ABSTRACT

EXPLORING THE NEED FOR A VETERAN-SPECIFIC GRIEF PROGRAM FOR THE ROBLEY REX VETERAN AFFAIRS MEDICAL CENTER (VAMC)

by Lauren Nicole Mindemann

This work is a pilot needs assessment undertaken for the Robley Rex Veteran Affairs Medical Center (VAMC) to explore whether or not there was a need for a veteran-specific grief program. The major three components of the study included: 1) a comprehensive literature review of veterans and grief; 2) development and implementation of a survey assessing need; and 3) recommendations to the medical center. More than 90% of veterans experienced the death of a close friend or relative and about one-quarter of them expressed interest in a veteran-specific grief program.
EXPLORING THE NEED FOR A VETERAN-SPECIFIC GRIEF PROGRAM FOR THE ROBLEY REX VETERAN AFFAIRS MEDICAL CENTER (VAMC)

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# Table of Contents

Grief and Veterans Framework ................................................................. 1

Background ............................................................................................. 2
  Grief and Denial ..................................................................................... 2
  Military Indoctrination and Erikson ....................................................... 3
  Post Traumatic Stress Disorder (PTSD) ................................................. 4
  Combat .................................................................................................. 5

Methodology ............................................................................................. 5

Results ...................................................................................................... 9

Discussion .............................................................................................. 10

Tables ...................................................................................................... 14

Appendices ............................................................................................. 17
  Appendix A: “Voice of the Veteran” Survey ......................................... 17
  Appendix B: Consent Form ................................................................. 19

Works Cited ............................................................................................. 20
List of Tables

Table 1 .................................................................................................................. 14
Table 2 .................................................................................................................. 15
Table 3 .................................................................................................................. 16
Dedication

I dedicate this thesis to my family, friends and the Department of Sociology and Gerontology. I would not be the person I am today without the guidance and support from all of you.

AMDG.
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Framework for Studying Grief Experienced by Veterans

All of us experience the loss of people we care about over the course of our lives. How does this grief and loss impact one’s life? How a person deals with loss and grief can affect their lives from the moment of the loss (Neria and Litz, 2003). In fact, Neria and Litz theorize that if a person chooses to deny the loss and does not allow a normal grief process, they could become stagnant, unable to completely move past the point in which the loss was experienced (Neria and Litz, 2003). It has been suggested that this stagnation will affect not only their ability to grieve, but their ability to feel other human emotions. Experiencing loss and dealing with grief is an important and unique aspect of an individual’s life (Garb, 1987).

It is the contention of this work that there are a number of factors that impact a veteran's ability to experience grief long after military service is concluded. Two important factors are the effects of military indoctrination and combat (Catherall, 1992; Elder and Clipp, 1989; Maguen et al., 2006). The stripping of the “self” that occurs during the first military training for newly enlisted soldiers can have positive or negative effects on who they are as a person and their ability to deal with change, especially grief (Grossman, 2009). With the stripping of the “self” comes the denial of the emotions “I”; rather the group as a whole, the unit, takes precedence over the individual (McGurk, Cotting, Britt and Adler, 2006). The attitude that emotions are a weakness carries on after military service, affecting the veterans ability to feel anything, as well as their ability to deal with past loss and unresolved grief (McGurk, Cotting, Britt and Adler, 2006; Stein, 2007; Neria and Litz, 2003). Erikson explains the significance this has when an individual/soldier relinquish “self”/autonomy to their superior, leaving them vulnerable and conflicted with their decision to give up their ability to think/feel for themselves (Erikson, 1963). All military branches indoctrinate their soldiers with the following ideas: “self” is gone; one can only succeed within their group of soldiers; emotions are signs of weakness, leave them behind; and if one loses a fellow comrade it should not affect one’s performance as a soldier or contribution to the group (Grossman, 2009; McGurk, Cotting, Britt and Adler, 2006; Thompson and McCrerey, 2006). The mental and psychological needs of veterans have been minimized over the years based on the indoctrination of military standards. Some of these standards include not addressing personal emotions and detachment from self and others during service (McGurk, Cotting, Britt and Adler, 2006). However, veterans returning to civilian society don’t typically have the tools to deal with the loss of fellow veterans and loss of significant others (Grossman, 2009; McGurk, Cotting, Britt and Adler, 2006).

Another major event in military service which can affect the individual after service is combat. How a person reacts in combat, their in-action or reaction, what they witness and how they cope with what they have seen or had to do will affect and, most of the time, change who they are (Stein, 2007). Military operations are characterized by multiple sources of stress, but more often than not the soldiers are left to their own devices to learn how to cope with the loss of friends, as well as the threat of death (Thompson and McCrerey, 2006). The different branches of military service have recognized this pitfall of their training but no one has changed their training to
include psychological/mental readiness training for military operations (Thompson and McCreary, 2006).

There is a gap in the psychological care of soldiers while they are in service, as well as after they are discharged. Soldiers have not been trained on how to deal with the changes incurred from military life and/or the loss of fellow soldiers (McGurk, Cotting, Britt and Adler, 2006; Thompson and McCreary, 2006). Additionally, there is no training or education on what is normal for soldiers to feel after they have been involved in a traumatic event (Grossman, 2009; McGurk, Cotting, Britt and Adler, 2006).

One of the critical questions raised by the Robley Rex Veteran Affairs Medical Center (VAMC) is: do veterans need assistance to help them navigate through loss and grief, past or present? Could a veteran-specific grief program help them process the losses experienced through combat and fallen veterans in later life? Little empirical research exists on this question, but for the future well-being of the impending baby boomer veterans and those serving in our present wars, it will be important to assess the need for a grief program. The goal of this study is to explore the need for the Robley Rex Veteran Affairs Medical Center (VAMC) to develop and implement a veteran-specific grief program.

**Background**

**Grief and Denial**

Grief has to be understood in the context which it occurs, especially with combat (Stein, 2007). During combat a person could experience the sudden loss of several comrades but if they were to take the time to properly “grieve” they might put themselves, or those around them, in danger because of their attention being focused on the loss rather than maintaining self-control and their own safety. The soldier has to maintain a certain degree of separation from the loss in order to be able to continue to function while in combat. Then, once they are out of immediate danger and the weight of the accumulated grief begins to set in it could be seen as too daunting of a task or overwhelming and, in line with their training, they create a wall likened to numbness that is impenetrable to the built up grief (Stein, 2007; Neria and Litz, 2003). This pathologic grief, also referred to as prolonged grief, can have similar effects on a person’s ability to grieve as complicated grief (Neria and Litz, 2003). When the grief is avoided or becomes a chronic condition that assimilates into a person’s life as “normal” behavior this is a characteristic of complicated grief (Neria and Litz, 2003). If a veteran experiences a significant loss during military service and is not allotted enough time to grieve the loss the anxiety, stress, guilt, or other emotions will affect how they interact with people, how close they allow themselves to get to their friends and family in the civilian world and inevitably how close they allow themselves to be to their own emotional well being (Neria and Litz, 2003; Settersten, 2006). The effects of grief will be with a person from the day of the loss until the day they are able to let the grief stop taking over their thoughts. If a veteran never learns how to deal with loss and grief, this could impact their entire life course (Settersten, 2006).
Soldiers in war, training or peace time who experience the loss of a fellow soldier are often unable to go through the grieving process because of the indoctrination of “emotional numbness”, when in service they are usually not allowed to participate in the funeral rites because of the necessity to carry on the tasks at hand (Neria and Litz, 2003). After the war has ended, its consequences continue to be felt by those involved and those indirectly involved through the mourning of those lost and in the minds of those left behind as the living tombs of the war and its savagery (Elder and Clipp, 1989).

Military Indoctrination and Erikson

According to Catherall (1992), “The warrior learns that natural human reactions of fear, exhaustion, grief and desire for comfort and safety are to be subordinated to the mission—military training encourages individuals to toughen up and ignore the feelings that are viewed as weak” (p.20). However, this mentality can have negative effects on soldiers during service and post-discharge because it creates an inability to cope with loss, in essence a denial of the loss. Pushing through is characterized with a moving on mentality; the event is put to the back of the mind in order to accomplish the task at hand. Once the task is accomplished, the loss, whether significant or not, takes a backseat to the other task that inevitably is asked of the soldier (Grossman, 2009; McGurk, Cotting, Britt and Adler, 2006). Once discharged from service some veterans are able to assimilate back into a loss mode, where they are able to cope and manage the losses incurred during service and those which occur in the civilian world. However, a lot of veterans have difficulty with loss, in or out of the service, because of the conditioning through their military training (Grossman, 2009; Settersten, 2006). Learning how to cope with loss in a healthy and positive manner is an important part of grieving and one where some veterans could use some guidance and education. This same difficulty could be experienced by civilians as well. The main difference is that most, if not all veterans will have experienced some type of loss in their military career and were told to “push through” (Grossman, 2009; McGurk, Cotting, Britt and Adler, 2006).

In Erikson’s *Childhood and Society* (1963) he discusses the eight stages a man goes through in his life; one which aptly applies to veterans is the topic of autonomy vs. shame and doubt. A person who joins a military branch relinquishes all sense of autonomy to his or her superiors with the trust that they will be trained and led properly. With their autonomy gone they are incredibly vulnerable and at the will of their superiors and this is where the shame and doubt come into play. Erikson (1963) describes shame as being when “one supposes they are completely exposed and conscious of being looked at, in one word self-conscious…rage turned against the self” (p.252). He then goes on to explain that doubt is the “brother” of shame, in that “where shame is dependent on the consciousness of being upright and exposed, doubt…has much to do with a consciousness of front and back” (p.253). When we look at the psychological toll this type of position can take on a person, aside from being in combat or having the sense of “self” stripped away during basic or boot camp, we are confronted with a major barrier for veterans, and those trying to provide their care. The problem being that anyone who has ever served in a military branch has to give up their self and take on the “group think” mentality in order to survive. They
likely have a constant struggle with what part of themselves to give up and what to hold on to, in terms of trying to figure out what will benefit the greater good of their group.

During combat soldiers have to make a choice, self or the group; this presents the possibility of losing one and then having to deal with the doubt or regret of their choice after they leave the situation or the military (Grossman, 2009). In essence, we train men to follow men, unwaveringly, and then once they are discharged there is no more leadership and they are left to wrestle with the meaning of their autonomy and the doubt and shame associated with any actions or inactions they were forced to choose during service. This never changes, the doubt and shame associated with military service, with war, is engrained in the veteran (Grossman, 2009; McGurk, Cotting, Britt and Adler, 2006). With every war there is a unique historical context in which it will affect the psychological well-being and adaption to life after combat, leaving a person tormented with rage, guilt, shame, dehumanization, abandonment and betrayal (Foy, 2002).

It is necessary for a sensible person to recognize fear but, at the same time, be trained to maintain normal functioning in the face of fear and/or anxiety; they have to overcome their fears and anxieties when faced with them (Erikson, 1963). How can veterans learn to do this? Soldiers are trained to subdue fear and anxiety and to be cool, calm and collected, at all times (Grossman, 2009). To be emotional in any situation is a loss of control of the self and jeopardizes the group as a whole, so when they leave the group how can they know when they are experiencing fear, anxiety, and to be more specific, loss or grief? If a veteran is not able to deal with these issues at some point in their lives then in the later stages of life they will have difficulty feeling anything that has to do with loss, spanning from the loss of a job to the loss of a significant person in their life (Fontana and Rosenheck, 1994; Snell, 1997). The inability to “feel” or understand the emotions as a result of loss will compound the unresolved grief until it is unbearable (Neria and Litz, 2003). This will affect their ability to cope with losing people and their ability to deal with their own mortality (Neria and Litz, 2003; Settersten, 2006). These are major issues within the mental health care of veterans who are dealing with Post-Traumatic Stress Disorder (PTSD) and other mental issues that inhibit their ability to function normally (Papa, 2008).

Post Traumatic Stress Disorder (PTSD)

It was predicted that by 2010, 25 million veterans will be at least 65 years and older, with 3 million of those veterans having served in the Vietnam war (King et al., 2007). Given that the population of Vietnam veterans was the catalyst for studies examining the effects of traumatic events in combat, which led to the conceptualization of Post Traumatic Stress Disorder (PTSD)¹, it is of paramount importance to develop programs and services to serve the psychological needs of veterans. Post Traumatic-Stress Disorder (PTSD) could overlap with unresolved grief

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¹ “Posttraumatic Stress Disorder (PTSD) is defined in the Diagnostic and Statistical Manual of mental disorders (DSM; American Psychiatric Association, 2000) as an anxiety disorder that encompasses symptom-clusters of re-experiencing, avoidance, and hyper arousal that develop after a traumatic event (Bolen, 2008).”
symptoms for some veterans; because of this overlap it will be important to understand how Post-Traumatic Stress Disorder (PTSD) could affect the grief process and vice versa (Kaiman, 2003). Research has found that exposure to combat is consistently related to the development of Post-Traumatic Stress Disorder (PTSD) with WWII, Korean and Vietnam veterans (McCraine, 2000). Post-traumatic stress disorder (PTSD) was first coined by a psychiatrist treating Sgt. Dwight Johnson, a Medal of Honor winner killed in Detroit at a grocery store where he opened fire and was killed at point blank range, was described as experiencing depression caused by his military service in the Vietnam War (Shatan, 1973). This was one of the first instances in which the stresses of the Vietnam War became evident apart from the actual war; the psychological war at home for veterans began its recognition with Sgt. Johnson.

**Combat**

War poses one of the single greatest threats to a person’s physical and mental health (Davies, 2001). Deployment to war zones is the duty that poses the highest risk for trauma exposure and post trauma mental health problems (Maguen et al., 2006). Combat has been found to have long term negative effects on veterans, with about 50% of Prisoners of War experiencing depression symptoms as late as 50 years after their military service (Aldwin, 1994). Exposure to combat increases the chances of an individual experiencing emotional and behavioral problems after the war has ended, and of even greater importance, those who are pre-disposed to stress because of psychological or social impairments are likely to suffer more psychologically during or after service (Settersten, 2006).

**Methodology**

The focus of this study was to answer the question: Is there a need for a veteran-specific grief program, post discharge?

The three major steps of the study were: (1) comprehensive literature review (2) development and administration of the needs assessment survey, “Voice of the Veteran” ² (3) and analysis of data and recommendations to the Robley Rex Veteran Affairs Medical Center (VAMC).

“Voice of the Veteran Survey” Development

Asking veterans about their grief, and more often than not unresolved grief, is a tremendous challenge (Stein, 2007). It was the goal of this needs assessment to explore the need for a veteran-specific grief program by looking at possible cases of unresolved grief. In preparation for the survey measurement instruments examining grief were assessed for their reliability and

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² Due to time and financial constraints, the quality management department offered the services of the patient ambassadors, Veteran Affairs (VA) employees whom perform routine satisfaction surveys, to administer the “Voice of the Veteran” survey. Another major constraint of the survey was a question limit due to national policy prohibiting surveys over 10 questions from being administered without national approval.
validity. Several grief instruments were reviewed as possible assessment tools but the Texas Revised Inventory of Grief was found to be the most relevant instrument for the survey.

**TRIG**

The Texas Revised Inventory of Grief (TRIG) is a grief measurement instrument comprised of 21 items, 13 measuring present grief and 8 measuring past grief. At first the TRIG was thought to measure unresolved grief, but recently it has been regarded as a measure of normal grieving (Futterman et al., 2010).

After review by Robley Rex Veteran Affairs Medical Center (VAMC) staff and University researchers 4 items from the 21 item TRIG instrument were selected. There are limitations in taking items out of an established instrument, but because of constraints of survey length imposed by the Veteran Affairs (VA) this was viewed as the best option. The TRIG items used were a five point, self reported Likert scale; items focused on current grief were selected. Once the grief instrument was chosen the task of developing the survey questions, in conjunction with the Hospice and Palliative Care unit staff, began.

The development of the “Voice of the Veteran” survey stemmed completely from what questions the Hospice and Palliative Care team was looking to answer for their program development. The survey started off with several demographic questions, such as age and gender, but as the survey began to take shape it became evident that with the 10 question maximum the questions would have to be focused on grief and war era in order to satisfy the need assessment goal.

One of the debates during survey development was whether or not the program should be even more specific to those who are still having difficulty accepting the loss of a fellow veteran or if it should be open to veterans experiencing the loss of any person in their life. In the survey, respondents were screened for grief and once this was completed, individuals were asked whether the death which most affected them was a veteran or a non-veteran. The literature review showed that most veterans have difficulty dealing with any grief post-discharge because of the military indoctrination of no feeling/emotional detachment from loss (Catherall, 1992; Erikson, 1963). Their difficulty in dealing with loss did not only encompass those lost during their military service but also their inability to deal with loss at any point in their life course (Garb, 1987; Settersten, 2006). The original intent of the Hospice and Palliative Care team was to only screen for veteran losses but after a discussion about how loss incurred during military service could affect the veterans ability to cope with loss and grief with non-veterans because of repressed feelings and unresolved grief from previous loss it was decided an item to assess non-veteran loss would be included (Shatan, 1973; Neria, 2003; Aldwin, 1994).

The quality management department offered to administer the surveys as part of their routine service satisfaction assessment process. Patient ambassadors, who work as part of the Veteran Affairs (VA) quality management process to regularly survey veterans, were used to collect the survey data. The patient ambassadors were instructed to notify the Primary Investigator or their supervisor if there were any issues while administering the questions to the veterans. The
original plan involved a pilot test of the instrument, but due to time limitations the pilot testing was not conducted. The survey went through seven rounds of revisions by researchers and Veteran Affairs (VA) personnel, some of whom were veterans, before it was finalized.

Once the survey was in its final format it was then submitted to the quality management department for necessary revisions. A final meeting was then held with the head of quality managements and the patient ambassadors to explain the goals of the needs assessment. A copy of the research proposal was given to those conducting the survey to serve as background for the project. This meeting was done to answer any questions about the survey, to determine the minimum number of surveys needed for data collection and to determine the length of time it would occur.

A copy of the survey can be found in Appendix A and a copy of the verbal consent form can be found in Appendix B.

All veterans who received care at the Community Based Out-patient Clinics, In-patient/Out-patient clinics and the emergency room from January 17th to February 8th were surveyed in-person. The original ending date of the survey was February 27th but due to extenuating circumstances was closed on the 9th.

Sample

The sample was purposeful and non-random and the study should be classified as an exploratory needs assessment. The sample includes veterans from WW I to as recent as Operation Iraqi Freedom. It was anticipated that the sample would be a minimum of 200 veterans, however the survey ended two weeks earlier than anticipated and the number of surveys completed was 75.

“Voice of the Veteran Survey” Data Collection/Entry

Once the survey was stopped all completed surveys were collected and the patient ambassadors were debriefed on their experiences of administering the “Voice of the Veteran” survey. One of the patient ambassadors had some very poignant statements about the survey and their opinion of the need for the program. The following are quotes from them about the survey as well as their own experience being a veteran and dealing with grief:

“This is really important subject matter, especially for veterans. I went through the military and they didn’t want us to feel anything. If we showed emotions it was looked at as a weakness. During training they (military) purged you of anything that would hinder the group as a whole and one of those things looked at as a hindrance was emotion. After I got out of the military I have had a hard time feeling anything and still do to this day. My spouse and I both look at feelings and emotions as weaknesses and have passed these ideas down to our kids. We (veterans) need something to help us learn how to feel again; we don’t know how.”
The veterans who participated in the survey seemed to have a hard time answering the question about whether their most significant loss was a veteran or non-veteran. The questions about grief caused some flashbacks and prompted some of the veterans to re-tell stories of losses that occurred while they were in combat or losses of significant others post-discharge. The big thing is that they wanted to answer the questions; they wanted to finish the survey even though it visibly made them upset. It was important to them to finish so that their contribution of answers could help some of their fellow veterans.

As previously described, data were collected in: Robley Rex Veteran Affairs Medical Center (VAMC); Community Based Out-Patient Centers (CBOC); Emergency Room (ER); and In-patient/Out-patient clinics. This was a cross-sectional data set and provided a snap shot of the veteran population who accessed services through the patient ambassadors at the locations specified. Those who were surveyed had to be veterans and able to listen/agree to the verbal consent form. Seventy five veterans agreed to participate in the study. Of the 75 veterans who participated, 70 had experienced a death in their life and 5 had not.

The data entry process began with entering the raw data into SPSS. Once all the data were entered the data set was exported into SAS for descriptive analyses. The data were divided into war era cohorts based on when they served. The following explain the dates of service and what war they corresponded to: World War II: 1939 to 1945; Korean War: 1950-1953; Vietnam War: 1960-1975; Persian/Gulf War: 1990-1991; OEF/OIF: 2001-2011. Any of the years that people served which were not during one of the war eras were classified as “non-combat veterans”. Some of the war eras had too small of cells and had to be combine. World War II veterans (2) and the Korean War veterans (5) were combined to form the WW II/Korean War cohort and the Persian/Gulf War veterans (9) and OIF/OEF veterans (5) were combined to form the Gulf/OIF/OEF cohort. There were 5 veterans that served in 2 or more wars based on their years of service.

The grief questions were originally coded as follows: Completely true: “1”; Mostly true: “2”; Neutral: “3”; Mostly false: “4”; and Completely false: “5”. They were then collapsed to Completely true/Mostly true: “1”; Neutral: “2”; and Mostly false/Completely false: “3”. Because of sample size limitations categories were collapsed as follows: Completely true/Mostly true: “1”; Neutral/Mostly false/Completely false: “0”.

Those who had experienced a death were categorized into those who answered “yes” to all 4 grief items, “yes” to 3 grief items, “yes” to 2 grief items, “yes” to 1 grief item and “yes” to 0 grief items. Those who answered “yes” to 2 or more of the grief items were categorized as “high grief” and those who answered “yes” to 1 or less of the grief items as “low grief”. The “high grief” respondents were cross tabbed with interest in the veteran-specific grief program to see if those who were experiencing grief were the most interested in the grief program.

Those who had experienced a death were categorized as “Death experience” and those who had never experienced a death were categorized as “No death experience”.

8
“Voice of the Veteran Survey” Discontinuance

During the survey development it was discussed that discomfort with the survey was a possible issue. Steps were taken to instruct the patient ambassadors what to do if the veterans became distressed during the survey. The survey was discussed in depth before it was administered and was reviewed and revised several times as well. Even with all these steps it was understood that if at any point during the survey it became apparent that the survey was too much for the veterans, or the patient ambassadors, to handle it was to stop immediately.

The survey began January 17th and originally was scheduled to end February 27th. However, February 9th the survey was ended. Flashbacks of deaths, disturbing scenes from war and other cases of unresolved grief were prominent for many of the veterans who chose to participate in the study. However, the main reason for the discontinuance of the survey was the patient ambassadors overwhelming workload. It was explained after the survey had ended they (patient ambassadors) had a difficult time handling the emotional breakdowns continually. Ending of the survey early may in itself be an indicator of the need for a veteran-specific grief program.

“Voice of the Veteran Survey” Analysis

This study was an exploratory needs assessment which focused on descriptive analysis. The goal of the analysis was to describe whether or not the veterans were still experiencing grief, whether the most significant loss was veteran or non-veteran, and what their level of interest was for a veteran-specific grief program.

Results

Overall, 93% of the 75 veterans surveyed had experienced the death of someone close to them post discharge (See Table 1). Although most veterans had experienced loss, for the majority of respondents (79%) the death reported was not a person they knew through their military service. This is an interesting finding because at the onset of the study there was discussion about developing a program only for veterans who had lost a fellow veteran. Somewhat surprisingly, the small group of non-combat veterans reported the highest proportion of veteran deaths (10 of 13).

Based on the four items screening for grief, (49.3%) of the respondents reported “Yes” to “I still get upset when I think about the person who died”. For the second grief item, “I am preoccupied with thoughts (often think) about the person who died”, (33.3%) of the veterans reported “Yes”. For the third grief item, “I can’t avoid thinking about the person who died”, (49.2%) reported “Yes”. For the final grief item, “I am unable to accept the death of the person who died”, (15.7%) reported “Yes”. Overall, this sample is experiencing some signs of grief. There is a need (See Table 2) from this sample of veterans, for a veteran-specific grief program. When the final question of whether or not the veterans were interested in participating in a
program/gathering to help them deal with the loss of a fellow veteran 24.2% reported “Yes” they were interested.

Of those who were interested in the program it was asked what location would be most preferred. There was a very low response rate (18) to this item and of those who responded, several chose multiple answers. The Robley Rex Veteran Affairs Medical Center (VAMC) (See Table 2) was chosen as the preferred location for the program to take place.

While sample size was limited, to gain a better understanding of the grief experience of sample members a more in-depth review of the grief questions was undertaken. Sample members were divided into high and low grief groupings based on the four grief questions described above. Individuals who answered yes to at least two of the four grief questions were considered to be in the high grief category. When looking at the “High grief” and “Low grief” grief categories for the sample (n=75), 25 of them were placed in the “High grief” category, (See Table 3). In examining the relationship between grief score and interest in participating in a grief program results showed that 36% of those with high grief reported interest compared to 14% for the low grief score group. This finding is consistent with the literature and important to the study, indicating that while there may be a need for assistance, there is not necessarily an acceptance of the need on the veterans part (Garb, 1987; Papa, 2008; Snell, 1997). That there are veterans categorized as “High grief” but not interested in the grief program is consistent with the theme of denial of grief/emotion in the literature (Garb, 1987; Neria and Litz, 2003).

**Discussion**

This assessment explored the need for a veteran-specific grief program for the Robley Rex Veteran Affairs Medical Center (VAMC). Findings showed that about one quarter of the veterans report being interested in attending a program to discuss how to better deal with grief. Additionally, the results of the “Voice of the Veteran survey” showed that a majority of the veteran losses were non-veteran losses. This is significant for future program development because initially it was assumed that the program would only be for veterans who had lost fellow veterans post-discharge. The data indicates that there is a need for a program that would not only focus on veterans who have lost fellow veterans post-discharge, but veterans who have lost non-veterans post-discharge as well.

A suggestive finding of the study pertains to those classified as “High grief” veterans. The fact that 9 (36%) reported they were interested in the veteran-specific grief program and were experiencing persistent grief symptoms could be an indicator for the need for the program. It is also interesting those 16 (64%) veterans whom were classified as “High grief” reported no interest in the veteran-specific grief program. This could reflect the difficulty in getting reliable data from veterans about grief. Two of the major reasons that veterans could have difficulty dealing with loss and grief may stem from their military indoctrination and “non-emotional” mentality (Catherall, 1992; Garb, 1987; Shatan, 1973; Elder and Clipp, 1989; Maguen et al., 2006). As seen in the literature, the veterans ability to deal with loss and grief will be affected by their military service (Stein, 2007; Papa, 2008; Neria and Litz, 2003).
It is also important that the needs of veterans who are dealing with grief not directly associated with their military service are taken into account. Structuring a program for veterans having difficulty dealing with grief in their life due to loss, whether past or present, will need to be sensitive to their inability to feel or show emotions, depending on the severity of their unresolved grief (Neria and Litz, 2003). The difference between a non-veteran and a veteran experiencing a loss is that the non-veteran was most likely never conditioned to believe that their livelihood and the good of the whole hinged on their ability to shut out emotions (Grossman, 2009; McGurk, Cotting, Britt and Adler, 2006). This is what will make a veteran-specific grief program unique; learning how to feel, how to grieve and then doing so.

The highest number of veterans still grieving the loss of a fellow veteran was found in the non-combat veteran cohort. There was a discussion about the affects of military training and non-emotion indoctrination that occurs throughout military service but this finding might serve as a basis for future research about peace time stress for those serving in the military. Further research could be conducted about the difference between peace time and combat veterans and their resilience to loss post-discharge and this small sample of veterans shows there could be some interesting differences.

If the Hospice and Palliative Care Unit does move forward with a program based on this report it would be prudent to conduct a pilot test of a partially developed program at the Robley Rex Veteran Affairs Medical Center (VAMC). It would be best to have the program focus on learning about what happens during military indoctrination, how that can affect life after military service, how to feel emotions, and even on the basic definition of grief.

A larger study could take place in which all of the Veteran Affairs Medical Centers could participate. This would provide a much larger sample and would be more generalizable to the veteran population. If the program at the Robley Rex Veteran Affairs Medical Center (VAMC) proves to be successful and a need is found region wide this need could be assessed nationwide and, one day, impact the entire U.S. veteran population. This study is the beginning of what will, hopefully, be a nationwide program that helps all veterans deal with grief and loss in their lives.

**Gerontological Implications**

How a person ages is interrelated with the sociocultural cohort effects, as well as with the socio-historical cohort effect (Fontana and Rosenheck, 1994). The socio-cultural cohort effect pertaining to veterans and aging can be seen through acceptance of war, societal expectations of how a veteran should or should not deal with their military experiences and mental illness stigmas (Fontana and Rosenheck, 1994). The socio-cultural cohort effect is linked to the socio-historical cohort effect through the acceptance of different historical events by the socio-cultural cohort (Fontana and Rosenheck, 1994). It is the socio-historical period which shapes the cohort and in effect, shapes their life course, the opportunities they have and the different social roles to be filled (Stoller and Gibson, 1994; Elder, 1996; Settersten, 2006). However, it is the socio-cultural cohort which defines what the historical events mean to their society, which will in turn affect the way veterans and their military service is viewed through the lens of society impacting
their integration into society post-discharge and their psychological well-being (Fontana and Rosenheck, 1994). For example, the World War II veterans fought a war that was accepted and supported by their socio-cultural cohort; they saved the U.S. and were treated as heroes. In contrast, the Vietnam veterans fought a war that was not socially acceptable and came home to a society that detested their involvement in the war. Vietnam veterans were not regarded as heroes and were not accepted back into society as easily, if ever, as other war era cohorts (Fontana and Rosenheck, 1994). The different war era cohorts integrated differently back into their society, functioned differently throughout their life course, in part due to their military service (Settersten, 2006). Having an understanding of how the life course is affected by military service will hopefully enable a more full understanding of the veteran and their socio-cultural and socio-historical cohort.

Military service and war, as part of the veterans socio-historical context, have to be acknowledged or else research conducted will not accurately portray the veteran. The unique role the military plays in shaping the individuals understanding of “self”, or lack thereof, is integral in understanding who they are, for example, at age 85 as a result of military indoctrination/experiences at age 20 (Erikson, 1963; McGurk, Cotting, Britt and Adler, 2006). The effects of military service/war on a person who is lacking a sense of “self” will be directed by society (Fontana and Rosenheck, 1994). The role of the socio-cultural cohort effect is immense in shaping all people from the cohort, but especially those who have a shapeless sense of who they are (Erikson, 1963; Fontana and Rosenheck, 1994). As stated earlier, the military training has never integrated training a soldier how to not be a soldier anymore, how to think outside of a group context nor how to accept who they became as a result of their service (Thompson and McCreary, 2006). The soldier is trained and then once they are discharged, left to their own devices and coping skills to disengage from the soldier mentality. If the soldier cannot disengage from the role of soldier then their soldier mentality will persist throughout their life course, particularly with emotional numbness and confused sense of autonomy (Erikson, 1963; McGurk, Cotting, Britt and Adler, 2006).

The loss and grief which is incurred through military service will have mitigating effects on the individual throughout the life course, especially with life reviews (Settersten, 2006; Settersten, 2003; Snell, 1997). The life reviews for veterans force a person to reevaluate their purpose and meaning in life, possibly bringing up issues of hopelessness or loss of control associated with traumatic events (Snell, 1997). Because of their military indoctrination/training of emotional numbness, essentially disabling them from being able to have normal grief/emotional reactions, a life review might be seen as a daunting and overwhelming task causing distress in the veterans life (Neria and Litz, 2003; Grossman, 2009; McGurk, Cotting, Britt and Adler, 2006; Snell, 1997). Based on the large number of veterans whom are beginning to enter their later years, life reviews and the effects of military service with those life reviews, will be an important part of understanding what happened during those historical time periods, as well as understanding the socio-cultural cohort effect and the different or similar views veterans have of themselves based on these effects (King, 2007). Understanding the impact of military service/war on the life course could possibly assist or alleviate the stress sometimes incurred with life reviews by explaining
why life reviews are difficult for veterans in a unique way based on their exposure to traumatic events/stressors and their societal acceptance (Davison, 2006; Fontana and Rosenheck, 1994). The effect of military service on the life course will impact the manner in which research is conducted as well as programming, enabling researchers to be more sensitive to the topic and aware of the differences for the different veteran war era cohorts. Every individual has a distinct life course, unique to their experiences, and as with war, the different war era cohorts, including non-combat veterans, will have to be researched within the context of their military service (Settersten, 2006; Settersten, 2003; Elder, 1995). There are differences between age-period cohorts and as such, there are differences with war-era cohorts (Settersten, 2003; Elder, 1995). Knowing there are differences will be an important part of any programming or research conducted by the Veteran Affairs (VA) or any other organization hoping to make an impact in veterans lives by showing the need for individualized programming and research to accommodate the differences of the war era cohorts.

Limitations

The first major limitation of this study was the sample size and selection. Seventy-five veterans was not a large enough number to find statistically significant patterns or themes in the data. While this needs assessment was done specifically for the Robley Rex Veteran Affairs Medical Center (VAMC) it would have made more of an impact with larger numbers for the Veteran Affairs Medical Center (VAMC). As well, the non-random sample did not lend itself to being generalizable. All of the veterans in the Louisville area were not asked to participate in the study, only those receiving care through the Veteran Affairs (VA). A large portion of veterans not receiving Veteran Affairs (VA) services or who did not receive care at the Veteran Affairs (VA) during the time period of the survey were not included in the sample. However, the tool developed could be used for other needs assessments to be conducted as long as modifications are made for better data output and the method of sampling is changed to have more generalizable results.

Another major limitation of the study was the survey length. Based on national policy, the Veteran Affairs (VA) is allowed to administer surveys that are under 10 questions without having to go through the national office for approval. Because of this constraint the questions used to screen for grief had to be chosen from the TRIG, but were not part of a tested subscale. The survey length and amount of surveys completed posed a significant limitation in analyzing the data and providing significant results.

Finally, not being able to assess whether the veterans who were categorized as combat veterans had actually been deployed and participated in combat was crucial information not obtained. As well, not being able to assess whether the veterans who were categorized as non-combat had taken part in peacetime conflict while deployed was crucial as well. It will be important for future studies to ascertain this information to better understand whether those who participated in combat are in more need of a grief program than those who did not.
### Table 1
Death Experience by War Era and of the Responses Toward the Grief-Related Questions by War Era

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total (n=75)</th>
<th>WW II &amp; Korean War (n=7)</th>
<th>Vietnam War (n=40)</th>
<th>Gulf/ OIF/OEF War (n= 14)</th>
<th>Non-Combat veterans (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since your discharge, have you experience the death of someone close to you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>70 (93.3%)</td>
<td>7 (100.0%)</td>
<td>39 (97.5%)</td>
<td>10 (71.4%)</td>
<td>14 (100.0%)</td>
</tr>
<tr>
<td>No</td>
<td>5 (6.7%)</td>
<td>0 (0.0%)</td>
<td>1 (2.5%)</td>
<td>4 (28.6%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>For Individuals with a death experience (n=70)³Did you know this person through your military service?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>20 (31.3%)</td>
<td>0 (0.0%)</td>
<td>8 (22.9%)</td>
<td>2 (20.0%)</td>
<td>10 (76.9%)</td>
</tr>
<tr>
<td>No</td>
<td>44 (66.7%)</td>
<td>6 (100.0%)</td>
<td>27 (77.1%)</td>
<td>8 (80.0%)</td>
<td>3 (23.1%)</td>
</tr>
<tr>
<td>I still get upset when I think about the person who died.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>33 (49.3%)</td>
<td>2 (33.3%)</td>
<td>18 (47.4%)</td>
<td>5 (50.0%)</td>
<td>8 (61.5%)</td>
</tr>
<tr>
<td>No/Neutral</td>
<td>34 (50.7%)</td>
<td>4 (66.7%)</td>
<td>20 (52.6%)</td>
<td>5 (50.0%)</td>
<td>5 (38.5%)</td>
</tr>
<tr>
<td>I am preoccupied with thoughts (often think) about the person who died.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22 (33.3%)</td>
<td>2 (33.3%)</td>
<td>12 (32.4%)</td>
<td>4 (40.0%)</td>
<td>4 (30.8%)</td>
</tr>
<tr>
<td>No/Neutral</td>
<td>44 (66.7%)</td>
<td>4 (66.7%)</td>
<td>25 (67.6%)</td>
<td>6 (60.0%)</td>
<td>9 (69.2%)</td>
</tr>
<tr>
<td>I can’t avoid thinking about the person who died.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>32 (49.2%)</td>
<td>1 (14.3%)</td>
<td>17 (48.6%)</td>
<td>8 (80.0%)</td>
<td>6 (46.2%)</td>
</tr>
<tr>
<td>No/Neutral</td>
<td>33 (50.8%)</td>
<td>6 (85.7%)</td>
<td>18 (51.4%)</td>
<td>2 (20.0%)</td>
<td>7 (53.9%)</td>
</tr>
<tr>
<td>I am unable to accept the death of the person who died.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>10 (15.7%)</td>
<td>0 (0.0%)</td>
<td>5 (13.9%)</td>
<td>1 (10.0%)</td>
<td>4 (33.3%)</td>
</tr>
<tr>
<td>No/Neutral</td>
<td>54 (84.3%)</td>
<td>6 (100.0%)</td>
<td>31 (86.1%)</td>
<td>9 (90.0%)</td>
<td>8 (66.7%)</td>
</tr>
</tbody>
</table>

³ The respondents who reported no death experience did not provide information
Death Experience is defined as having experienced a significant loss in the Veterans life and No Death Experience is defined as never having experienced a significant loss in the Veterans life.

The total count does not match due to missing cases.

Of the 75 participants, 18 responded to the last question regarding preferred location and of the 18 respondents, 7 participants selected more than 1 location as preferred.

### Table 2
Frequencies and Percentages for Interest in Program and Preferred Location

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total (n=66)³</th>
<th>WW II &amp; Korean War (n=6)</th>
<th>Vietnam War (n=35)</th>
<th>Gulf/OIF/OEF War (n=14)</th>
<th>Non-Combat veterans (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you be interested in attending a program to discuss how to deal with the loss of a fellow veteran?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16 (24.2%)</td>
<td>3 (50.0%)</td>
<td>9 (25.7%)</td>
<td>3 (21.4%)</td>
<td>1 (9.1%)</td>
</tr>
<tr>
<td>No</td>
<td>50 (75.8%)</td>
<td>3 (50.0%)</td>
<td>26 (74.3%)</td>
<td>11 (78.6%)</td>
<td>10 (90.9%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>Preferred Location Frequencies (n=18)⁶</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are willing to attend a gathering to discuss how to deal with the loss of a fellow veteran what location would be preferred?</td>
<td>Robley Rex VA Medical Center (VAMC) 10</td>
</tr>
<tr>
<td></td>
<td>Local Veterans of Foreign War (VFW) 6</td>
</tr>
<tr>
<td></td>
<td>Local Disabled American Veterans (DAV) 5</td>
</tr>
<tr>
<td></td>
<td>Community Based Out-patient Center (CBOC) 5</td>
</tr>
</tbody>
</table>

---

³Death Experience is defined as having experienced a significant loss in the Veterans life and No Death Experience is defined as never having experienced a significant loss in the Veterans life.

⁴The total count does not match due to missing cases.

⁶Of the 75 participants, 18 responded to the last question regarding preferred location and of the 18 respondents, 7 participants selected more than 1 location as preferred.
Table 3
Frequencies and percentages for those interested in a veteran-specific grief program according to “High grief” and “Low grief” categories

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total (n=75)</th>
<th>High Grief(^7) (n=25)</th>
<th>Low Grief(^8) (n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you be interested in attending a program to discuss how to deal with the loss of a fellow veteran?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16 (24.2%)</td>
<td>9 (36.0%)</td>
<td>7 (14.0%)</td>
</tr>
<tr>
<td>No</td>
<td>50 (75.8%)</td>
<td>16 (64.0%)</td>
<td>43 (86.0%)</td>
</tr>
</tbody>
</table>

\(^7\) “High grief” categorizes those participants which answered “Yes” to 2 or more of the grief items

\(^8\) “Low grief” categorizes those participants which answered “Yes” to 1 or less of the grief items
Appendix A

Voice of the Veteran Survey

1. What years did you serve in the military? _____ to ______

2. Since your discharge, have you experienced the death of someone close to you? ___Yes ___No

***If “No” please proceed to question 9.

Think about the death which affected you the most and answer the next few questions according to the extent that each statement describes your current feelings about this person's death.

3. I still get upset when I think about the person who died. Would you say that statement is:

   READ ALL RESPONSES:
   __Completely true ?
   __Mostly true ?
   __Neutral ?
   __Mostly false?
   __Completely false ?

4. I am preoccupied with thoughts (often think) about the person who died. Would you say that statement is:

   READ ALL RESPONSES :
   __Completely true ?
   __Mostly true?
   __Neutral ?
   __Mostly false?
   __Completely false?

5. I can't avoid thinking about the person who died. Would you say that statement is:

   READ ALL RESPONSES:
   __Completely true?
6. I am unable to accept the death of the person who died. Would you say that statement is:

READ ALL RESPONSES:

__Completely true?

__Mostly true?

__Neutral?

__Mostly false?

__Completely false?

7. Did you know this person through your military service? ___Yes ___No

8. When did this death occur? Month _____ Year _____

9. The VA is considering a program to assist Veterans in dealing with grief. Would you be interested in attending a gathering to discuss how best to help Veterans deal with losing fellow Veterans? ___Yes ___No

***If question 9 is answered “No” Voice of the Veteran Questions are complete.

10. If you are willing to attend a gathering what location would be best for you?

READ ALL RESPONSES:

a. Robley Rex VA Medical Center

b. Community Out-Patient Clinic (CBOC)

c. Local Disabled American Veterans (DAV)

d. Local Veterans of Foreign War (VFW)

e. Other:_________________________________________
Appendix B

Consent Form

You are invited to participate in a “Voice of the Veteran” interview that is being conducted with veterans at the different community out-patient clinics (CBOCs) by patient ambassadors in January and February. This short survey is about past and present losses you have experienced in your life, and how you are dealing with them. You will not be asked to include your name or any identifying information. Your responses are completely confidential. The interview should take about 10 minutes. Your participation is voluntary and you may quit at any time, or decline to answer any questions that make you uncomfortable. You will not be asked to do anything that exposes you to risks beyond those of everyday life. The benefit of the study is to help us know whether there is a need for a veteran-specific grief program which would help Veterans deal with past and present losses, specifically losses of fellow veterans during or after military service. If you feel comfortable participating in this study, please verbally consent and I will begin the questions.


