. If we are unequivocally good stewards.

Jodie Ellis-Hart, LCSW, is a general outpatient mental health provider and behavioral health interdisciplinary coordinator at Milwaukee VA Medical Center.
VA medical center offers hope and healing across generations

By Susan D. Decker

Walking one morning into the Seattle VA Medical Center, I encountered a procession of staff and family members who were accompanying the body of a deceased veteran, an American flag draped over the gurney. I stopped, along with everyone else in the hallway, the strains of a harmonica breaking the silence. Some placed their hands over their hearts; others saluted.

This is one of many encounters that are unique to the VA. Whether strolling through the “marketplace” where vendors sell military memorabilia or walking through the entrance, where veteran volunteers respectfully greet patients and visitors, one is acutely aware of a culture of dignity and respect.

I completed two units of CPE and a yearlong residency at VA Puget Sound. As chaplain interns, we were integrated into the fabric of the chaplain office. We gathered for prayer every morning. As a Catholic, I offered Holy Communion to our Catholic patients. The chaplain corps, along with other medical staff, are a community of providers, who honor the sacrifices that our veterans have made in the name of country.

Many years earlier, my father had spent several months at that same medical center. Like many of the veterans I met, he had suffered his entire adult life from psychological, emotional, and spiritual wounds he had experienced as a Marine in World War II. Like today’s most vulnerable returning veterans, he was never able to fully integrate back into society or realize his dreams for his post-war life. The psychological and spiritual wounds he carried affected him and our family deeply. However, in no way did they diminish my memory of him and his intrinsic goodness as a child of God.

Sebastian Junger, in his book *Tribe: On Homecoming and Belonging*, writes about the difficulty that veterans often experience upon reentry into civilian life. During wartime, veterans rely on each other for safety and protection. They have a strong sense of belonging and purpose, which may disappear upon returning home. Junger posits that a veteran may experience an existential crisis, where questions about one’s personal and social identities may interfere with one’s ability to regain a foothold in society.

The effects of war on returning soldiers have been well documented. Many veterans suffering from post-traumatic stress disorder and other mental illnesses often end up in the psychiatric unit for several days or weeks. I met many such patients there who were homeless. Many exhibited the physical signs of having had a difficult life, fraught with health problems and isolation from relationships and community. Some shared stories about the support and value of their family life, how relationships had helped them reenter civilian life after military service. I remember one oncology patient who credited his Jesuit background for having brought him back from despair after the Vietnam War. The majority, however, and especially war veterans, seemed to have suffered great loss of independence, relationships, and economic stability. These were the soldiers I met in the psych unit.
It was within this context that I found my most rewarding and challenging visits. My CPE supervisor held weekly hands-on art activities as a way of creating community among veterans. Patients were invited to paint masks or canvases, color, or just sit and join in conversation. Soft background music contributed to a creative and friendly environment.

Conversation inevitably centered on veterans’ shared personal experiences of being in the military and combat. The instant camaraderie was palpable. Creating art became the vehicle for self-expression. At the end of each session, patients voluntarily shared the feelings that had been evoked from creating their art. For some, it was their first opportunity for self-reflection and expression. I’ll never forget the day when one veteran disclosed, in a quiet manner while painting a mask, his plans to end his life. That revelation was the beginning of a long-term treatment plan that helped save his life.

While the majority of psychiatric patients were male, there were also women, suffering from PTSD and often from sexual harassment and abuse. I remember clearly how one female veteran, after expressing her anger on canvas, decided to pursue her unrealized dream of becoming an artist.

Jesus Christ’s public life was a ministry of hope. As chaplains, we are called in imitation to Christ to offer hope. We, as Catholics, profess that every human life is sacred and that all people are created in the image and likeness of God. Our veterans deserve our respect and care, for their dignity and worth cannot be diminished by any condition.

*Susan D. Decker, MAPS, BCC is a per diem chaplain at the Seattle Cancer Care Alliance.*
Honoring the health care needs of our nation’s veterans

By Sr. Georgeann Roudebush

It may surprise you to learn that 25% of those who die every year in the United States are veterans.

I have family members who have served as well as relatives currently serving, and I want them to have the best quality care possible. Through the healthcare we provide, we can honor our veterans by building a trusting relationship, actively listening to their concerns, respecting their stories, and providing veteran-focused care.

Healing their wounds begins and continues as veterans feel free to talk about their experiences. Some veterans may have special emotional needs, and their feelings can grow stronger as they near the end of life. Common themes include forgiveness, complicated grief, guilt and/or shame, the reemergence of post-traumatic stress disorder, and moral regret.

Members of the armed forces are trained to take orders and work together as a team. Military culture promotes stoicism, and veterans may avoid showing emotions, especially those that indicate weakness. While each veteran’s individual experience is unique, there are common challenges they may share.

Many combat veterans experience PTSD. While it is normal to react to trauma with fear and shock, people with PTSD experience symptoms weeks, months, sometimes years after the initial event. PTSD is common in prisoners of war, who may feel the effects of their experience on their emotional and physical health long after they come home. It is important to be aware that serious illness can trigger emotions and memories from past trauma. This is especially true for those at end of life.

Veterans who have seen action may have been wounded in combat or been subjected to extreme weather or disease. Some may have been exposed to chemical or biological weapons or radiation on duty. Whether in a combat zone or on a military base, veterans may have been exposed to occupational hazards such as working with toxins, loud noises or heavy machinery which can cause health-related issues.

While some members of the military may have never seen active combat, it is important for them to be recognized for their service. No matter the role they played, all servicemen and servicewomen deserve our respect.

To provide the best care possible, SSM Health at Home has implemented We Honor Veterans, a pioneering campaign developed by the National Hospice and Palliative Care Organization in collaboration with the Department of Veterans Affairs (www.wehonorveterans.org). The program helps healthcare providers better care for patients with military service by recognizing the challenges they may be facing.

As part of We Honor Veterans, partner organizations assess their ability to serve veterans and integrate best practices for providing quality care to veteran patients. Participating agencies educate staff and volunteers about each war and the unique experiences and complications felt
by those who served in them. This can be especially important for veterans who experienced
combat service or trauma which can resurface during a serious illness.

In addition to the education and training that We Honor Veterans provides, there are several
things we can do as spiritual care providers to engage with veteran patients.

Saying or writing “thank you” can mean a lot.

Take time to look at pictures, letters and other mementos they may have saved.

Military awards and medals are symbols of a veteran’s service and are usually displayed. Inquire
about them to start a conversation. Consider holding a pinning ceremony where family and
friends gather to celebrate their loved one’s service as a pin and certificate are presented.

Start a veteran-to-veteran volunteer program. Military veterans are part of a distinct culture
with their own common language and experience. Many hospice patients wish to be connected
to volunteers who share their experiences.

Does your veteran patient have a bucket list of items they would like to accomplish? Perhaps
you can work with caregivers and community resources to help make their wishes reality. One
way to help veterans fulfill a dream is to sign them up for an Honor Flight (www.honorflight.org).
The group has chapters across the country that help fly veterans to Washington, DC, to visit the
memorials that have been built in their honor.

A generation of World War II and Korean veterans are now facing end-of-life care decisions, and
Vietnam War veterans are not far behind. In years to come, those who have served in the Gulf
War, Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom will need care
as well.

We owe all our veterans our respect and thanks for defending our freedom. As spiritual care
providers, it is essential to be motivated by love and to have a passion for the care we provide.
Our passion for our work is vital as we bring the healing power of Jesus to those we serve.

**Sr. Georgeann Roudebush is spiritual and grief counselor for SSM Health At Home in Madison, WI.**