NAZARENE THEOLOGICAL SEMINARY

POST TRAUMATIC STRESS DISORDER (PTSD): A STUDY OF THE SPIRITUAL EFFECTS AND RELATION OF COMBAT PTSD TO RECOVERY

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POST TRAUMATIC STRESS DISORDER (PTSD): A STUDY OF THE SPIRITUAL EFFECTS AND RELATION OF COMBAT PTSD TO RECOVERY

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ABSTRACT

Daily, I encounter many Veterans who have Substance Use Disorder (SUD), but behind the SUD often lies Post Traumatic Stress Disorder (PTSD). In my research, I have found that many of these Veterans suffer from a particular type of PTSD, combat PTSD, and some from an injury to their soul. I asked a diverse group of co-morbid SUD and PTSD sufferers to provide commentary about their experiences and about the role of spirituality in their recovery. Respondents were given a semi-structured qualitative interview and their responses were sorted. Findings suggest a strong support for spirituality as an aid to PTSD recovery.

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CHAPTER ONE

WHY THIS STUDY?

I am a chaplain with the Veterans Administration (VA). Currently, I work with Veterans[1] who have substance abuse issues and are diagnosed with Substance Use Disorder (SUD). These Veterans use the Twelve Step programs offered through Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). There is a spiritual component inherent in both of these programs. Veterans who have returned to the AA/NA program tell me that if they forego the spiritual component, their recovery won't last. One said, "You have two choices: get spiritual help, or die." Many of these Veterans have admitted to me that they drink or use drugs so they can either not remember or forget something that lies beyond, something traumatic. Another said, "I have nightmares. I drink so I can sleep." The temporary solution to their problem then becomes another problem. Howard Wasdin, a Veteran involved in the battle for Mogadishu, Somalia, which was famously portrayed in the book and movie, *Black Hawk Down*, said, "When you hurt on so many levels, alcohol-induced numbness becomes addictive."[2]

Many of these Veterans I work with also have a diagnosis of Post Traumatic Stress Disorder (PTSD). Some may be officially diagnosed by the Veterans Administration (VA) with PTSD, while others may be pursuing this diagnosis and may self-report.

[1] I capitalize the word "Veteran" as both a title and to show deep respect for those who have put on a uniform.

[2] Howard Wasdin and Joel Kilpatrick, *The Last Rescue: How Faith and Love Saved a Navy SEAL Sniper*, (Nashville, TN: Nelson Books, 2014), 76.

PTSD is pernicious and devastating. Many Veterans suffer throughout their lifetime due to one experienced event.

A 2008 telephone study conducted by the RAND Corporation of 1,965 previously deployed Veterans found that 14 percent of them screened positive for PTSD. The researchers speculate, "Assuming that the prevalence found in this study is representative of the 1.64 million service members who had been deployed for OEF/OIF[3] as of October 2007, we estimate that approximately 300,000 individuals currently suffer from PTSD or major depression."[4] While PTSD is identified as a stress disorder, it is not the same as depression. Perhaps other studies will look at only PTSD. While acknowledging these differences, the numbers of those suffering from PTSD can only have increased since that time.

There are many treatment modalities for PTSD that address some of the issues presented. These are often addressed from a psychological basis, not a spiritual basis.[5] And yet, some of the trauma incurred may have its roots in the spiritual realm, not the psychological. If spirituality is important for SUD, could it not also be important for a traumatic event like PTSD?

All who minister to active duty and reserve military, Veterans, and their families, are in a unique position to serve, listen, and help. Military and VA Chaplains are especially important as this is their primary field of service, training, and often, interest. It is also

[3] OEF refers to Operation Enduring Freedom, U.S. military operations in Afghanistan; OIF refers to Operation Iraqi Freedom, U.S. military operations in Iraq.

[4] Terri Tanielian and Lisa H. Jaycox, editors, "Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery." xxi, http://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG720.pdf (Accessed November 4, 2014.)

[5] While I am not setting up an adversarial distinction between the bases, I am merely stating that the basis often forms the approach.

easy to identify with another's reality if one is proximal to that reality. There are times when as a military chaplain, I had a captive audience: I lived, slept, ate, and played where I worked, as did my parishioners. I can identify with my Veterans because I was a part of that reality. I was an active duty Marine and later, a Navy Chaplain. I have been deployed and have also been in combat areas. Because I can identify, my role is to listen, and then to guide them to applying their faith to their lives by advocating the very faith they espouse. For some, the goal is to encounter a living, vibrant faith. This is, and has been, my parish.

While there have been numerous studies of patients with co-morbid SUD and PTSD, and some have focused on Veterans,[6] it seems the majority have discussed general PTSD. I will argue later that this is not the kind of PTSD Veterans may be exposed to in combat.[7] If what I see in a SUD domiciliary is an indication of the Veteran population, then the trend for co-morbidity seems to be increasing for this population. Still, even though some of these studies do not focus solely on Veterans, the information is interesting and may be applicable to Veterans. Pamela Brown's study on women found that targeted treatment for co-morbid PTSD and SUD might benefit both disorders.[8] Another study by Brown focused solely on relapse by women, thereby making the

[6] D. Scott McLeod, et al., "Genetic and Environmental Influences on the Relationship among Combat Exposure, Posttraumatic Stress Disorder Symptoms, and Alcohol Use." *Journal of Traumatic Stress*, 14(2)(2001):259-275.

[7] Joshua Dolan, "Treatment of Dual Diagnosis Post Traumatic Stress Disorder and Substance Use Disorders: A Meta-Analysis." (2012). Marquette University Dissertations (2009 -). Paper 177. http://epublications.marquette.edu/dissertations_mu/177(Accessed September 25, 2014.)

[8] Pamela J. Brown, "Outcome in Female Patients with both Substance Use and Post-Traumatic Stress Disorders. *Alcoholism Treatment Quarterly*, 3, Vol 18, (2000):127.

results potentially inapplicable to male subjects.[9] And yet, there have been some promising findings. In another study, Brown says, "When one disorder worsened, the other disorder was more likely to worsen. When one disorder improved, the other disorder was likely to improve as well."[10] This is an indication that these disorders should be treated concurrently, not separately.

This is also a clarion call for more research. Brown reports,

> Traditionally, substance abuse researchers and PTSD researchers have worked in mutually exclusive organizations and programs, have received funding from separate government agencies, and have disseminated their findings in different specialized journals. Clearly, the schism between the two fields must be bridged if we hope to develop effective, integrated, comprehensive treatments for patients suffering from both SUDs and PTSD.[11]

Pastors, ministers, rabbis, and chaplains may encounter, or have congregations with, Veterans who cross the spectrum of multigenerational, socio-economic, racial, cultural, gender, and spiritual/philosophical boundaries, as well as type and severity of PTSD, length of deployment, type and branch of service, and type and severity of SUD.

The theme of this project is to study what effect spirituality (and the lack of) has on both PTSD and recovery from PTSD, and the relationship of recovery to faith, to give the pastor[12] a means of working with the Veteran. This can be done by understanding the

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[9] Pamela J. Brown, Robert L. Stout, and Timothy Mueller, "Posttraumatic Stress Disorder and Substance Abuse Relapse Among Women: A Pilot Study." *Psychology of Addictive Behaviors*, 2, Vol 10, (1996):124-128.

[10] Pamela J. Brown, Robert L. Stout, and Jolyne Gannon-Rowley, "Substance Use Disorder-PTSD Comorbidity: Patients' Perceptions of Symptom Interplay and Treatment Issues." *Journal of Substance Abuse Treatment*, 5, Vol 15, (1998):447.

[11] Pamela J. Brown, and Paige C. Ouimette, "Introduction to the Special Section on Substance Use Disorder and Posttraumatic Stress Disorder Comorbidity." *Psychology of Addictive Behaviors*, 2, Vol 13, (1999): 77.

[12] Here I include any clergyperson, in a variety of contexts, that work with and minister to Veterans.

processes involved in getting the Veteran to that point, knowing one's own limitations, and by knowing when to refer to appropriate help.

Available research on spirituality will be presented, combined with current qualitative interviews from a sample of Veterans with PTSD. The subjects were Veterans recruited from public recovery programs for SUD, as there are none locally for PTSD. The parameters used to establish PTSD are included as Appendices B and C.

Suggestions are given as to how this may then be utilized by clergy, pastors, and chaplains. My prayer is that neither the Veteran nor the one trying to help him or her feel alone.

This paper addresses:

1. How have combat experiences (combat PTSD) affected one's faith?
2. How has a recovery program affected faith?
3. How has faith affected PTSD and Substance Use Disorder (SUD)?
4. Is recovery from SUD also helpful in recovery from PTSD if it involves a spiritual component?

The five chapters in this paper, followed by appendices, are as follows:

Chapter 1 Why this Study?
This chapter gives an overview of the paper and introduce the purpose of the study.

Chapter 2 What the Experts Say
This chapter addresses what the current literature has informed the various components and issues surrounding PTSD.

Chapter 3 Nuts and Bolts of Research: Understanding this Audience
This chapter describes the specific components and complete flow of the plan developed from research to address the contextual problem God is helping us to address.

Chapter 4 What this Audience Says
This chapter records and organizes all data gathered during the project.

Chapter 5 Summary and Conclusions: What Now?
This chapter summarizes and analyzes the data to discern what worked and why, and what did not work and why. I also include recommendations for future study.

Appendix A: Informed Consent Form

Appendix B: Burns PTSD Scale

Appendix C: PCL-5 PTSD Checklist

CHAPTER TWO

WHAT THE EXPERTS SAY

Theme

The theme of this project is to study what effect spirituality (or the lack of) has on both PTSD and recovery from PTSD, and the relationship of recovery to faith, to give the pastor a means of working with the Veteran. To do so, it is necessary to look at the available literature that surrounds this subject. We begin with some operational definitions, followed by a discussion of each as to the applicability to this subject.

Operational Definitions

PTSD

PTSD is considered a psychiatric disorder. There have recently been discussions about whether to call this Post Traumatic Stress or Post Traumatic Stress Disorder.[13]

In 2013, the American Psychiatric Association (APA) revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5). While there were changes made throughout the criterions A-G, those most applicable to spirituality involve two criteria: Criterion A: Stressors, and Criterion D: Negative alterations. The current diagnostic for the two criteria are specified below:

Criterion A[14]. Exposure to actual death or threatened death, actual or threatened serious injury, or actual or threatened sexual violence in one (or more) following ways:

[13] The Department of Defense (DOD) seems to believe that warriors, having gone through combat, may admit to having stress, but feel the labeling of "disorder" as pejorative. The APA and DOD disagree on the title.

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the event(s) as it occurred to others
3. Learning that the traumatic event(s) occurred to a close family member or close friend was exposed to trauma. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s), usually in the course of professional duties (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless the exposure is work related.

The only change to this criterion is that the DSM-IV noted "The person's response involved intense fear, helplessness, or horror."[15] This has been removed in the DSM-V. While the DSM-V has been in print since 2013, it takes time for agencies to change paperwork, reporting, and mindset. At the time this paper was written, change was on-going in the VA.

Criterion D[16]: Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs)
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined")

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[14] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. (Arlington, VA; American Psychiatric Publishing, 2013), 271.

[15] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. (Arlington, VA; American Psychiatric Publishing, 2000), 467.

[16] American Psychiatric Association, *DSM-5.*, 271-272.

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that led the individual to blame himself/herself or others
4. Persistent negative emotional state (e.g. fear, horror, anger, guilt, or shame) [trauma- related emotions]
5. Markedly diminished interest or participation in significant activities [pre-traumatic]
6. Feeling detachment or estrangement from others [alienated]
7. Persistent inability to experience positive emotions (e.g. inability to experience happiness, satisfaction, or loving feelings) [constricted affect]

The criteria for PTSD are not combat-specific, i.e., the stressors can come from events in everyday life unrelated to combat. Simply put, PTSD can be described as "I saw," "I experienced," "I felt." Also, PTSD sufferers vary in their response, their severity, and, ultimately, their recovery, based on many factors, one of which is prior trauma exposure. David Wood reminds us that much of the body's response to danger is a survival tactic, which is a good thing when one is in a survival situation, "Many of the symptoms of post-traumatic stress—nervousness, insomnia, anxiety in crowds, jumping at a sudden loud noise—are primitive, involuntary instincts necessary to survival in a combat zone."[17] But after the situation passes, these same survival skills can hamper function. As Jennifer Vasterling, et al, relate, "All service members must learn skills that are essential, but specific, to survival in a combat environment; these same skills, if not sufficiently adapted, can lead to significant problems upon returning home."[18] This transition, from combat with skills learned leading to survival, to a civilian setting

[17] David Wood, "Iraq, Afghanistan War Veterans Struggle With Combat Trauma", http://www.huffingtonpost.com/2012/07/04/iraq- afghanistan-war-veterans-combat-trauma n 1645701.html. posted 7/4/2012, 6, (Accessed July 9, 2012.)

[18] Jennifer J. Vasterling, Erin S. Daly, and Matthew J. Friedman, "Posttraumatic Stress Reactions Over Time: The Battlefield, Homecoming, and Long-term Closure," ed. Josef I. Ruzek, et al., *Caring for Veterans with Deployment-Related Stress Disorders: Iraq, Afghanistan, and Beyond*. (Washington, D.C.: American Psychological Association, 2011), 40.

where a new set of skills need to overwrite previous learning, is fraught with stress. Some never make this transition.

For Criterion A, Bruce P. Dohrenwend looked at the roles of three primary factors; severity of combat exposure (e.g., life experiences or traumatic events during combat), pre-war vulnerabilities (e.g., childhood physical abuse, family history of substance abuse) and involvement in harming civilian or prisoners. While the severity of combat exposure was the strongest predictor of whether the soldiers developed PTSD, pre-war vulnerability was just as important in predicting the persistence of the PTSD over time.[19]

Jonathan Shay uses a term that for me differentiates the complex PTSD many combat Veterans have, "combat post-traumatic stress disorder."[20] Combat PTSD may differ from other types of PTSD in that there may be an elevated sense of danger. Jennifer Vasterling tells us, "The battlefield differs from many other life-threatening contexts. Dangers often persist for days or months at a time, potentially leading to prolonged stress responses."[21] Responses to stressors are often learned. Virtually every combat Veteran I have talked to has suffered from some form of hyper-vigilance and hyper-alertness, responses forged in the stressors of the heat of battle.

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[19] Bruce P. Dohrenwend, et al., "The Roles of Combat Exposure, Personal Vulnerability, and Involvement in Harm to Civilians or Prisoners in Vietnam War-Related Posttraumatic Stress Disorder," *Clinical Psychological Science*, 10, Vol 20, (2012): 12-13.

[20] Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character.* (NY: Simon and Schuster, 1995), xx.

[21] Jennifer J. Vasterling, "Posttraumatic Stress Reactions Over Time: The Battlefield, Homecoming, and Long-term Closure," In *Caring for Veterans with Deployment-Related Stress Disorders: Iraq, Afghanistan, and Beyond*, 37.

The result? As Edward Tick puts it, "In war, chaos overwhelms compassion, violence replaces cooperation, instinct replaces rationality, gut dominates mind."[22] The responses learned in war do not end when the war ends. Daniel Pitchford elaborates, "War changes people. Even more, a person who experiences war endures the worst of humanity in that he or she must choose to kill or be killed or even to flee so that so-called safety and refuge can be found."[23] Simply put, combat PTSD may have an element of "I did." These experiences affect the mind and the soul.

PTSD can happen to anyone, given the right (or wrong) circumstances. It also affects people in unique ways. Their reactions may seem abnormal and may cause them to wonder if that is normal behavior. This tension is explained by Victor Frankl, "An abnormal reaction to an abnormal situation is normal behavior."[24] The one changed remains changed. A return to normalcy is an exercise in futility because the abnormality of experience changes what was once normal; the old normal is no more. The search begins for a new normal.

It may pay to bear in mind what Nigel Biggar said of war and apply it to PTSD, "The danger, however, is that intellectual tidiness with its careful logic, clear concepts, and nice distinctions ceases to do justice to the intractable messiness of flesh-and-blood

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[22] Edward Tick, *War and the Soul: Healing Our Nation's Veterans from Post-Traumatic Stress Disorder*. (Wheaton, IL: Quest Books, 2005), 16.

[23] Daniel Pitchford, "An Existential Study of Iraq Veterans' Traumatizing Experiences," UMI: 3339401, San Francisco: Saybrook Graduate School and Research Center, 2008, 9.

[24] Victor E. Frankl, *Man's Search for Meaning*. (Boston: Beacon Press, 2006), 20.

human experience—that it buys clarity at the expense of reality."[25] The reality is that as war is messy, so also PTSD is messy and may require a variety of approaches from multiple disciplines, a true multidisciplinary team approach. Another reality, as shown in the many criteria for it, is that PTSD sufferers may have both similar and dissimilar experiences. This is also true for depth of trauma, support systems, and successes in recovery.

Robert Certain seems to agree when he speaks about society providing a "'lifeline' anchored to society's ethical core."[26] He continues, "It is also important that some sort of mechanism be in place to 'reel in the lifeline' when the battle is done. Parades and medals provide a secular answer; confession and absolution provide the religious answer."[27] To go further, the answer may lie in confession and absolution within a community of faith, guided by Scripture, and using the discipline of prayer.

SUD

It has already been mentioned that Veterans may have co-morbid disorders. SUD is one that is presented frequently. SUD has several elements involved. The DSM-5 tells us, "The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems."[28] In other words, the substance itself overwhelms the individual's resources, including the will, to not use.

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[25] Nigel Biggar, *In Defence of War.* (Oxford: Oxford University Press, 2014), 4.

[26] Robert Certain, *Unchained Eagle: From Prisoner of War to Prisoner of Christ*. (Palm Springs, CA: ETC Publications, 2003), 275.

[27] Ibid., 275.

[28] American Psychiatric Association, *DSM-5*, 483.

Confession

There are several questions that need to be answered. The first one is, how is confession defined? Perhaps it would be easier to begin with the word "confess". What does "confess" mean?

The American Heritage Dictionary defines "confess"[29] as a transitive verb:

1. to disclose or acknowledge (something damaging or inconvenient to oneself); admit

2. to acknowledge belief or faith in

3a. to make known (one's sins) to God or to a priest

3b. to hear the confession of (a penitent)

It also includes the use as an intransitive verb:

1. to admit or acknowledge

2. to tell one's sins to a priest

Confession, then, would be the act of confessing. Using the above definition, confession has in this paper two different elements: 1) "I have it." This is the admission. This type of confession is the entry point for identifying Veterans with PTSD, where they can be officially diagnosed with the label of PTSD. (They can be self-identified, but then the VA, and by extension, Chaplains Service, does not officially enter into the picture.)[30] 2) "I did it." This is the disclosure. Both of these elements are necessary for healing to occur. Once identified, the Veteran can then relate their story of what transpired. These

[29] *American Heritage Dictionary.* 2nd college ed. (Boston: Houghton Mifflin, 1982), 308.

[30] The research in this paper will focus on both officially diagnosed and self-diagnosed PTSD sufferers.

recollections are sentinel events, a "something happened that I will never forget" experience. These sentinel events may consume one's thoughts. Confessing them can be therapeutic. A burden shared often becomes a burden lifted.

Additionally, confession often involves relating that confession to a clergy member and, perhaps, making a faith statement. So, all the aspects of the word "confess" may be utilized.

The Bible tells us in James 5:16, "Therefore, confess your sins to one another, and pray for one another so that you may be healed. The effective prayer of a righteous man can accomplish much."[31] This may be difficult. While some may agree that there is sin involved in the events that led to PTSD, others may not agree. Yet, they may agree that all is not well, that something burdens them. Confession, while painful, is necessary to recovery. Confession, then, may be used to lighten the load that burdens by sharing with someone who will listen in a caring, supportive way.

Alcoholics Anonymous (AA) uses a spiritual form of confession, especially in Step 4 and Step 5. Members are to "make a searching and fearless moral inventory of ourselves" (Step Four); and "admit to God, to ourselves, and to another human being the exact nature of our wrongs." (Step Five).[32] Mental health professions are valuing and discussing the role of faith in mental health. Recently the VA has had several

[31] *New American Standard Bible (NASB)*, (Lockman Foundation, 1995), James 5:16. (All biblical quotations used in this paper are from the NASB, unless otherwise noted.)

[32] Alcoholics Anonymous, *Twelve Steps and Twelve Traditions*, (NY: Alcoholics Anonymous World Services, Inc., 2009), 6.

conferences on "Bridging Mental Health and Chaplaincy" and produced videos on that subject. Simon Dein tells us, "The evidence suggests that, on balance, religious involvement is generally conducive to better mental health."[33] He continues, "A person's strong religious beliefs may facilitate coping with existential issues whereas those who hold weaker beliefs may demonstrate heightened anxiety."[34] He suggests that mental health "…therapists must endeavor to understand the patient's worldview and, if necessary, consult with clergy."[35] Since one's worldview often reflects their faith, then therapists must seek to understand the patient's faith that impacts on the therapy. Working with SUD Veterans, I have found that many combat Veterans who self-medicate do so in order to forget and/or to not remember certain memories. PTSD may be centered in, and a result of, those memories.

Discussion

Individual Confession

Confession can be made to one person or to the church. For individuals, Martin L. Smith tells us, "Only the act of bringing everything out into the full light of day in the presence of another will suffice to bring release and relief, the assurance of really handing over sin to God."[36] George Bowman reminds us, "It is God against whom sin

[33] Simon Dein, "Religion, Spirituality, and Mental Health: Theoretical and Clinical Perspectives," *Psychiatric Times*, 1, Vol 27, (January 2010): 1.

[34] Ibid., 3.

[35] Ibid., 5.

[36] Martin L. Smith, *Reconciliation: Preparing For Confession in the Episcopal Church*. (Cambridge, MA: Cowley Publications, 1985), 22.

has been committed and it is God who clears the guilt and forgives the sinner."[37] Obviously, Bowman ties confession to sin. I must note that I have spoken with Veterans who feel guilt but may not agree with the concept that they have sinned.[38] And yet they feel guilt. This guilt may be a desire for restoration. Restoration to what? It is a restoration to normalcy, to God, to self-image, to identity, to innocence, and/or to the past. This desire for restoration can only come about because something is broken, and that something is often a negative view of self. Many times this is relational, self in regard to something else, someone else, or the Other. This negative view of self in regard to God is something that will be addressed later in this chapter, under the heading "Guilt". Brokenness does not necessarily have to be sin, but rather, a disruption of the familiar based on one or several sentinel events that may be or are life-changing. Some individuals may prefer private confession over public or corporate confession. A preference for private confession, David Belgum informs us, is due to, "The plea for privileged communication and the secrecy of private confession is due to the rejection, which to the sinner seems inevitable, were the congregation to know his true nature."[39] If we regard the one who confesses as disabled, then, "A truly functional confession aims at restoring the disabled's integrity and self-regard, returning him to the community from which he has alienated himself, and to loving service in holy stewardship of the life God has given him."[40]

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[37] George W. Bowman III, *The Dynamics of Confession.* (Richmond, VA: John Knox Press), 1969, 24.

[38] Sin is a theological term and needs to be introduced here, but it is not a condemnation of individuals for the impossible situations the military often puts them in, often through no fault of their own.

[39] David Belgum, *Guilt: Where Psychology and Religion Meet*. (Englewood Cliffs, NJ: Prentice-Hall, 1963), 13.

[40] Ibid., 140-141.

Corporate Confession

While confession can be personal, on a one-to-one basis,[41] it can also be corporate. Aaron Murray–Swank, et al., tells us that, "Spiritual confession, when it is practiced in a group or between two individuals, is likely to promote a sense of connectedness through the expression of personal sinfulness in a shared context of beliefs and value regarding sin."[42] One method for dealing with this is a Service/Sacrament/Rite of Reconciliation. The Catholic Sacrament of Reconciliation "(also known as Penance, or Penance and Reconciliation) has these three elements: conversion, confession and celebration."[43] Many high liturgical churches (Catholics,[44] Orthodox,[45] and Episcopalians[46]) have this rite or sacrament. Interestingly, Nazarenes also have this as a suggested rite, called a Service of Reconciliation.[47]

Admission of the pain is a confession, of sorts, or at least an initial movement toward the actual precipitating causes. Public articulation of the pain can then lead to finding

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[41] Jim Forest, *Confession: Doorway to Forgiveness*. (Maryknoll, NY: Orbis Books, 2002), xiv.

[42] Aaron B. Murray-Swank, Kelly M. McConnell, and Kenneth I. Pargament, "Understanding Spiritual Confession: A Review and Theoretical Synthesis," *Mental Health, Religion, and Culture*, 3, Vol 10, (May 2007): 284.

[43] "The Sacraments: Reconciliation," http://www.americancatholic.org/features/special/default.aspx?id=32 accessed March 23, 2013.

[44] Donal O.Cuilleanain, *A Guidebook for Confession: The Sacrament of Reconciliation*. (Princeton: Scepter Publishers, 1996), 10-11.

[45] Jim Forest, xii-xvi.

[46] Book of Common Prayer, http://www.bcponline.org, 457-452. (Accessed March 23, 2013.)

[47] Jesse C. Middendorf, *Church Rituals Handbook*. 2nd ed. Church of the Nazarene, (Kansas City: Beacon Hill Press, 2009), 202-210.

meaning through the pain. This can often find expression in the public sense. In this public sense, Walter Brueggemann speaks of embracing rather than eradicating, managing, or even tolerating pain. To embrace the pain, not just on an individual level, but on a corporate and communal level, means a "public processing of pain."[48] It is this public articulation of pain that leads to the public processing of pain that is necessary for the individual to release the pain. Shay addresses this when discussing recovery. Using Homer's *The Illiad* as a reference point, and the main character Achilles as a model, Shay argues, "… that healing from trauma depends upon communalization of that trauma…."[49] When a community can embrace the pain, then the community can assist the individual to begin the healing process.

It is also this public articulation of pain that begins to foster hope. Brueggemann continues, "… Hope emerges among those who publicly articulate and process their grief over their suffering."[50] This hope leads to a rebuilding of faith. The faith community empowers the individual to acknowledge and rise above the pain. Because of this, Brueggemann can say, "All faithful theology begins in pain."[51] While Brueggemann sees suffering as theological, Frankl sees suffering as existential, "To live is to suffer, to survive is to find meaning in the suffering. If there is a purpose in life at all, there must be a purpose in suffering and in dying."[52]

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[48] Walter Brueggemann, *Hope Within History*. (Westminster: John Knox Press, 1987), 16.

[49] Jonathan Shay, xx.

[50] Walter Brueggemann, *Hope Within History*, 84.

[51] Ibid., 114.

[52] Victor E. Frankl, 11.

Surrender

Christopher Dyslin connects confession with spiritual surrender. He says, "I propose here that the confession of sin to another person is the active ingredient in spiritual surrender, a pride-destructive force, as well as a chief venue of grace."[53] Confession, then, leads to willful surrender. Dyslin continues, "As one surrenders spiritually, that willingness reflects an increasing acceptance of the truth about the limitations of human power and control and growing recognition of reality regarding the ultimate source of power."[54] AA recognizes that growth only comes through surrender. Step Three says, "Made a decision to turn over our will and our lives to the care of God as we understood Him."[55] This echoes what is said in James 4:7, "Submit therefore to God. Resist the devil and he will flee from you."

Repentance

Much of the literature dealing with confession refers to something that precedes repentance, namely confession. Smith tells us, "… repentance is not just regret for past wrongdoing but a change of heart, a change of direction, a matter of conversion or reconversion to God."[56]

The Bible tells us in Acts 26:20 that repentance is a turning to God, "… that they should repent and turn to God…." This passage continues that this repentance leads to "…

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[53] Christopher W. Dyslin, "The Power of Powerlessness: The Role of Spiritual Surrender and Interpersonal Confession in the Treatment of Addiction," *Journal of Psychology and Christianity*, 1, Vol 27, (Spring 2008): 49.

[54] Ibid., 43.

[55] Alcoholics Anonymous, 5.

[56] Martin L. Smith, 21.

performing deeds appropriate to repentance," to "… do works worthy of repentance,"[57] and to "…do deeds consistent with repentance."[58] It also says earlier in Acts 11:18 that, "… repentance that leads to life."

Guilt/Shame

Criterion D in the DSM-5 is about "negative alterations in cognitions and mood that began or worsened after the traumatic event."[59] Symptom #3 specifically deals with blame: "Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences."[60] Confession as concerning PTSD may begin with guilt or shame.[61] This is consistent with many of the feelings associated with PTSD. Ashwin Budden reports, "In studies surveying a range of traumatic stressors, a small but significant percentage of people diagnosed with PTSD report feelings of shame and anger at the most intense moments of the traumatic events rather than fear and terror."[62] Shame and guilt affect both how PTSD is viewed (as a stress disorder or as an identity or recovery disorder) and how it is treated.

Guilt and/or shame are subjects that may be the foundation for the desire to confess. Guilt is referred to in different ways. Smith declares, "Carrying painful, unhealed

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[57] *Holman Christian Standard Bible (HCSB)*, Holman Bible Publishers, 2009, Acts 26:20.

[58] *New Revised Standard Version Bible (NRSV)*, National Council of the Churches of Christ in the United States of America, 1989, Acts 26:20.

[59] American Psychiatric Association, *DSM-5*, 271.

[60] Ibid., 272.

[61] While there is a difference between guilt and shame, for the purposes of this paper, there will be no distinction. The difference is mainly one of doing or having been done against: in guilt, one is acting, "I have done wrong" (deed); in shame, one is being acted upon, "I am wrong" (core identity). Many Veterans feel both shame and guilt.

[62] Ashwin Budden, "The Role of Shame in Posttraumatic Stress Disorder: A Proposal for a Socio-Emotional Model for DSM-V," *Social Science and Medicine*, Vol 69, (2009): 1033.

memories, self-mistrust or bitter shame uses up the energy and attention that ought to be available for living in the present and meeting its challenges."[63] Bowman tells us, "To face guilt is to face self."[64] Often, a Veteran may come face-to-face with his/her moral center. Murray-Swank, et al., say, "…guilt is an internal signal that shapes relationship-enhancing behavior."[65] The result? There is a difference between what was normative behavior and what is now normative behavior. Sometimes this includes a search for this "new normal." A Department of Veterans Affairs (VA) pamphlet tells us,

> These experiences can sometimes lead to long-lasting difficult spiritual and moral questions. The result may be loss of faith, increased guilt and self-blame, and alienation from other people and from God. Individuals may experience a disconnection between these beliefs they were raised with, their expectations about what military service would be like, and their actual war-zone experiences.[66]

Sometimes this tension is exacerbated by theologians and may cause further guilt. Richard Hays, in "Violence in Defense of Justice," asks the question, "Is it appropriate for those who profess to be followers of this gentle Shepherd to take up lethal weapons against enemies?"[67] Throughout his book, he lays a foundation for his response, so it is no great wonder what that response would be. His exegesis of the New Testament leads him to not allow violence in any form, even when in defense of those who are

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[63] Martin L. Smith, 34.

[64] George W. Bowman, 71.

[65] Aaron B. Murray-Swank, 283.

[66] "Spirituality and Trauma: Professionals Working Together," Department of Veterans Affairs, National Center for PTSD. Washington, D.C. http://www.ptsd.va.gov/professiona/pages/fs-spiritualtiy.asp, 2,(Accessed January 25, 2013.)

[67] Richard B. Hays, *The Moral Vision of the New Testament*. (NY: Harper Collins, 1996), 317.

vulnerable, or unprotected, or infirm, or young, or old. Further, to engage in violence is un-Christian. Therefore, a Christian can't be involved in war. He seems to imply that soldiers are sinners, simply because they are soldiers. This is not an uncommon sentiment that I have personally encountered in churches, denominational meetings, and seminaries.

Nigel Biggar refutes this by emphasizing that we all sin by our natures; not by the vocation: "On no occasion does it (the New Testament) suggest that a soldier's salvation involves the renunciation of military service as such."[68] Being a soldier is not a sin in itself. In Matthew 8:5-13 (also Luke 7:1-10), Jesus encounters an unnamed centurion. In 8:10, we read, "Now, when Jesus heard this, He marveled and said to those who were following, 'Truly I say to you, I have not found such great faith with anyone in Israel.'" And in Acts 10: 1-31, we find Peter who encounters, "… Cornelius, a centurion, a righteous and God-fearing and well-spoken of by the entire nation, all the Jews …." If there was ever an opportunity by Jesus and Peter to emphasize Hays' views and decry the profession of arms, these two are it. They do not do so, but instead praise the soldiers' faith.

We are all sinners, by nature, by commission, and by omission. Biggar goes on to note that if military service is not incompatible with Christian discipleship it must be compatible, "then we must infer that it (the New Testament) has no objection in principle to the publicly authorized use of lethal force."[69] He calls those who believe

[68] Nigel Biggar, 41.

[69] Ibid, 42.

that pacifism is the only response to Christ as "morally inconsistent", saying pacifists "…keep their hands clean only because others are required to get them dirty."[70] These two responses are important to the addition or assuaging of guilt. The viewpoint of Hays adds guilt to a situation that may already be, or potentially be, volatile, filled with remorse, and leading to despair. Biggar's response removes the guilt from being a warrior. Simply killing, then, is not unchristian: "Soldiers, whatever their nationality, are not murderers, but executioners."[71] While this distinction may be lost on some, for the warrior the distinction is clear. Biggar speaks of the "double effect" of the agent's intention and the reflexive impact, "Good effects I may intend, but evil effects I may accept only as a side effect."[72] The result may be killing, but not murder, "Morally speaking, deliberately to cause death in this fashion is not the same as intending to kill."[73]

How the individual views this distinction hinges on what the Bible says about killing. And this, in turn, depends on the version of the translation. The commandment from God, as expressed in the Ten Commandments as found in Deuteronomy 5:17 says, "You shall not murder." Interestingly, this wording in the *New American Standard Bible* is the same in most translations, including the *New Revised Standard Version*[74] and the *Holman Christian Standard Bible*.[75] The exception is the *King James Version* in that it

[70] Ibid., 43.

[71] Ibid., 82.

[72] Ibid., 93-94.

[73] Ibid., 101.

[74] *New Revised Standard Version Bible (NRSV)*, Deuteronomy 5:17.

[75] *Holman Christian Standard Bible (HCSB),* Deuteronomy 5:17.

says, "Thou shalt not kill."[76] If the majority translations are correct, then even the Bible, and therefore, God, differentiates between killing and murder. U.S. laws are based on the Ten Commandments, so we as a society also make a distinction between killing and murder.

To go further, in Hebrew, there is a difference between unlawful taking of life, תִּרְצָח (*ratzah),* as found in Exodus 20:13 and Deuteronomy 5:17, and of lawful taking of life, הָרַג (*harag),* as found in Exodus 32: 27-28. To conjoin the two Exodus passages, Moses is on the mountain receiving both the spoken word and the written word (the Ten Commandments) of God. He has been there for almost fifty days when God suddenly tells him in Exodus 32: 7 to "Go down at once!" When Moses gets to the encampment, he sees their sin, calls the people, and says, as recorded in Exodus 32:27-28, "Thus says the Lord, the God of Israel, 'Every man of you put his sword upon his thigh, and go back and forth from gate to gate in the camp, and kill every man his brother, and every man his friend, and every man his neighbor.'" Notice, Moses said, "God says." Since Moses was in the very presence of God and heard the voice of God speak, he knew what He said. Is Moses guilty of breaking the commandment, or is there a distinction between killing and murder?

If there is a distinction between killing and murder, then feelings of guilt may at times actually be false guilt. One way to see the difference is to remember and acknowledge that upon accepting God's forgiveness, God forgives, but also forgets, as found in Hebrews 10:17, "And their sins and their lawless deeds I will remember no more." If

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[76] *King James Version (KJV),* Public Domain, Deuteronomy 5:17.

one accepts God's forgiveness on Monday, if then on Tuesday one feels guilt for the same act, then it is certainly not from God but is false guilt sent from Satan.

Identity

Kent Drescher reports that this tension affects our thoughts, and, "Our thoughts can be erroneously deceptive, at times."[77] He explains that changing our thoughts is not easy, "Our thoughts are less under control than our behavior."[78] But going further, he says that all is not lost, "Our behavior ultimately influences our thinking, our judgment of who we are."[79] He asks, "Who am I? What say do I have in that process?"[80] And we can shape that process. He says, "Our identity is shaped by our actions. If we want to become a certain person, we have to act like that person."[81] We have a say in that development process of who we are to become. A saying in AA is "I am not who I was, and not yet who I will become." Many of the Veterans I encounter confuse the activity with the self. Another saying that cuts to the heart of this is, "I am not my addiction." Another comment heard is, "My past defines me." I counter with, "If your past defines you, your past confines you." Bring that past into the present. We are more than what we do. We are more than our failures or our successes. We are even more than the sum of our parts. And we do have a choice and a voice in who we are to become.

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[77] Kent D. Drescher, telephonic interview by author, National Center for PTSD, Menlo Park, CA, February 8, 2013.

[78] Ibid., interview.

[79] Ibid., interview.

[80] Ibid., interview.

[81] Ibid., interview.

Absolution

Smith believes the remedy is "…the grace of absolution. This grace is the actual release from guilt…."[82] Guilt can happen apart from an acknowledgement of sin. Sin is not necessary for guilt to happen. The goal is to relieve the guilt. Murray-Swank adds, "… many people viewed confession as an initial step to forgiveness and reconciliation with God, resulting in a decrease of guilt and anxiety."[83] Confession is the road to absolution, an acceptance of both God's forgiveness, and of one's own. Confession is not necessarily an admission of sin; it may be more of the feeling one has about something. Sometimes the confession is simply, "I feel guilt." Since many people admit to feeling guilt, to not admit that there is guilt brings its own problems. Forest reminds us, "…a sure symptom of moral death is not to feel guilty."[84] I would add, "If there is a reason to feel guilty." And if there is a reason to feel guilt, to then deny the guilt is to deny the grace of absolution.

Moral Injury

A VA pamphlet reminds us, "Additionally, in certain types of traumatic events, such as war, an individual can be both victim and perpetrator of trauma."[85] Alan Fontana tells us, "Feelings of personal responsibility for killing others and for failing to prevent the death of others are two sets of traumatic experiences that often accompany combat

[82] Martin L. Smith, 21.

[83] Aaron B. Murray-Swank, 281.

[84] Jim Forest, 6.

[85] "Spirituality and Trauma: Professionals Working Together," 2.

exposure."[86] The APA in their DSM-5 acknowledges this as a peri-traumatic factor that adds a layer to PTSD, "…for military personnel, being a perpetrator, witnessing atrocities, or killing the enemy."[87] Dave Grossman reports, "Killing comes with a price, and societies must learn that their soldiers will have to spend the rest of their lives living with what they have done."[88] Kevin Sites, an embedded reporter, quotes one Veteran, "'… it's not what I did in the war, it's what the war did to me.'"[89]

Combat-related PTSD gives rise to many questions, sometimes of an existential nature. Alan Fontana raises this issue, "Similarly, existential questions are qualitatively different from questions of interpersonal and social dysfunction in that the resolution of existential questions requires examination of the bases for moral judgments."[90] This brings up the issues of morals and moral injury. Brett Litz explains morals, "Morals are defined as the personal and shared familial, societal, and legal rules for social behavior, either tacit or explicit. Morals are fundamental assumptions about how things should work and how one should behave in the world."[91] Litz continues, "…moral injury involves an act of transgression that creates dissonance and conflict because it violates

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[86] Alan Fontana, and Robert Rosenheck, "Trauma, Change in Strength of Religious Faith, and Mental Health Service Use Among Veterans Treated for PTSD," *The Journal of Nervous and Mental Disease*, 9, Volume 192, (September 2004): 582.

[87] American Psychiatric Association, *DSM-5*, 278.

[88] Dave Grossman, *On Killing: The Psychological Cost of Learning to Kill in War and Society*. (NY: Back Bay Books, 2009), 194.

[89] Kevin Sites, *The Things They Cannot Say: Stories Soldiers Won't Tell You about What They've Seen, Done or Failed to Do in War*. (NY: Harper Collins Publishers, 2013), 162.

[90] Alan Fontana, 583.

[91] Brett T. Litz, et al., "Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy," *Clinical Psychology Review*, 2009, 29, 699.

assumptions and beliefs about right and wrong and personal goodness."[92] Everett Worthington adds, "Moral injury frequently involves religious or spiritual conflict."[93] For the purposes of this paper, moral injury and spiritual injury will be used interchangeably.

Presently, moral injury is not considered separate from PTSD. But there are some who feel that PTSD and moral injury are separate and distinct. Rita Nakashima Brock says, "Moral injury is not PTSD."[94] She continues, "Veterans with moral injury have souls in anguish, not a psychological disorder."[95]

For others, there seems to be a connection. Shira Maguen explains, "Thus, the key precondition for moral injury is an act of transgression…."[96] A formula could be: **PTSD + transgression = moral injury**. It is not PTSD that leads to moral injury, but PTSD plus an act of transgression. These acts may be more common when PTSD is a result of combat. Within that formula, Litz reports, "Killing, regardless of role, is a better predictor of chronic PTSD symptoms than other indices of combat, mirroring some of the results of atrocities."[97] Worthington echoes that sentiment but adds that

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[92] Ibid., 698.

[93] Everett L. Worthington and Diane Langberg, "Religious Considerations and Self-Forgiveness in Treating Complex Trauma and Moral Injury in Present and Former Soldiers," *Journal of Psychology and Theology*, 4, Vol 40, (2012): 281.

[94] Rita Nakashima Brock and Gabriella Lettini, *Soul Repair: Recovering from Moral Injury after War*. (Boston: Beacon Press, 2012), xiii.

[95] Ibid,, 51.

[96] Shira Maguen and Brett Litz, "Moral Injury in the Context of War," Department of Veterans Affairs, National Center for PTSD. Washington, D.C.: Government Printing Office. http://www.ptsd.va.gov/professional/pages/moral_injury_at_war.asp, 1,(Accessed January 25, 2013.)

[97] Brett Litz, 697.

killing in combat is "…better than virtually all other indices of combat."[98] And yet, killing, in and of itself, is not a universal guarantee of the onset of PTSD.

Shira Maguen summarizes this by saying, "Transgression is not necessary for a PTSD diagnosis nor does the PTSD syndrome sufficiently capture moral injury (shame, self-handicapping guilt, etc.)"[99] This is information that a pastoral response would need to know. While not all PTSD involves combat, when it constitutes part of the sufferer's PTSD, then a different set of questions need to be asked. While not all PTSD involves a spiritual injury, when the combat PTSD involves acts of transgression, then spiritual injury may be present. There may be a question whether one can have a spiritual injury without any PTSD.

Both of these terms, "moral injury" and "spiritual injury", may not fully and accurately reflect the pain the sufferer feels. Part of the reason for this may be that not all acts are transgressions but yet may still be causes. An example is driving a car in a neighborhood, obeying all the laws, yet unable to stop in time when a child runs from behind a line of parked cars to chase after a ball. While there may have been no ill intent, still the result is a child is dead. Did the driver transgress a legal or a spiritual law? No. Did the driver cause the child's death? Yes.

Another concern is not the denotation, but the connotation of either moral injury or spiritual injury. There is baggage with both terms. The most common concern I have heard with spiritual injury is, "I'm not spiritual." And with moral injury, does the term go deep enough? Is there something deeper than violating one's moral center?

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[98] Everett L. Worthington, 278.

[99] Shira Maguen, 2.

Consider the term "soul injury" that Deborah Grassman defines as "the un-mourned grief and unforgiven guilt that sometimes lingers in war's aftermath."[100] In highlighting both the grief and the guilt, the term "soul injury" combines the best of what we are trying to say when we use the terms "moral injury" or "spiritual injury" interchangeably while emphasizing a causal factor without emphasizing a transgression. The formula then becomes: **soul injury + PTSD = combat PTSD**. This is the operating definition we will use.

Even within this framework, why do two people, who have gone through similar events experience them differently? An example is Eli Wiesel and Victor Frankl. Both were Jews that experienced the horror of concentration camps during the Nazi Holocaust in WWII. Both lost family members, experienced privation, saw untold horrors. And yet, these experiences did not break the spirit of Frankl, who said "man can preserve a vestige of spiritual freedom, of independence of mind, even in such terrible conditions of psychic and physical stress."[101] Frankl wrote of his experiences in the concentration camps, as stated previously, "If there is meaning in life at all, then there must be meaning in suffering."[102] Contrast this with Wiesel, who spoke about his experiences, "Never shall I forget those moments which murdered my God and my soul and turned my dreams to dust."[103]

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[100] Deborah Grassman, "Wounded Warriors: Their Last Battle," Conference presentation, Midland, TX, March 6, 2015.

[101] Victor E. Frankl, 65.

[102] Ibid., 67.

[103] Eli Wiesel, *Night*. (NY: Bantam Books, 1982), 32.

Dohrenwend, et al, may have the answer to that question: prior traumatic experiences, prior mental health issues, and age.[104] Why age? This relates to the spiritual core of who humanity is, and how present experiences are filtered or seen through the lenses of past experiences. In other words, age may add to one's moral filter, giving it the ability necessary to filter out what harms one. Without age, without some exposure to the world through experience, one's moral filters may easily be overwhelmed. Frankl, 37, was an established psychiatrist before Auschwitz; before Auschwitz, Wiesel was a teenager.

It is interesting to note an older Wiesel was asked the question, "Do you still have faith in God as the ultimate redeemer?" His response may show the use of age as a filter, not just prior, but even after the traumatic experiences,

> I would be within my rights to give up faith in God, and I could invoke six million reasons to justify such a decision. But I am incapable of straying from the path charted by my forefathers, who felt duty-bound to live for God. Without the faith of my ancestors, my own faith in humanity would be diminished. So my wounded faith endures.[105]

It seems as if Wiesel was able to reframe his experiences through the lens of age and accumulated experiences, including the processing of his religious faith. Neither age nor time negates the experiences; rather, it reframes them in light of other experiences. The past is brought into the present, and filtered, for use in the future. Perhaps this reframing is a continual exercise and is necessary.

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[104] Bruce Dohrenwend, 14-15.

[105] Aron Hirt-Manheimer, "Against Indifference: A Conversation with Elie Wiesel," *Reform Judaism Online*. http://reformjudaismmag.org/Articles/index.cfm?id=1074&goback=%2Egde_108049_member_590968685042704384 3,(Accessed August 26, 2014.)

Self-Forgiveness

The reintegration of self may require exploring the concept of forgiveness, especially that of self-forgiveness. Julie Hall points out, "…reconciliation with the self is necessary in self-forgiveness."[106] What this means is that, "In order to truly forgive oneself, one must either explicitly or implicitly acknowledge that one's behavior was wrong and accept the responsibility of blame for such behavior."[107] The question for some Veterans is, interestingly, not if God will forgive them, but if they will forgive themselves. One Veteran I interviewed put it this way, "Even if God could forgive me, I can't forgive myself." Litz informs us, "The more time passes, the more service members will be convinced that not only their actions, but they are unforgiveable. In other words, service members and Veterans with moral injury will fail to see a path toward renewal and reconciliation; they will fail to forgive themselves and experience self-condemnation."[108] This self-condemnation can be manifested with such behaviors as "…shame, guilt, demoralization, self-handicapping behaviors (e.g., self-sabotaging relationships), and self-harm (e.g., parasuicidal behaviors)."[109] This may happen when forgiving oneself is seen as a sign of disrespect, as Hall points out, "A second frequent concern related to self-forgiveness is that it is a sign of disrespect toward the victim, and thus is only appropriate after the offender is granted forgiveness by the victim."[110] This

[106] Julie H. Hall and Frank D. Fingham, "Self-Forgiveness: The Stepchild of Forgiveness Research," *Journal of Social and Clinical Psychology*, 5, Vol 24, (2005): 624.

[107] Ibid., 626.

[108] Brett T. Litz, 700.

[109] Shira Maguen, 1.

[110] Julie H. Hall, 628.

does bring up the question: if the victim dies, does that negate the possibility of being forgiven and forgiving the self? Hall seems to answer this: "When an offender acknowledges and accepts responsibility for wrongdoing and is willing to apologize or make restitution to the victim, self-forgiveness is not a sign of disrespect."[111] This may be an intention if not an action. Finally, it is seen as a good sign that God can forgive, "There is preliminary evidence to suggest that perceived forgiveness from God is positively associated with self-forgiveness."[112] Worthington adds, "Often self-condemnation drives people to recognize their wrongdoing and further drives them back to God seeking forgiveness, healing, and restoration."[113]

Going back to moral injury, Worthington links the two, "Self-forgiveness is the culmination of moral repair (initiated by God's conviction and fulfilled by God's mercy and Jesus' sacrificial love), and the derivative social repair and psychological repair."[114] Worthington has designed an alliterative acrostic for steps to responsible self-forgiveness that anyone dealing with sufferers of PTSD could embrace, but especially pastoral counselors.[115]

There are six steps:
Step 1: Receive God's forgiveness
Step 2: Repair relationships
Step 3: Rethink ruminations
Step 4: REACH emotional self-forgiveness
R= recall hurt without blame

[111] Ibid. 628.

[112] Ibid., 630.

[113] Everett L. Worthington, 277.

[114] Ibid., 282.

[115] Ibid., 284-285.

E= emotional replacement
A= altruistic gift of forgiveness
C= committing publicly to forgiveness experienced
H= holding on to forgiveness when doubts arise

Step 5: Rebuild self-acceptance

Step 6: Resolve to live virtuously

This last step of Worthington: Resolving to live virtuously, is akin to the concept of spiritual growth. What is meant by spiritual growth? It is a maturation of faith, a deeper level of faith. Confession highlights a conversation sufferers have with themselves, as well as with others and with God. For some, to confess means not to deny anymore. Only in the admission can there be growth.

Forgiving God

Julie Exline has brought up another concern in the realm of forgiveness: forgiving God. She says, "What exactly does it mean to forgive God? .... Even if people do not believe that God has willfully harmed them, they may become intensely angry if they believe that God caused or allowed some highly painful or unfair event to occur."[116] While some may struggle with this concept, this inability to forgive God impacts the faith of many of the Veterans I see. Exline continues, "Such perceptions may prompt intense feelings of betrayal and rage, especially if God's actions are perceived as intentional, unjustifiable, and highly damaging."[117]

This theological question: "Did God allow or did God cause this event, this suffering?" is not an easy question to answer. Not to sidestep, but often when this question is asked of me, there is another question underneath, "Does God love me?" This may be asked in

[116] Julie J. Exline, Ann M. Yali, and Marci Lobel, "When God Disappoints: Difficulty Forgiving God and its Role in Negative Emotion," *Journal of Health Psychology*, 3, Vol 4, Issue 3, (1999): 366.

[117] Ibid., 367.

terms of "What did I do wrong?," "Why is God is punishing me?," and, "Is God loving?" All of these questions are questions of worth, value, meaning, and purpose. So I ask them to elaborate, "What do you mean when you ask this?" If I find that the question is one of the ones listed above, then I can respond to their pain. To the question of "Does God love me?" I respond with a resounding "Yes!" Only after finding the root question can we address other questions. I do add that God is grieving with them, a sharing of pain. To answer their question without knowing the journey they have crossed is to not help them. My role is to walk with them, often on their journey of self-discovery.

A VA pamphlet[118] favors asking about a patient's beliefs, using these questions that may be asked by anybody, as a spirituality tool:

> These questions are likely a useful starting place….
> 1. Are you affiliated with a religious or spiritual community?
> 2. Do you see yourself as a religious or spiritual person? If so, in what way?
> 3. Has the event affected your religiousness and if so, in what ways?
> 4. Has your religion or spirituality been involved in the way you have coped with this event? If so, in what way?

Confession also involves the sufferer's participation, his choosing a direction. Smith notes, "So, confession is often the beginning of a new sense of the weight and meaninglessness of our acts, and the need to choose, to commit ourselves and shapes our lives purposefully and consistently."[119]

Prayer

In formulating a pastoral theology of care for Veterans with PTSD, there is at least one principle that must be addressed, remembered, and kept foremost in the mind. Mark

[118] Ibid., 3.

[119] Martin L. Smith, 44.

Gignilliat, in exploring Karl Barth in his *Church Dogmatics*, says, "For Barth, all of one's theological exegetical labours from beginning to end must take place in the context of prayer."[120] He continues, "It conceives of the entire exegetical task as first and foremost an obedient exercise of prayer."[121] This principle of prayer before exegesis has just as much weight in formulating a pastoral theology of care for Veterans with PTSD. We are called to bathe the process, as well as the individual sufferer and the counselor, in prayer.

What kind of prayer? There are many types of prayer, as evidenced by the many books on the subject in both secular and Christian book-stores. A quick perusal shows titles like, "The ACTS Prayer," "The Prayer of Jabez," "Daniel's Prayer," and "The Lord's Prayer." While each of these prayers have a focus and application, the type of prayer can be left up to the individual. I am more interested in discussing the purpose, the power, and the practice of prayer.

What is the purpose of prayer? It is to know the mind of Christ and the will of God. It is to align oneself with that will. It is to change hearts and situations; often this means that the heart of the one who prays is changed. The founder of the Church of Nazarene puts it in a different way. Phineas F. Bresee put it this way, "The aim of the prayer meeting is to get heaven open and the glory down."[122]

We often pray when prayer is all we have. We come in apparent weakness, but leave filled with power. II Corinthians 12:9 says, And He has said to me, 'My grace is

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[120] Mark Gignilliat, "Ora et Labora: Barth's Forgotten Hermeneutical Principle," *Expository Times*, 6, Vol 120, (March 2009): 277.

[121] Ibid., 280.

[122] Cory Jones, "Repairing the Altar in the Church," http://nmi.nazarene.org/workshops/Files/Workshops/106/106JonesRepairingtheAltar2013.pdf, (Accessed April 17, 2015).

sufficient for you, for power is perfected in weakness.' Most gladly, therefore, I will rather boast about my weaknesses, so that the power of Christ may dwell in me." This type of prayer is passionate: out of our hearts, with our whole being, wrestling with God, as Jacob did at Peniel as recorded in Genesis 32:24-32. When we look at Jacob wrestling with God, and not letting go of God, we see the glory of God abiding.

What is the power of prayer? Prayer can change both hearts and situations. Remembering James 5:16, "Therefore, confess your sins to one another, and pray for one another so that you may be healed. The effective prayer of a righteous man can accomplish much." How much can be accomplished is evidenced in the Bible itself. In Exodus 32, we see that evidence in a very real way when God declares to Moses His intention to destroy the Israelites. Moses then intercedes for the people. And in Exodus 32:14 we see this amazing sentence on the effects of that intercession, "So the Lord changed His mind about the harm which He said He would do to His people." See the effect of prayer from one person who prays passionately!

What is the practice of prayer? The first part of the passage in James tells us to confess to, and pray for, one another. One can assume this means to do so often. Matthew 6:33 tells us, "But seek first His kingdom and His righteousness." We are to seek God: to seek His will, to seek His face, to seek Him. This is the spiritual discipline of prayer, a practice that I encourage the sufferer to adopt.

I find that once we are ready to pray, I invite the sufferer to tell what he or she wants me to pray for. I then pray for that. I have found that over time, the focus of the prayer changes, from self to others, from inward to outward. If the sufferer has been seeking God, then it is not one who prays, but a prayer meeting seeking God.

Hope

Kenneth Graham, on commenting on Storm Swain's research at Ground Zero for 9/11, quotes her:

> A resurrection mentality neither denies nor negates death but, rather, affirms that which is life giving beyond death, a resurrection life where one, at least in the case of Jesus in the Gospels, still bears scars of death but lives with them. This can be as profound as experiencing the presence of God and a transformation of self and as simple as the life-giving things one needs to do to live in the face of a disaster in the midst of a community of care.[123]

This theology of Christian resurrection amid unmentionable and indescribable trauma offers hope, while facing the devastation that has been evidenced, which often includes death. Facing trauma head-on, both the effects and the causes, allows recovery efforts to focus on the God-who-walks-alongside, the God of hope and healing.

This concept of God-who-walks-alongside may be attributed to Edward Shillebeeckx, who formulated a theology of suffering. Elizabeth Kennedy Tillar describes his theology in this way,

> His concept of beneficial suffering is defined in a two-fold way: (1) compassionate, inter-subjective service to individuals and (2) a critical orientation to unjust socio-political structures that dehumanize or oppress people. Suffering for others can take several forms, which are not perceived as exclusive of each other: suffering vicariously, instead of others; suffering with others for their benefit; and expiatory self-sacrifice. In Schillebeeckx's theology, suffering in any form is redemptive when it is unmitigated self-surrender through and for others in unwavering communion with God.[124]

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[123] Larry K. Graham, "Trauma and Transformation at Ground Zero: A Pastoral Theology," *Journal of Pastoral Theology*, 2, Vol 22, (Winter 2012): 7-4.

[124] Elizabeth K. Tillar, "Suffering for Others in the Theology of Edward Schillebeeckx," PhD dissertation, January 1, 2000. ETD Collection for Fordham University. Paper AA19955973. http://fordham.bepress.com/dissertations/AA19955973, 1, (Accessed July 9, 2012.)

Kathleen McManus adds this thought from Schillebeeckx, "… it is only obedience to God that can save us from—or rather through—suffering, sin, and evil."[125] The strength to come through suffering comes from God. She adds that Jesus' connection to humanity "lies in Jesus' own relationship of unbroken communion with God through suffering and death."[126] Suffering can be a form of communion with God and identity with Christ. This expression of suffering for and with others may be a vital link in recovery.

Sometimes hope can be kept alive by what we notice and appreciate. Tick speaks about one thing that may do this, namely beauty, "Beauty offers order, purpose and grace… without beauty your soul dies."[127] Sometimes an appreciation of what is beautiful, and this can be anything, can get us through the suffering.

Personality

In teaching, one learns that students learn differently. Some may be aural learners, while some are more visual. Some need to hear themselves recite, and others learn kinesthetically, by doing. Just as there are different learning styles, there are different personality styles or attitudes. Isabel Myers and Katherine Briggs, in developing the Myers-Briggs Temperament Inventory (MBTI), differentiated between the "attitudes" of introversion and extraversion. In extraversion, "attention seems to flow out, or to be drawn out, to the objects and people of the environment. There is a desire to act on the

[125] Kathleen McManus, "Suffering in the Theology of Edward Schillebeeckx," *Theological Studies* 60, (1999): 486.

[126] Ibid., 480.

[127] Edward Tick, 20.

environment to affirm its importance, to increase its effect."[128] This is understood to be where one recharges, where one feels ready to face a new day: with and around others. Public settings are desirable.

Conversely, in introversion, "energy is drawn from the environment and consolidated within one's position. The main interests of the introvert are in the inner world of concepts and ideas."[129] This is understood to be that one recharges in solitude and solitary activities. These may be activities as diverse as curling up around a book to read, communing with nature, walking the dogs, and hiking alone. The emphasis is not to be around other people.

The significance of this distinction between introversion and extraversion as personality attitudes is directly related to recovery efforts. How one relates to another may help determine the coping mechanisms that are used to aid in recovery. Where does one get strength to stay clean, dry, and sober? From others? From oneself? Where is the support system? From a group? From a select few individuals? To know the answers to these questions is to know an aspect of one's personality, and to know oneself helps to identify support systems that are vital in the recovery process. For example, AA has group meetings, which seems to help those with extraversion, but it also stresses an individual sponsor, which seems to help those with introversion.

Theology

While AA is secular, the founders freely spoke about their own spiritual experiences and their faith in God. The "Big Book" from Alcoholics Anonymous discusses faith and

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[128] Isabel Briggs Myers and Mary H. McCaulley, *Manual: A Guide to the Development and Use of the Myers-Briggs Temperament Indicator*. (Palo Alto, CA: Consulting Psychologists Press, 1985), 13.

[129] Ibid., 13.

submission or surrender in a Higher Power, and names it, by stating, "… we had to fearlessly face the proposition that either God is everything or else He is nothing. God either is, or He isn't. What was our choice to be?"[130] This states that God is the Higher Power. John Baker echoes this when he says, "You will never know that God is all you need until God is all you get."[131]

Jürgen Moltmann speaks of being transformed into the *Imago Dei*, the image of God, "When the crucified Jesus is called the 'image of the invisible God,' the meaning is that this is God, and God is like us."[132] This concept of God the Son suffering is further clarified, "And therefore, the suffering of abandonment is overcome by the suffering of love, which is not afraid of what is sick and ugly, but accepts it and takes it to itself in order to heal it."[133] What attracts converts to Christ is this theology of suffering, "To the extent that men in misery feel his solidarity with them, their solidarity with his suffering brings them out of their situation."[134] Even God suffers, "It is the unconditional and therefore boundless love which proceeds from the grief of the Father and the dying of the Son and reaches forsaken men in order to create in them the possibility and the force of new life."[135] Suffering, then, can not only be used for good, but can be necessary for true unconditional, or *agape*, love to come forth,

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[130] Alcoholics Anonymous , 53.

[131] John Baker, *Your First Step to Celebrate Victory: How God Can Heal Your Life*. (Grand Rapids, MI: Zondervan, 2012), 244.

[132] Jürgen Moltmann, *The Crucified God: the Cross of Christ As the Foundation and Criticism of Christian Theology*. (Minneapolis, MN: Augsburg Fortress Publishers, 1983), 205.

[133] Ibid., 46.

[134] Ibid., 51.

[135] Ibid., 245.

> He suffers because he lives, and he is alive because he loves. The person who can no longer love, even himself, no longer suffers, for he is without grief, without feeling and indifferent. Therefore the one who loves becomes vulnerable, can be hurt and disappointed. Where we suffer because we love, God suffers in us."[136]

Dietrich Bonhoeffer speaks similarly of being conformed to Christ, "and thus to be everything that God created him to be."[137] This means that we must be willing to suffer, "… he must drink of the earthly cup to the dregs, and only in his doing so is the crucified and risen Lord with him, and he crucified and risen with Christ."[138] It is the Resurrection that makes the suffering worthwhile.

This echoes Schillebeeckx's theology of suffering, for a cause, for others. There is strength in tying our suffering to that of Christ on the cross, and to that of God suffering watching him die. Ken Williams notes that a purpose of suffering is, "To share in Christ's sufferings, becoming like Him in His death."[139] This echoes Moltmann's thought of being transformed into the *Imago Dei*.

Frankl saw a meaning, even a beauty in suffering, but more for what could be learned rather than the *Imago Dei*. While not a theologian but rather a psychiatrist asking existential questions, he still gets to the root of the problem, as noted earlier, "If there is

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[136] Ibid., 253.

[137] Michael Van Dyke, *Radical Integrity: The Story of Dietrich Bonhoeffer*. (Uhrichsville, OH: Barbour Publishing, 2001), 178.

[138] Dietrich Bonhoeffer, *Letters and Papers from Prison.* Enlarged ed. (NY: SCM Press, 1971), 337.

[139] Ken Williams, "Toward a Biblical Theology of Suffering," http://www.google.com/search/q=theology+of+suffering&hl=en&safe=active&gbv=2&gs-l=serp.1.0.0j0i303l3j0i22l2.10110.10110.0.13922.1.1.0.0.0.219.219.2-1.1.0...0.0FeVvKueK4VM&oq=theology=of+suffering, 4, (Accessed July 10, 2012.)

meaning in life at all, then there must be meaning in suffering."[140] He might have agreed with Schillebeeckx in suffering for a cause.

Brueggemann speaks of prophets that remind the community both of their shared history and of their future together, all in and through God. He tells us, in his preface to *Prophetic Imagination*, what the community needs to "raise up prophets." These are as follows: a long and available memory, an expressed sense of pain, an active practice of hope, and an effective mode of discourse.[141] Brueggemann has expressed these themes before in other works, especially the idea of a communal cry of pain that serves as both an accepted release and lessening from pain and a foundation from which hope arises.[142] This communal cry of pain helps to frame the individual suffering. Brueggemann uses the Exodus from Egypt as a backdrop to subsuming the individual in and to the society. He says, "Israel's self-identity is from the outset a public one. From the beginning, personal life is experienced as participation in and appropriation of the public realities of oppression and pain."[143] The result? Brueggemann explains, "As Israel tells its faith-forming narrative, the pain is received, resolved, and honored by Yahweh, the Lord of the Exodus…."[144] Because we can see the pain of the individual and the community's response as a community, we can extrapolate to the current: what is our society's collective response to the individual sufferer of PTSD? For it is the individual who suffers individually, as part of the community, and, more importantly, on behalf of the

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[140] Victor E. Frankl, 67.

[141] Walter Brueggemann, *The Prophetic Imagination*. 2nd ed. (Minneapolis: Fortress Press, 2001), xvi.

[142] Walter Brueggemann, *Hope Within History,* 24.

[143] Ibid., 11.

[144] Ibid., 18.

community. Therefore, there needs to be a communal response, a veritable communal cry of pain. The prophetic voice that arises from these conditions has as its purpose "to nurture, nourish, and evoke a consciousness and perception alternative"[145] to the current dominant consciousness of the culture.

On a societal or cultural level, Tick argues that we have a quasi-warrior society. The entry point into this culture is Boot Camp. The reminders of the former life are taken away (hair, clothes, jewelry, and control over waking, bathing, dressing, and sleeping) and are being overwritten with the attributes of a new culture (uniformity, shared experience, devotion to duty, and obedience). Of this enculturation, Tick adds, "The second essential component for making wars is constructed around one very simple rule: kill the other before he kills you."[146] Herein is where we as a society fail the individual. Where other warrior societies, such as the Samurai of Japan or the Native Americans of the Western Plains of the U.S., had mechanisms to deal with all aspects of life, Boot Camp may be the initiatory and only such experience of the modern U.S. warrior. Upon returning from deployment to a war zone, there may not be much societal input, other than perhaps a parade and "Welcome Home" events. Tick emphasizes, "If and when soldiers do return after perhaps some initial fanfare they are expected to reintegrate into mainstream consumer culture with little or no help."[147] There are Veteran organizations such as the American Legion, Veterans of Foreign Wars, Purple Heart Society, and Disabled American Veterans, to name a few, but they are voluntary

[145] Walter Brueggemann, *The Prophetic Imagination*, 3.

[146] Tick, 87.

[147] Ibid., 65.

independent organizations. The result is that our Veterans have PTSD, which Tick defines as "a constellation of fixated experience, delayed growth, devastated character, interrupted initiation, and unsupported recovery."[148] In order to help our Veterans, which is to help our society, could we model both our treatment of PTSD and of being a Veteran, to the concept of an integrated warrior society, by at the least, having culturally supported recovery programs? While some may argue that this is best done by government, there is a compelling argument, backed by some of the resources already mentioned, that says churches and other private sources are better suited to meeting the needs of a mobile society. Currently, support groups are voluntary, are groups (therefore for extraverts), and, for those groups within the Vet Center,[149] are prohibited from identifying its clientele.

Treatment Modalities

Biology

Generally, there are three biological models that help explain PTSD–SUD co-morbidity. Bryce Hruska and Douglas Delahanty list them, "… the self-medication hypothesis, the substance-induced anxiety enhancement hypothesis, and the shared vulnerability hypothesis."[150] The first model focuses on PTSD leading to SUD; the second model

[148] Ibid., 107.

[149] The Vet Center Program was established by Congress in 1979 out of the recognition that a significant number of Vietnam era Vets were still experiencing readjustment problems, and had fears of reporting those problems. It is now for all Veterans, and is confidential. Some services are also available to family members.

[150] Bryce Hruska and Douglas Delahanty, "PTSD-SUD Biological Mechanisms: Self-Medication and Beyond," ed. Paige Ouimette and Pamela P. Read. *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorder*s. 2nd ed. (Washington, D.C.: American Psychological Association, 2014), 36.

inverts that; the third model suggests that they both occur about the same time. D. Scott McLeod, in looking at male-male twin pairs in which both members served in the military, seems to dismiss the first two models, "Taken together, these findings suggest that the self-medication hypothesis does not explain either the association between PTSD symptoms and alcohol use or between combat and alcohol use."[151] This goes against what Wasdin experienced, as quoted earlier, "When you hurt on so many levels, alcohol-induced numbness becomes addictive." It also goes against many of my own experiences working with Veterans, many of whom drank so they could quiet their minds enough to sleep. To quote again the unnamed Veteran from page 1, "I have nightmares. I drink so I can sleep." They drank to either not remember or to forget, at least temporarily.

Initially McLeod seems to favor the third model, while dismissing genetic factors,

> These findings are most consistent with the shared vulnerability hypothesis in that combat exposure, PTSD symptoms, and alcohol use are associated because some portion of the genes that influence vulnerability to combat also influence vulnerability to alcohol consumption and to PTSD symptoms. Specific unique environmental factors were, however, more important than genetic factors for PTSD symptoms and for current alcohol use.[152]

My experience, both before and after my research, suggests that there is a limited form of the self-medication hypothesis: some Veterans with intrusive PTSD memories may find their PTSD to be a cause of some SUD, which is then used as a coping mechanism by helping them either to forget or to not remember. Eventually the coping mechanism becomes another problem, which masks the original problem.

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[151] D. Scott McLeod, 272.

[152] Ibid., 270.

Psychology

Current psychological models for treatment revolve around empirically-based treatments. While each of these modalities require expertise, there is a discussion, especially around concurrent treatment, of using a care-team model, which "… does not require the individual practitioner to develop the type of expertise in multiple domains that may be difficult given finite resources for training and education available in some areas."[153]

Barbara Rothbaum, et al, report,

> Cognitive-behavior therapy (CBT), a set of techniques that are directive, problem-focused, and delivered short term, is the psychotherapy approach with the most empirical support for its effectiveness. All the treatment guidelines for PTSD recommend CBT for PTSD. The CBT technique with the most evidence for its efficacy … is exposure therapy, in which patients are aided in confronting the trauma-related memories and cues in a therapeutic manner.[154]

CBT can be used as a stand-alone model. Chaplains are not included in the delivery of the therapy, although they may be consulted as needed external to the therapy.

A variation of CBT is Integrated Cognitive Behavioral Therapy, or ICBT. Barbara Hermann, et al, explains, "Treatment consists of psychoeducation linking PTSD and

[153] Jay A Morrison, Erin C. Berenz, and Scott E. Coffey, "Exposure-Based, Trauma-Focused Treatment for Comorbid PTSD-SUD," In *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders*, ed. Paige Ouimette and Pamela P. Read. 2nd ed. (Washington, D.C.: American Psychological Association, 2014), 272.

[154] Barbara O. Rothbaum, Maryrose Gerardi, Bekh Bradley, and Matthew J. Friedman , "Evidence-Based Treatments for Posttraumatic Stress Disorder in Operation Enduring Freedom and Operation Iraqi Freedom Military Personnel," In *Caring for Veterans with Deployment-Related Stress Disorders: Iraq, Afghanistan, and Beyond,* ed. Josef I. Ruzek, Paula P. Schnurr, Jennifer J. Vasterling, and Matthew J. Friedman. (Washington, D.C.: American Psychological Association, 2011), 219.

SUD, breathing retraining, and cognitive restructuring."[155] She concludes with, "… ICBT may be best suited for patients with more severe PTSD and non-alcohol SUD; however, a larger trial is needed."[156]

While CBT is the therapy with the most evidence, it is not the only one. It focuses on treatment after the event. Some focus on early intervention. Joseph Ruzek explains, "Early intervention routinely includes the encouragement of basic care components such as rest, recreation, return to normal routines and roles, mutual social support, and education of survivors and families."[157]

Other programs deal with prevention intervention. One such model is in use by the military, the Stress Continuum Model. William Nash explains,

> The stress continuum model is a heuristic tool developed in the Marine Corps to provide a framework for prevention intervention across their spectrum. It categorizes all possible stress states into one of four color-coded stress zones. The two ends of the stress continuum are easily defined and well known. The Green 'Ready' Zone, to the left end of the continuum, is the zone of low or absent distress or dysfunction due to stress; it is the zone of wellness and resistance to current stress load. The Red 'Ill' Zone, to the far right of the continuum, is the zone of diagnosable stress-related mental disorders such as PTSD, depression, and substance abuse.
>
> The Yellow 'Reacting' Zone is defined as the stress zone of normal, common, and transient states of distress or changes in functioning. Yellow Zone stress reactions, by definition, always disappear as soon as the stress is removed. Yellow Zone stress reactions are not only normal but necessary, because such states of strain are essential to the development of greater capacity and competence, whether physical, mental, social, or spiritual.

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[155] Barbara A. Hermann, , Jessica L. Hamblen, Nancy C. Bernady, and Paula P. Schnurr, "Evaluating the Evidence for PTSD-SUD Treatment," In *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders*, 239.

[156] Ibid., 239.

[157] Joseph I. Ruzek, and Patricia Watson, "Early Intervention to Prevent PTSD and Other Trauma-Related Problems," *NC-PTSD Quarterly*, 4, Vol 12, (Fall 2001): 3.

> In contrast, the Orange 'Injured' Zone is the zone of more severe and persistent states of distress or alterations in functioning, conceived to be caused by one of four stressor types: (a) life threat, (b) loss, (c) moral injury, or (d) cumulative wear-and-tear from many stressors over a prolonged period of time. [158]

One interesting thing about this model is that chaplains are included at every level of this treatment, often as part of a multidisciplinary team approach. This affords an opportunity to have an integrated approach, early on in the treatment, focused on the individual.

A different set of models receiving recognition use a stage–based framework. These use Judith Herman's model[159]: Stage 1: Safety; Stage 2: Mourning and Remembrance; Stage 3: Reconnection. One such model is Seeking Safety (SS), developed by Lisa M. Najavits. It "prioritizes stabilizing the patient, teaching coping skills, and reducing the most destructive symptoms."[160]

While Seeking Safety is a Stage 1 model focusing on the present, Creating Change (CC), is a Stage 2 model, focusing on the past, also developed by Najavits. This model is a therapy that can be used for both PTSD and SUD. There are several topics in each therapy. One of the differences between SS and CC is that, "… in SS each topic

[158] William P. Nash, Lillian Krantz, Nathan Stein, Richard J. Westphal, and Bret Litz, "Comprehensive Soldier Fitness, Battlemind, and the Stress Continuum Model: Military Organizational Approaches to Prevention," In *Caring for Veterans with Deployment-Related Stress Disorders: Iraq, Afghanistan, and Beyond*, 205.

[159] Judith Herman, *Trauma and Recovery*, (NY: Basic Books, 1997), 156.

[160] Barbara Hermann, Jessica L. Hamblen, Nancy C. Bernady, and Paula P. Schnurr, "Evaluating the Evidence for PTSD-SUD Treatment," In *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders*, ed. Paige Ouimette and Pamela P. Read. 2nd ed. (Washington, D.C.: American Psychological Association, 2014), 240.

represents a safe coping skill; in CC, each topic represents a processing theme."[161] CC is the next step after SS, and the two models can be used separately or combined (sequentially, concurrently, or alternating).[162]

Another model is Acceptance and Commitment Therapy (ACT). Russ Harris informs us, "ACT gets its name from one of its core messages: accept what is out of your personal control, and commit to taking action that enriches your life. The aim of ACT is to help us create a rich, full, and meaningful life, while accepting the pain that life inevitably brings."[163] To help accomplish this, Harris teaches, "The six core therapeutic processes in ACT are contacting the present moment, defusion, acceptance, self-as-context, values, and committed action."[164] Harris explains acceptance versus control, "ACT advocates acceptance under two circumstances: 1. When control of thoughts and feelings is limited or impossible. 2. When control of thoughts and feelings is possible, but the methods used reduce quality of life."[165] This is precisely why ACT may be a therapy for addictions, "Many addictions begin as an attempt to avoid or get rid of

[161] Lisa M. Najavits, "Creating Change: A New Past-Focused Model for Trauma and Substance Abuse," In *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders*, 296.

[162] Lisa M. Najavits and Kay M. Johnson, "Pilot Study of Creating Change, a New Past-Focused Model for PTSD and Substance Abuse," *The American Journal on Addictions*, XX, (2014): 2.

[163] Russ Harris, *ACT Made Simple: An Easy-to-Read Primer on Acceptance and Commitment Therapy*, (Oakland, CA: New Harbinger Publications, 2009), 2.

[164] Ibid., 9.

[165] Ibid., 26.

unwanted thoughts or feelings…."[166] This may also work with PTSD, since many dealing with enormous trauma are persons seeking to forget.

Spirituality

The VA has postulated spiritual strategies for the recovery of PTSD sufferers. A VA pamphlet[167] instructs us,

> Spirituality may improve post-trauma outcomes through:
>
> 1. reduction of behavioral risks through healthy religious lifestyles (e.g. less drinking or smoking),
> 2. expanded social support through involvement in spiritual communities,
> 3. enhancement of coping skills and helpful ways of understanding trauma that result in meaning-making, and
> 4. physiological mechanisms such as activation of the 'relaxation response' through prayer or meditation. Feelings of isolation, loneliness, and depression related to grief and loss may be lessened by the social support of a spiritual community.

Spiritual growth has been presented as a deeper level of faith. Words used convey the present action of God, as someone who values relationship with us. Perhaps the sentinel event that caused the PTSD has led to spiritual growth through the contemplation of the event. That it may lead to spiritual growth involves many factors. Contemplation has to be based on how we relate to each other and recharge, as an introvert or extravert. Signal events may acquire a different meaning over time. An example is the 23rd Psalm, where the line, "Yea, though I walk through the valley of the shadow of death, I shall fear no evil," may mean something different at different ages, based on one's experiences. Yet, the experience at 10 may still be valid at the age of 20, 30, 40…. The difference is in the layers added to the meaning, to one's meaning and interpretation. Sometimes this perspective allows for a fresh insight.

[166] Ibid., 24.

[167] "Spirituality and Trauma: Professionals Working Together," 2.

One spiritual approach to what Allen Clark calls Combat Faith Ministry in *Wounded Soldier, Healing Warrior*, is his Battle Plan for Victory, which is outlined over ten pages.[168] It is an outline and excellent resource for what churches can do not just for hurting Veterans, but also for hurting individuals.

Another resource is *The Combat Trauma Healing Manual,* geared for the individual sufferer, leading the person through a mnemonic on studying the Bible, to putting on spiritual Kevlar, looking at the schemes of Satan, and finally to wearing a new identity—one in Christ. Chris Adsit tells us, "One very effective way to release the unprocessed emotions of the past, heal traumatic memories, and counteract some of the physiological consequences of your trauma, is to experience a more powerful episode…."[169] An experience with Christ leads to, "…images, senses, feelings, actions, and meanings of the past are confronted, re-experienced, processed, released, and overpowered by this new episode with Jesus."[170] This is reframing experiences, over-writing the experiences with new meanings, replacing the negative value with a positive value.

The "Big Book" from Alcoholics Anonymous tells of this overwriting as an "emotional rearrangement" due to spiritual experience, "Ideas, emotions, and attitudes which were once the guiding forces of these men are suddenly cast to one side, and a completely

[168] Allen B. Clark, *Wounded Soldier, Healing Warrior*, (St Paul, MN: Zenith Press, 2007), 303-311.

[169] Chris Adsit, *The Combat Trauma Healing Manual: Christ-Centered Solutions for Combat Trauma.* (Newport News, VA: Military Ministry Press, 2007), 29.

[170] Ibid., 29.

new set of conceptions and motives begin to dominate them."[171] This emotional rearrangement may also be called "finding the new normal." We are not what we once were, but we have a voice with God in who we are to become. To go further, we have a voice in the man and woman of God we are to become. This echoes II Corinthians 5:17, "Therefore if anyone is in Christ, he is a new creature; the old things passed away; behold, new things have come."

We try to find meaning, not just in our future, but in our past. And, God does not let our past go to waste. He has "plans for me," as found in Jeremiah 29:11, "For I know the plans that I have for you," declares the Lord, "plans for welfare and not for calamity to give you a future and a hope," include my past, my present, and my future. As Allen Clark puts it, "This time of personal trauma and turmoil in my life forced me to examine the truth about my real world of the present—my situation as it now existed." [172] His conclusion? He finds, "My self-image was based on my value in God's eyes…."[173]

By typing in the words "Christian recovery program," a quick Google search of the Internet yields 12,900,000 hits. Scanning the list reveals this to be grouped into either recovery programs or treatment centers. Within my local area, two Christian recovery programs are available: Celebrate Recovery and Reformer's Unanimous.

Celebrate Recovery is a recovery program "from any hurt, habit, or hang-up," as John Baker, the founder says. It modifies the Twelve Steps found in AA, each step

[171] Alcoholics Anonymous, 27.

[172] Allen B. Clark, 175.

[173] Ibid., 255.

surrounding one Scripture passage. There are also eight recovery principles taken from the Beatitudes found in Matthew 5: 3-10.[174] There is a mnemonic, RECOVERY, to help participants remember the principles.

Reformers Unanimous, found at reformersrecovery.com, uses ten recovery principles,[175] focusing on memorizing Scripture. To assist in this, there is a motivational award system that its founder, Steve Curington, says is "evidence of a program that believes in acknowledging accomplishment and rewarding participation." This is done at every gathering. The title of the program comes from Romans 12:1-2, and the participants earn and progress to titles such as Transformer, Conformer, and Reformer.

There are other websites that afford pastor the assistance he/she may require to help the Veteran. One is the VA's website devoted to PTSD, the National Center for PTSD (NCPTSD): www.ptsd.va.gov, through their PTSD Consultation Program. This free service for all VA employees and providers who treat Veterans outside of VA is available to answer questions and provide consultation related to PTSD.

Another website is the Department of Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury: http://dcoe.mil, which has information webinars, and links to social media that caregivers and Veterans can access.

The HealthCare Chaplaincy Network: www.healthcarechaplaincy.org/, has a program for assisting Veterans: http://www.chaplaincareforveterans.org/; either the Veteran or

[174] John Baker, 29.

[175] Steve Curington, "The Ten Principles," 2013 Reformers Unanimous Christian Addiction Recovery Program, http://reformersrecovery.com/10principles, (Accessed June 20, 2014.)

the caregiver can access the information. Deborah Grassman's website on soul injury is also invaluable: www.soulinjury.org.

What can pastors do? The main thing is to listen. Drescher says, "My approach to Veterans, in a non-threatening, non-confrontational way, is to invite them in. I walk them through their values, new meaning for living, and allowing them to reflect on their own historic faith perspective to move forward."[176] Storytelling is important both for the Veteran and for the community. Tick agrees, but adds that the reason is, "Veterans' stories need to be told in a way that transfers the moral weight of the event from the individual to the community."[177]

If confession, both private and public, is necessary, then being a confessor or referring to a confessor is also necessary. Many churches have, or at least can use, a Service of Reconciliation. The preparation for this public ceremony can uncover depths of sin, as well as the process for alleviating that sin. Confession is a moving forward, accepting the past while embracing the future. Using Worthington's acrostic as a template for spiritual growth may be a vital link in moving forward.

Another area where churches and ministries can help in recovery is providing sanctuaries, or safe places. Carrie Doehring says, "Recovery involves first creating

[176] Kent Drescher, interview.

[177] Edward Tick, 223.

safety and trust…."[178] It is in these safe harbors that rituals may be of use. Tick states, "Warriors need elaborate rituals cleansing them of pain and stain."[179] He then outlines "four essential steps: purification and cleansing; story-telling; restitution in the family and the nation; and initiation as a warrior."[180] Of the first step, he advocates a Native American sweat lodge for some. But he warns, "These are best done by ritual in the context of a supportive community."[181]

To move from the unsafe to the safe involves transition. I John 2:8 discusses transition points, "… the darkness is passing away and the true Light is already shining." The church can recognize that transition points between expected reality and reality are traumatic. Yet, this pain of transition is necessary to move away from the pain of PTSD.

When PTSD is not addressed, it will continue to fester. The DSM-5 states, "Symptom recurrence and intensification may occur in response to reminders of the original trauma, ongoing life stressors, or newly experienced traumatic events. For older individuals, declining health, worsening cognitive functioning and social isolation may exacerbate PTSD symptoms."[182]

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[178] Carrie Doehring, *Internal Desecration: Traumatization and Representations of God*. (Lanham, MD: University Press of America, 1991), 137.

[179] Edward Tick, 102.

[180] Ibid., 189.

[181] Ibid., 211.

[182] American Psychiatric Association, *DSM-5*, 277.

PTSD has been with humanity, probably as long as there have been wars. Past societies dealt with the pain, often as community. The future of PTSD may lie, partially, in the past. We owe our Veterans, as a society, a future in which the past does not overwhelm. While there have been advances in our understanding of our bodies and minds, sometimes here has been an over-emphasis on the new and unproven over the tried and true. Sometimes progress involves regress. This is a call to look at whatever works, whether old or new.

In this next section, we will see how the past, for some, may cloud their view of the future, and yet, for others, becomes only one of many filters with which to see the future.

CHAPTER THREE

NUTS AND BOLTS OF RESEARCH: UNDERSTANDING THIS AUDIENCE

Location and population of the study

This study took place in one small city (population:25,000) where a VA domiciliary[183] is present as a residence program for SUD. Many of the Veterans in the SUD program also suffered from PTSD. SUD then became a gateway for studying PTSD. PTSD for participants was either officially diagnosed, in the process of being diagnosed, or self-reported.

Participants in this study either resided in this city or were present for the residence program. After the program ended, some went on to other programs, went home, or attempted to start over somewhere else. There was one Veteran who died shortly after the interview.

Access

In order to use the domiciliary as an available pool for study, a VA Institutional Review Board (IRB) was required to give approval and permission. I could not find any VA IRBs that wanted to take responsibility for a study at an off-site small VA domiciliary not associated with a major university. Therefore, I was not given access to these participants. Several months passed through the application and review process before the announcement was made. Fortunately, there were community programs present or there would not have been an available pool. This meant that subjects would self-report both their PTSD and SUD.

[183] A domiciliary is basically a dormitory, in this case with meeting rooms, a kitchen, dining hall, recreation rooms, washers and dryers, and offices for support staff.

Missional context

Many of the Veterans actively involved in the domiciliary were repeat participants in a SUD recovery program. As previously discussed, the information was gathered at different locations. While many identified with the Christian faith, faith practice was limited and sporadic. Those in the sample that did not self-identify as Christian identified themselves as spiritual. This self-reporting of spirituality, combined with the different locations and the type of locations, made approachability delicate, as trust had to be earned. This did not and does not negate the spiritual need. It may actually make it more acute.

Identification

The term "chaplain" is instantly recognizable to many Veterans, as it is a term used by the military to denote their embedded clergy. Because of this, many Veterans understand the term and may relate to a chaplain, especially if they feel that the chaplain's experiences are commensurate with their own experiences. If this is the case, a chaplain can speak their language. In my case, I was a military chaplain, so there is a common language.

Research methodology

Participants

Since I am a chaplain at a facility working with Veterans with SUD, there may be some volunteers who may feel coerced because of my position. Mary Clark Moschella warns against this:

> The line between inviting people to participate and coercing them can be blurry, especially in congregations or organizations with top-down power structures. When

> congregations are in the habit of doing whatever their pastor says, or even merely respecting their pastor's position, they may automatically assume that it is their religious obligation to comply with the leader's request for participation in the study. It is incumbent upon the pastoral leader to emphasize the participant's freedom of choice. [184]

I intentionally tried to avoid this dilemma. First of all, I used an informed consent form, included as Appendix A, which I will discuss in more detail on the next page.

As already discussed, because of circumstances, I did not recruit from among the SUD populace at the VA domiciliary, a residence program for SUD. Instead I visited local public programs. Interestingly, because many of the subjects in the VA SUD program also were allowed to go to the public programs held in the community, it made little difference.

Recruitment

Subjects recruited were a community sample of co-morbid (PTSD and SUD) Veterans. Participants were primarily Veterans who were diagnosed with SUD by the VA, based on DSM criteria. Some of these were residing at a VA SUD domiciliary while working on their SUD addictions and recovery; some did not reside there but continued to work on their addictions; and some resided at home after having worked on, and in some cases, through their addictions.

All study participants met criteria for some form of PTSD. Generally, the diagnosis of PTSD was given by the VA, based on DSM-IV criteria.[185] However, some PTSD diagnoses might have been in the process of being approved. In that case, two instruments were used to further substantiate PTSD: the Burns PTSD Scale and the

[184] Mary Clark Moschella, *Ethnography as a Pastoral Practice: An Introduction*, (Cleveland, Pilgrim Press, 2008), 91.

[185] This is due to the changeover process that is continuing, from DSM-IV to DSM-V.

PCL-5 PTSD Checklist, both of which are 20-question self-survey instruments. These instruments are included as Appendices B and C. My intent was to use these instruments when PTSD was not self-reported as having been documented by the VA.

There was an attempt to further recruit only those with combat-related PTSD, but that severely limited the available pool. A pre-questionnaire, formerly geared for this, was then used to differentiate combat-related PTSD from other types of PTSD. These are the questions asked on the self-report pre-questionnaire:

1. Have you been exposed to combat?
2. Do you think you have Post Traumatic Stress Disorder (PTSD)?
3. Do you think your substance abuse is related to your combat experience(s)?

Within those parameters, the sample was random. Subjects were recruited from public SUD recovery programs: AA, NA, Reformer's Unanimous, and Celebrate Recovery.

I found where recovery programs were meeting. AA and NA each met locally in secular meeting places. Reformer's Unanimous and Celebrate Recovery each met in a church, albeit separate churches. I then made the rounds, introduced myself, announced my purpose, and asked for volunteers.

I would have to explain my research and the purpose more than once. I encountered much resistance. Some of this I attributed to the "fog' one has after time spent using mind-altering substances. It takes time to diffuse the fog. Much of this I attributed to mistrust. I was asked, "What was I going to do with their information?" This translated as, "What was my ulterior motive?" Answering that I had none did not lessen their anxiety.

When an addict, and here I include alcoholics, loses trust in humanity, mere words will not restore the trust. Even though I was not the one who had broken the trust, I represented those that did, simply because I was present. I was meticulously open, answering anything they asked me. Some were able to overcome their mistrust; most were not. I had not anticipated overwhelming rejection, so I did not record negative responses. A rough estimate, though, was for every one subject I interviewed, I personally asked fifteen people, a 6.7% acceptance rate. The limited access I had to the subjects was reflected here. Compounding this was the fact that I began interviewing shortly after a total knee-replacement surgery, during the rehabilitation stage, where I was not at work for six weeks. This means that for six weeks I had virtually no access to those I wanted to interview. It also meant that many of those Veterans who knew me had rotated out, and the ones who arrived did not know me. While I would not have approached them officially, they would have recognized me at these community meetings. It also meant I had difficulty in mobility.

I was able to interview one who was able to extend trust to me. He first agreed to an interview, then another agreed from there. Word-of-mouth allowed me to interview others. While not a snowball-effect, I was able to interview some Veterans.

My numbers remained small and time was encroaching. My focus shifted to interviewing subjects that I knew had PTSD but was unsure if they had SUD. Self-reporting let me know that while few of these had gone through a substance abuse program, many admitted to alcohol abuse as drug of choice. While this affected the numbers of SUD Veterans, it did not affect the question of spirituality in the recovery process of PTSD.

I interviewed the subjects in a variety of locations: a church, a coffee shop, a vehicle, a shopping mall, my office, their homes, my home. One subject I interviewed by phone. In essence, wherever the subjects felt comfortable. This also extended as to time. If they wanted to meet in the morning, at noon, or in the evening, I made myself available to their schedules.

Scope

The scope of the project (time-frame) was one month. Age at the time of trauma was recorded. Participants at the time of interview ranged in age from 31 to 78. Conflict was also recorded (i.e., Vietnam, Kosovo, Gulf, Iraq, or Afghanistan.) There was an almost equal distribution between Vietnam and Iraq/Afghanistan. While separate conflicts, many of the younger Veterans served in more than one conflict, and may have had several combat missions in each conflict. The sex of all subjects was male.

Procedure

To respect the confidentiality of the information provided, I used an informed consent form, included as Attachment A. This served as a contract for my behavior, in that I would hold their information "in strict confidence," while allowing "me consent to anonymously quote you." Some gave me permission to use their names, for which I was appreciative and thanked them for, but declined due to the sensitive nature of the responses given.

If the presence of PTSD was known to me, I did not use either of the scales. If it was suspect, I used the scales. For uniformity, the scales should have been used with each subject. Of the subjects, 66% had confirmed PTSD, so they were not given the scales. The remainder, or 33%, were given the scales for PTSD confirmation.

To interview someone is to listen. Moschella reminds that this is a pastoral practice, "Listening can be a means of grace, as it brings forth stories through which people make sense of their lives and become aware of the larger reality."[186] The art of listening was accomplished by using qualitative interviews. Both written and oral informed consent were obtained from all study participants. Responses were written down at the moment of reporting. If I did not understand something, I asked clarifying questions. While this may have affected the flow of the interview, I think it gave the interviewee more time to think through the response to be given.

There are four points addressed in this paper:

1. How have combat experiences (combat PTSD) affected one's faith?
2. How has a recovery program affected faith?
3. How has faith affected PTSD and SUD?
4. Is recovery from SUD also helpful in recovery from PTSD if it involves a spiritual component?

This was accomplished by asking the following narrative interview questions:

1. Tell me about your faith practice before your combat experience.
2. How, if at all, did your faith practice change because of your combat experience?
3. How has being in a substance abuse recovery program affected the practice of your faith?
4. How has being in a substance abuse recovery program affected your faith?

In the beginning, most of the subjects were confirmed SUD and potential PTSD sufferers, to be determined by the two instruments and pre-questionnaire. Toward the end of the project, more of the subjects were confirmed PTSD with a potential for SUD. I had not expected this, as the instruments were to substantiate PTSD, not SUD. Also, this means that the two latter questions might be invalid.

I ended favoring the PCL-5 over the Burns PTSD Scale as it was more PTSD-specific. Use of the Burns scale showed that it also typed for depression and anxiety, which was

[186] Ibid., 144.

not the focus of this research. Burns himself, in the "How to Score the 20-Item PTSD Scale," located in Appendix B, notes that there is something wrong with his scale, it is inexact because it was designed "to create a user-friendly test that will make it easy for you to assess the DSM-IV criteria quickly and accurately." The PCL-5, found in Appendix C, is designed for PTSD, "When necessary, the PCL can be scored to provide a presumptive diagnosis."

Fortunately, all the subjects who had a primary diagnosis of PTSD admitted they had some problems with alcohol. While this does not mean they used a recovery program, it means they were aware of the same issues many Veterans beginning recovery face: denial, anger, cognitive dissonance, broken relationships, loss of hope, financial issues, legal issues, and residence issues (homelessness).

Many of the questions led into other questions. Occasionally I would have to ask clarifying questions. Sometimes I would ask the question again. But, I did not want to press the issue if I sensed resistance. I recognized that for some interview subjects, some of the questions would not be answered.

Triangulation

Robert Stake discusses the concept of triangulation to check the accuracy of the data gathered by having the informants check the data that they themselves gave. He advocates using multiple methods of observation, interview, document review, and member checking, "having the actor check for accuracy and palatability (when no

further data is to be collected from that actor.)"[187] Tim Sensing seems to agree with this although he labels this "data triangulation."[188]

After the interviews were typed, the interview subjects were asked to check the data for accuracy. There was a blank space on the typed interview record where member checking was noted. There was one subject who died before the data could be checked. The data obtained was triangulated by survey, by interview, and by member checking. Sensing also discusses "external validity," which he defines as "the degree to which findings derived from one context or under one set of conditions may be assumed to apply in other settings or under other conditions."[189] While this generalizability to a greater community may be difficult to assess, that fact is that it may lead others to test these conclusions in other areas. Some of these findings may be generalized precisely because the interview subjects were taken from readily available community sources: AA, NA, Celebrate Recovery, and Reformer's Unanimous groups as opposed to a purely residential facility, e.g., the SUD domiciliary at the VA.

[187] Robert E. Stake, *The Art of Case Study Research*, (Thousand Oaks: Sage Publications, 1995), 114.

[188] Tim Sensing, *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses*, (Eugene: Wipf & Stock Publishers, 2011), 73.

[189] Ibid., 215.

CHAPTER FOUR

WHAT THIS AUDIENCE SAYS

Particulars

Participants

The participants in this research were nine dual diagnosed (SUD and PTSD) Veterans attending one of several SUD recovery programs in this city. The primary diagnosis was SUD; that was the reason these Veterans were present, either in the VA domiciliary or in an outside recovery program. PTSD was additionally diagnosed primarily by the VA. However, a PTSD diagnosis could also come from self-reporting. The pre-questionnaire was used as an instrument of self-reporting. This also served to eliminate those without a dual-diagnosis from the study.

Caveat

The subjects are not identified by name. Yet, because of the sensitive nature of the information collected, the fact that for many there is spiritual injury involved, and that for some the actions presented may be considered illegal, the entirety of the interviews will not be presented. They will be on file, available upon request. Only that which is necessary for this paper will be presented.

Data collected

The data collected was: demographics (age and gender), SUD (yes or no), combat (yes or no), PTSD (yes or no), faith and faith expression, narrative responses to specific questions, and unstructured narrative.

Demographics

Age: the youngest subject interviewed was 31; the oldest was 78. The range of ages was from 31 to 78.

The most recent time between combat experience and the interview is six years. The younger ages (31, 31, and 32) reflect the most recent conflicts: Operation Enduring Freedom (OEF) which took place in Afghanistan, and Operation Iraqi Freedom, (OIF), which took place in Iraq. These two conflicts were fought concurrently. All of the subjects interviewed who were involved in either OEF or OIF were involved in both, sometimes with multiple deployments to each.

The middle group of ages (46 and 47) center around the 1st Gulf War, namely Operation Desert Shield (bombing) and Operation Desert Storm (ground war) that took place in Kuwait. This will be referenced collectively as Desert Storm.

The latter group of ages (66, 67, 67, and 78) are of those who served in the Vietnam conflict.

With one exception, most of the subjects interviewed served their combat tour or tours in their 20's. The exception was the 78 year old who had been in the service for some time prior to combat. Because of this he was also in a position of leadership and served three tours in Vietnam.

Sex: all subjects were male. This was not a conscious decision. The availability of female combat Veterans in the city where the research took place was negligible. There were female Veterans who had PTSD, but it was not PTSD acquired from combat.

There were simply more female Veterans who only had substance issues than had both SUD and PTSD.

Theater of War

While no conflicts were purposely left out, the subjects interviewed came from only three conflicts. There were no WWII or Korean subjects in the sample. The data collected showed that:

The number of OEF/OIF Veterans was 3.

The number of Desert Storm Veterans was 2.

The number of Vietnam Veterans was 4.

Even though often written as OEF/OIF, these were actually two different theaters of war, with different terrain, changing climate, composition of forces, and rules of engagement.

Other than these two campaigns, there were no conflicts where subjects served in more than one conflict. Within each conflict, a Veteran could, and often did, serve more than one tour. The length of each tour was defined by the operational tempo and needs of the service. So, for Vietnam, one subject served three tours, while in OEF/ OIF, one subject served ten tours. The only campaign where this was not an issue was in Desert Storm, where the overall length of the campaign was a little more than a year total. It has been said that all combat is the same, and that all combat is different. That is what makes treating combat Veterans difficult, in that there may be a commonality of experiences, yet an uncommonness of terrain, weather, rules of engagement, and identification of enemy forces, as well as “friendlies”.

Findings

Structured Questions

In response to the theme of this project, "to study what effect spirituality (and the lack of) has on both PTSD and recovery from PTSD, and the relationship of recovery to faith," there were four structured narrative interview questions posed:

1. Tell me about your faith practice before your combat experience.
2. How, if at all, did your faith practice change because of your combat experience?
3. How has being in a substance abuse recovery program affected the practice of your faith?
4. How has being in a substance abuse recovery program affected your faith?

Each subject was asked these questions. Not all subjects answered the questions in the way they were posed. Non-interruption of the narrative flow was prized over a strict sequential response to each question. Sometimes I would ask clarifying questions after they stopped speaking.

Question One

For question 1. "Tell me about your faith practice before your combat experience," Table 1 reflects the following:

Subject	Short answer
A	Participated "3 times weekly"
B	"Went to church regularly"
C	"I don't go to church"
D	"I was raised in church"
E	"I grew up going to church"
F	"I was less engaged before"
G	"I was on the pulpit and preaching by 15"
H	"I accepted Christ in VBS as a kid'
I	"I was raised a devout Episcopalian"

Table 1

Even though some did not address the frequency of their attendance prior to combat, the results show that at least seven of nine, or 78%, attended church regularly. Two, or 22%, replied they did not attend regularly. Of these two, one reported no attendance.

For this sample, that only one person did not attend prior to the events of combat may be significant. For this group, then, pre-event attendance was the norm. Perhaps church attendance gave one the form of hope in the midst of anxiety, peace in the midst of darkness, remembrance of a physical, tangible Presence, and connection to the Other. Without specifically asking the respondents about this, I can only speculate and connect to my own experiences, which I know may be different in scope, intensity, duration, and location.

Question Two

Question 2 asks, "How, if at all, did your faith practice change because of your combat experience?" Table 2 reflects the following:

Subject	Short answer
A	Practice changed because of "availability, duties"
B	"brought back previous trauma"
C	"I feel that God abandoned me"
D	"no churches were involved"
E	"I felt protected by God"
F	"My faith practice has increased since my initial combat experience"
G	"Church was gone after Thom"
H	"It didn't"
I	"I did not know of a time I did not believe in Christ"

Table 2

Combat seems to affect individuals differently. Three, or 33%, said their faith practice did not change. One, 11%, went further and said it increased. One, 11%, said that faith practice changed due to "availability and duties". Upon further questioning, availability was of chapel services, while duties refer to job assignments. Both of these refer to being in the rear of combat operations while in a supposedly safe environment. The intent was to continue faith practice, and the change was not due to negative combat

experiences but simply to scheduling. There were four, or 44%, that stopped their faith practice, and all of these were because of negative experiences.

One of the subjects whose faith practice did change by decreasing, changed in response to the inhumane and seemingly illogical actions of the enemy. Subject G reported,

> Through a Catholic orphanage, I met a couple who had a son, Thom. They wanted a better life for him. He was 9 years old. They wanted me to adopt him. My first wife said yes. I talked with them, ate with them once in a while, when we were going through their village. At the end of my tour, the red tape wasn't done, so he stayed while the red tape was cleared up. One time we went through, he and his dad were impaled on poles in the center of the village, with leaflets saying, "This is what happens to collaborators." We cut them down, the villagers buried them.

This was delivered in a monotone, with absolutely no inflection of voice nor change of facial expression. When he related other events, his voice and face reflected emotion. This could be significant. There seemed to be, after a passage of almost fifty years, an emotional block where he would not let himself feel, or grieve. After he had said this, then he said, "Church was gone after Thom." Or, rather, God was gone; he would not let himself worship the God who allowed this grievous wrong to happen.

Another found that relationships suffered, which soured faith and faith practice. Subject D said,

> My wife ran off with my best friend from Vietnam. Spent total of 363 days in hospital. Released back to limited duty. Trying to make a marriage work that didn't. For two years I chased drilling rigs. No one knew where I was. If they knew my name was Mike, OK. If they knew my last name, it was time to leave and chase another drilling rig. When I was gone for two years, no churches were involved.

Both of these examples show the ravages caused by experiences, both caused by deployments, one especially caused by the horrors of combat. For subject G, there were visuals that could not be erased, nor assuaged by an image of a loving God. This

became an issue of theodicy, where God just didn't make sense. This was combined with a debauched lifestyle, a running from God, for various reasons. In the next section, these two show that this was an identity issue, a question of: "I'm not who I thought I was; who am I now?"

Conversely, there were two who showed an increase, both in their faith and in their attendance. One Veteran credits the hand of God protecting him. Subject E says,

> Right after we drove through that riot, I felt I was protected by God. During the riot, though, it was scary, adrenaline-pumping. It was only 60 seconds but it felt like an eternity. One thing that reaffirmed the protection of God, our vehicle was the only one that didn't have shattered windows. The next day we felt as if we had run the world's most insane PT test.

Another Veteran, subject F said,

> I have been on ten deployments over eight years, 500 combat missions, 100-120 ground assault missions with Special Operations Forces. Once I left conventional units and went to Special Forces, experiences were more intense. Targets we went after were not low-priority, low-risk firefights, our risk of encountering resistance to our presence was greatly increased. My combat experiences changed in that I saw God allow things He didn't necessarily want. Probably sometimes I shouldn't have lived—but I did. A few feet, a few inches, could have changed everything. Only way to reconcile that is God had chosen me for something. No other explanation.

One Veteran states that while his faith did not waver, he admits some confusion. Subject I said,

> Immediately after (combat) I was confused about what I had learned in church and what I had done in combat. This didn't keep me from trying to live a Christian life. … Because some of my men got killed, I had the mindset that what I believed about Jesus didn't work. I have since learned that I was asking too much of Jesus. I thought He should protect us more, but then I realized He did not have as much control because the enemy wasn't on the same page. That was my way of thinking.

This subject shows that he was trying to reconcile previous training (church) to later training (combat) to find a synthesis of action, in essence, a systematic practical

theology. This working out of one's faith in the foxhole of reality, this conversation between God and self, is theological reflection in action. This may occur at the moment of the event, but often later when all the experiences are synthesized so they can be reconciled. The question one may ask may be, "What does this mean?"

One who said his faith practice did not change did express that the experience of combat changed him. Subject H said,

> Back in the compound on laydown guarding the perimeter, my buddy got killed. Missed me by one inch. Only by the grace of God was I not killed too. … Things that never change for me: can't stand to be around people; can't sleep well; nightmares. I don't like crowds, or being caught between two people. I think of the verse, "Greater is He that is in me than he that is in the world."

I believe the inclusion of Scripture is related to the deliverance from death.

It seems that it may be neither combat duration nor frequency, but rather combat experience and intensity, that may be the greater factors in whether faith and faith practice are impacted either negatively or positively.

Question Three

Question three wonders, "How has being in a substance abuse recovery program affected the practice of your faith?" Table 3 reflects the following:

Subject	Short answer
A	"AA strengthened my practice of my faith"
B	"I go to church now. It hasn't stopped my attendance"
C	"I don't believe in organized religion"
D	"I turned my life around when I realized I had a debt to pay"
E	No answer
F	No answer
G	"I have wellness of life. Believing, having faith"
H	"I was convicted by God to give up drinking and smoking"
I	"I carried the Bible I got in Boot camp wherever I went"

Table 3

Subject D's thoughts make more sense in their entirety,

> In and out of relationships for 20 years. Guilt—I didn't feel privileged enough to go back to church. Didn't go for about 20 years. I know I was messing up and didn't have the confidence to go. …I turned my life around when I realized I had a debt to pay. I owed to the men who did not survive to live a life of honor.

Table 3 shows that six, or 66%, answered the question in a positive manner, while only one, or 11%, answered negatively. That Veteran, subject C, went on to say, "But, I'm trying to focus more on what God wants me to do. I've asked God for more help. I'm gonna have to start trusting Him again." There has been a slight movement during the recovery program for him that was not evident prior. Two, or 22%, chose not to answer.

Question Four

Question four is, "How has being in a substance abuse recovery program affected your faith?" Table 4 reflects the following:

Subject	Short answer
A	"When I first went to AA, it strengthened my faith"
B	"Pain is inevitable; misery is optional. …Only God can straighten it out"
C	"…I've been praying these past two weeks"
D	"Snuck in the back of church … 25 years ago on a Wednesday night"
E	No answer
F	"I believe that's what He has called me to do and that's what I work on"
G	"I never asked for forgiveness, until a week ago"
H	"Everyone with PTSD needs something to focus on, and God is my focus"
I	No answer

Table 4

This question brought the most variety of responses. Subject A expands about having doubts and on relapsing after an initial gain,

> It all stemmed from one incident. A big firefight, exchange of gunfire. I dropped a loaded SAW 249 that did not fire. A sister unit fired with a .50 cal that hit my Kevlar. We should not have survived, looking at the bullet holes later. … Someone was watching over me.

> I had been sober for three years, then faltered again. I drink because I should have died, but I didn't. I feel like there should be a higher purpose for me. I feel guilty that I don't know what that is. I feel frustrated that this is what I've become.

Subject B informs us about letting go, in order to have peace,

> From 16 to 46, 30 years, I've been drunk. Lots of pain, misery, destruction, anger. I've put myself through a lot of stuff. It was self-induced. Pain is inevitable; misery is optional. I have a lot of self-induced misery. … I know I can't change the past. I have to let it go. It's easy to say that. I can't let it go. Yet, the only way I know I'm gonna have any peace with it, is to let God take it. Only God can straighten it out. The only way to have peace is to put it in God's hands, let him carry the burden, the memory.

Even though subject E did not answer the question, and while he drank to excess and did not enter a SUD treatment program, he states,

> … I felt there was a reason for the things I went through to prove to me #1 that He does exist, and #2, that He loves me as only a father could, and #3, He does have bigger and better plans for me. Once I let go of everything, and realized that this was something I had to go through, it just made my life a whole lot easier. … Once I found (*family's name is redacted*) I had a mission in life—to take care of them. It felt good to be able to do that.

Subject F speaks about finding God's will for his life, and how that brings peace,

> I work with Veterans and kids, working with trauma through horses. That's my quiet time. God has given me a gift to communicate with horses and with people and help people create trust with horses and help them draw parallels with that animal and their life. I believe that's what He has called me to do and that's what I work on.

Subject G speaks about asking for forgiveness but not expecting it and not deserving it. His statement shows he is in the process of accepting God's forgiveness, as well as forgiving himself. He says, "I never asked for forgiveness, until about a week ago. I had to pay penance. If I didn't punish myself, who would? I keep the memory alive. Even if God could forgive me, I couldn't forgive myself." His theology of God is too small,

while his guilt is too great for him to accept God's grace. But he is moving forward in accepting that God is willing to forgive him and that God is big enough to forgive him. These Veterans are trying to make sense out of trauma, a sentinel event in their lives.

Summary

The research found that:

1. The experiences, not the frequency, of combat PTSD may more adversely affect faith;
2. A successful completion of a SUD recovery program seems to positively affect faith;
3. Some Veterans do not use a recovery program, but sobriety is difficult for them;
4. Some of the Veterans in the SUD recovery program also suffer from PTSD;
5. Some of the Veterans with PTSD also suffer from SUD;
6. Faith recovery may be an integral part of PTSD recovery.
7. Future research can look at combat intensity as well as combat duration and combat frequency as factors that impact faith.

Limitations and Delimitations

Limitations

There are a number of limitations. First, the sample size is too small to generalize conclusions to all Veterans. A larger study of combat Veterans with dual diagnoses of PTSD and SUD needs to be undertaken. A second limitation is that all the participants expressed Christianity as their faith. While the location of the participants may have something to do with this, it means that the results cannot be generalized to other types of religious beliefs. More research is needed to investigate the role of faith in response to an individual's traumatic experiences. A third limitation is the time since the event. The more recent the interview to the event, the more vivid the memories may be. A fourth limitation is that no females were preselected for combat-related PTSD, therefore the study involved a single gender, male. One reason is that no females presented

themselves as having co-morbid PTSD and SUD. Perhaps gender differences would be important in studying both co-morbidity and faith practice. A fifth limitation is that this study takes place in several community public locations where both Veterans and non-Veterans assemble. As such, the results may not be transferable to public or private assemblies. A sixth limitation is that this study includes Veterans who self-diagnose as having PTSD as opposed to having gone through the rigors of an official diagnosis. The seventh limitation is that aspects of SUD were not differentiated by substance. Finally, the eighth limitation is on the interview question number two, "How, if at all, did your faith practice change because of your combat experience?" This question did not differentiate as to the timing: immediately after the event causing PTSD (while still in combat) or at some later time (upon resettlement from deployment). Perhaps all the questions could be grouped into three categories: before, during, and after.

Delimitations

There are some Veterans who will suffer from both PTSD and SUD. Just as there is a dual diagnosis, the treatment should also address both diagnoses. This treatment should be concurrent.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS: WHAT NOW?

Contemplation

In trying to make sense of the traumatic event or events resulting in PTSD, it may lead some to a greater faith and practice, and lead some to a loss of faith and practice. A strengthening of faith may protect the individual from the more deleterious effects of PTSD. Spiritual growth seems to be evidenced through the contemplation of the sentinel event or events. It is this contemplation, often over a period of years, that gives one's PTSD meaning. It is interesting to note that in trying to make sense of the trauma, some may strengthen their faith, often because of the trauma. For almost all the subjects in this study, this contemplation led to a deeper level of faith, although not without some considerations.

Cognitive

One consideration deals both with the cognitive and with identity. The cognitive may be an altering of assumptions, of the world, of the concept of fairness, and of God. If assumptions about these spheres are shattered, so that what was normal is no longer, then there is a quest for the "new normal". The "Big Book" of Alcoholic Anonymous refers to this process as "emotional rearrangement" due to a spiritual experience, "Ideas emotions, and attitudes which were once the guiding forces of the lives of these men are cast to one side, and a completely new set of conceptions and motives begin to dominate them."[190] This shattering may affect faith and faith practice. Hagar ter Kuile says,

[190] Alcoholics Anonymous, 27.

"Therefore, a shattering of these assumptions can be expected to impact an individual's religiosity."[191]

The responses to the questions asked show this to be the case. For some, the trauma event or events is what shatters the normal. For others, it is leaving the environment and the physical location where as one Veteran put it, "I was in my element. I felt alive." For others, it is the combination of the traumatic event happening in the line of duty, often in combat, contrasted with the realization that this way of life is no more. In other words, what was normal in no longer; the search is on for the new normal. This may set some adrift, where they feel abandoned, and never feel they will be complete again. It may be a half-hearted search.

Often, someone who is devastated by PTSD lives in the past. The event or events may imprison them in that time. Often when someone says, "My past defines me," they mean, "My past confines me." Ironically, they hold the keys to their release. They become their own jailers.

A large part of recovery from PTSD is discovering a new normal. This may be a life review, what in AA is Step 4, previously cited, as "a fearless and searching moral inventory" of both the events and the person.

Identity

When assumptions of self are added to the loss of what was considered normal, this becomes an identity issue. Not only is there a search for the new normal, but also for a new status of the self within the new normal. It is not simply a question of "Who am I?" but one of "Who am I now?" For Christians, this can be framed, not just "Who am I?'

[191] Hagar ter Kuile, and Thomas Ehring, "Predictors of Changes in Religiosity After Trauma: Trauma Religiosity, and Posttraumatic Stress Disorder," *Psychological Trauma: Theory, Research, Practice, and Policy*, 4, Vol 6, (2014): 354.

but “Whose am I?” A key to identity in Christ is found in Acts 17:28, “for in Him we live and move and exist….” If I can find my identity in Christ, I can rise above the past and my pain, and focus on the future.

Because we have a God-who-walks-alongside, the God of hope and healing, we can face and lead others to face trauma head-on, both the effects and the causes. Suffering can be a form of communion with God and identity with Christ. The theology of Christian resurrection, amid unmentionable and indescribable trauma, offers hope. This hope exists, even while facing the devastation that has been evidenced, which often includes death. The future does not remain bleak, but is something to be strived for. If PTSD causes one to look to the past and see the future as more of the past, then faith enables one to look to the future with hope.

Missio Dei

The *missio dei* is the mission of God. What is the mission of God in regard to Veterans? How are Veterans different than non-Veterans? At the root level, we, each of us, are simply people who are suffering. What is the mission of God to people who suffer? To help relieve their suffering by pointing them to the God who delivers.

Missionality

If churches and congregations are indeed missional, that is, carrying out the mission of God, then this framework of interweaving faith, family, and friends can prove a useful model for churches to play an important role in PTSD recovery. Churches can integrate the Veteran by going where they are and addressing their needs. Some Veterans and families may be lonely, in a new town without friends. Some may have children that

would welcome inclusion. For the families of those deployed, they might appreciate some handyman or dependable go-to person. Older couples could also be surrogate grandparents. Since the military attracts young people, the conception of what is older may be relative and may simply mean someone older than the one or ones ministered to. In essence, missionality here is remembering that the families left behind also serve on a front line, often without support. We can become that support. Here are some ideas what a church can do if they have Veterans or are near a military base:

1. Serve a meal for troops or Veterans on special occasions: Memorial Day, Flag Day, Independence Day, and Veterans Day.
2. Serve a meal on random days (do check with the military for a calendar of activities.)
3. Adopt a military family, especially if military member is on deployment—this works for Veterans, too.
4. Host a Veteran's Day breakfast/lunch, or a Men's or Women's Prayer Breakfast, or a family meal in conjunction with an outreach event. People come because they are invited.
5. Do service projects with and for Veterans.
6. Place military members and Veterans on church prayer lists and bulletins.

Family and friends

Based on the research literature already presented and discussed, there seems to be three areas of resiliency: faith, family, and friends. These are areas that spiritual providers, be they chaplains, clergy, or pastors, can address. While we cannot change the past dynamics of a family, we can educate and provide new venues to create the family of choice. AA is all about providing a resource for alcoholics (NA for addicts). Is this not a new family? What is church but a relational enterprise to improve relations between individuals, between the individual and the group, and between sufferer and God? Do not people go to church for fellowship? Is not the entry point often because they are

asked? The answer to the above questions is: yes! Church often takes the role of family, especially if the family of birth is toxic.

Let us also not forget that often the bonds formed in the military are centered in shared experiences. This camaraderie is even more evident when individuals share combat experiences. If the shared experiences are combat-related, then this seems to be more important than even unit-affiliation. It follows that once that connection is severed by leaving the combat area, leaving the unit, and/or leaving active duty, what will follow is a loss. Individuals need to acknowledge that loss in order to be able to grieve that loss. So, if churches can be both simply a safe place to share that loss, but even more importantly, if churches can assemble several who have known the close affiliations of being comrades-in-arms, then that same safe place can become a home, a family. Some of the churches in this community have reached out to the suffering Veterans, providing them open arms, a ready ear, and a welcoming smile. Providing a safe place where a sufferer can be vulnerable may, and probably will, go a long way toward healing.

Faith

Faith is something that can be addressed if we are willing to reframe the theology, as discussed earlier. Discussions about this go to the heart of our soul, our moral or spiritual center, where the soul injury resides. While not everyone will agree on the approach or the terms, the need for discussion is there. I pray we can assist that discussion.

Let us remember the term "soul injury" as defined by Deborah Grassman, "the un-mourned grief and unforgiven guilt that sometimes lingers in war's aftermath." If

combat PTSD involves a transgressive or causal element: **combat PTSD** = **soul injury + PTSD**, then the spiritual model must include a spiritual dimension, for which chaplains, ministers, and clergy are in a unique place to provide relief from this spiritual malady precisely because they are who they are, i.e., chaplains not psychologists, and because they are visible in the community. The result is that they may be approached before a mental health worker is approached.

A faith community has the unique place that models faith as necessary for holistic health, peace, and a joy-filled life. Chaplains, ministers, and clergy can point to the God-who–walks alongside, to the One who grieves with us, and to the One who delivers. We can also point to, and be in conversation with, the broader Christian Church, as the corporate body of faith in action, of Christ lived out every day.

Compassion

These three, faith, family, and friends, are the heart of where we as a faith community can intercede. This is what Christians do: we live out our faith, in community, in brotherhood and sisterhood. We are not perfect; we are broken vessels in recovery. But because God has reached us in our pain, we can then reach out to others in their pain. We can do this with empathy, a connecting of one's pain to another's pain, which is not just sympathy. We do this with compassion, literally "with passion," sharing a burden. A burden shared is a burden lessened. This is often accomplished by prayer. Are we not called to bathe the process, as well as the individual sufferer, in prayer? An example may be a public invitation for the community to gather for prayer for Veterans, for this nation, and for the consequences of war. A corporate confession may begin here. I gave a prayer at a Memorial Day event, which happened to be the 50th anniversary of the

Vietnam War. I apologized for my generation and society's treatment of returning Vietnam servicemen and women. Afterwards, many of the Vietnam Veterans told me that hearing that one statement meant more to them than all the other speeches combined. They remembered nothing else about what I had said, except that I had apologized, a corporate apology.

Imago Dei

The *imago dei* is the image of God. If we are made in the image of God, can see the image of God in ourselves? Can we see it in someone else? What does it take to see this? In my work with SUD Veterans, I have found that many suffer from a negative self-image, and that it is reinforced by family and society. Once they are labeled by the court system, the police, the VA, or family, it is hard to break the label. The concern for churches is how we see the sufferer. Do we see the wounded warrior as a victim mourning the loss of identity and as a future disciple to be embraced? Perhaps this is also true for those who suffer from PTSD.

Confession

Both Edward Tick and Robert Certain discuss what we can do after the event. Earlier, I quoted Certain, "Parades and medals provide a secular answer; confession and absolution provide the religious answer." To be able to share, to confess in order to receive absolution, requires trust. Trust only comes from presence. Are there places where churches can be to provide the compassion of Christ? Yes: wherever it is that Veterans gather.

The purpose of individual confession, as David Belgum told us, is to restore the dignity of the individual and return him or her to community and to God. This desire for restoration can only come about because something is broken, and that something is often a negative view of self. Brokenness does not necessarily have to be sin, but rather, a disruption of the familiar based on one or several sentinel events that may be or are life-changing.

The purpose of corporate confession, as Walter Brueggemann told us, is to embrace the pain so as to foster hope, which then rebuilds faith. Jonathan Shay reminds us that only when the community embraces the collective pain, can the individual step outside the pain to begin healing.

This is what Walter Brueggemann and Edward Tick were referring to, where the individual can rest in a supportive community, a community that collectively shares the burden of the individual. This allows them to find meaning within the suffering as Victor Frankl and Edward Schillebeeckx discussed. Is this possible? We can know only if we try, first as a community of faith in just one community.

Corporate confession is one way to express the inexpressible and, often, indefinable need to release the pain. When a faith community confesses, it builds trust in the affected community. Corporate confession to wars, how Veterans were treated, and compassion to Veterans' issues, builds bridges of trust to Veterans so Veterans can then trust the faith community with their individualized pain.

Resurrection

Larry Graham reminds us of a theology of Christian resurrection, often amid unmentionable and indescribable trauma and death. This offers hope. It is in facing the

devastation that has been evidenced, both the effects and the causes, that allows us to focus on the God-who -walks-alongside, the God of hope and healing.

Pain

Listening

Pain, unaddressed, will continue. Subject B said, "Pain is inevitable; misery is optional." Faith is what can remove the pain from the memory. Often this is through forgiveness: of self, of others, and of God. Many of the stories I hear center on this subject of unforgiveness. We know that once we accept the grace of forgiveness for ourselves and extend it forward toward others, we are free from the guilt, sin, and stain of the event. This happens at that moment of the acceptance of God's grace. And yet, we also recognize that for some, there may be a focus on feeling or emotions; without which, there is doubt. For them, I say, "When we can remember the event without the pain, we have achieved forgiveness." Not just the definition but the expression lived out. This is what the faith community can express with conviction. Using Worthington's six steps listed in Chapter Two as a template for spiritual growth may be a vital link in moving forward.

Be prepared to listen. Be prepared to hear pain. Where spiritual injury is involved, there is soul pain. There may be a mixture of emotions that are turbulent, waiting to burst. The stories told in the previous chapter evoke soul pain and cannot but speak to our hearts. Each Veteran, indeed every person, has a story to tell. There is a thought common to hospice care that a person will continue to tell a story until they know they are heard. With each re-telling, the pain loses its grip on the wounded soul. Sometimes

our role may be just to listen, to listen with our being. While the telling of painful events is itself painful, this is a pain of transition to something beyond, from unsafe to safe. This pain of transition is necessary to move away from the pain of PTSD.

Prayer

None of this can go forward with bathing the process, the individuals, and the care-givers in prayer. We have already discussed the purpose of prayer: to know the mind of Christ and the will of God; to align oneself with that will; and to change hearts and situations (often this means that the heart of the one who prays is changed). All of these are worthy goals. But is that all? Is there more? The founder of the Church of Nazarene puts it in a different way. Phineas F. Bresee tells us, "The aim of the prayer meeting is to get heaven open and the glory down."

We often pray when prayer is all we have. We come in apparent weakness, but leave filled with power. II Corinthians 12:9 says, "And He has said to me, 'My grace is sufficient for you, for power is perfected in weakness.' Most gladly, therefore, I will rather boast about my weaknesses, so that the power of Christ may dwell in me." This type of prayer is passionate: out of our hearts, with our whole being, wrestling with God, as Jacob did at Peniel as recorded in Genesis 32:24-32. When we look at Jacob wrestling with God, we see the glory of God abiding.

What is the power of prayer? Prayer can change both hearts and situations. Remembering James 5:16, "Therefore, confess your sins to one another, and pray for one another so that you may be healed. The effective prayer of a righteous man can accomplish much." How much can be accomplished is evidenced in the Bible itself. In Exodus 32, we see that evidence in a very real way when God declares to Moses His

intention to destroy the Israelites. Moses then intercedes for the people. And in Exodus 32:14 we see this amazing sentence on the effects of that intercession, "So the Lord changed His mind about the harm which He said He would do to His people." See the effect of prayer from one person who prays passionately!

What is the practice of prayer? The passage in James tells us to confess to, and pray for, one another. One can assume this means to do so often. Matthew 6:33 tells us, "But seek first His kingdom and His righteousness." We are to seek God: to seek His will, to seek His face, to seek Him. This is the spiritual discipline of prayer, a practice that I encourage the sufferer to adopt.

Spiritual Recovery Programs

Safe places

Sufferers need to meet in safe places. This is another area where churches and ministries can help in recovery, by providing sanctuaries, or safe places, in which to meet. There is ministry in the liminal space between safe and unsafe. This is a transition point, crucial in reaching the Veteran, and crucial for the Veteran.

Churches can host AA/NA meetings. Churches can also get involved in spiritual recovery programs, such as Celebrate Recovery and Reformer's Unanimous, to either complement or replace existing AA programs. Interestingly, the approaches used by these programs can be applied equally to PTSD and SUD. Celebrate Recovery goes further, and says that we each have hurts, hang-ups, and habits we that need God to deal with.

Because of the sheer number of Veterans diagnosed with PTSD who are not being reached through the available channels, the VA has begun building bridges between mental health and chaplaincy. This is something that churches could do in, and for, the community. Churches can collaborate with the various mental health services that are available to reach and help the Veteran who suffers by offering programs, by listing their affiliation with various agencies, and by having trained people on staff to listen and refer. This also means building these bridges long before a crisis happens.

Sponsors

Veterans in recovery tell me they need sponsors. Sponsors are safe places, in the form of people, to whom the darkest recesses of one's heart can be opened and shared. A sponsor is someone who can be trusted, who can be called on at any time of the night. Is this not a definition of discipleship, of Christianity in action, of being Christ to someone?

Toolbox

Everett Worthington's six steps for moral repair through self-forgiveness, Allen Clark's Battle Plan for Victory, and Chris Adsit's *The Combat Trauma Healing Manual: Christ-Centered Solutions for Combat Trauma*, all discussed previously, are tools that any follower of Christ interested in working with Veterans with combat PTSD should have in their toolbox.

I include these websites that I use and that can afford the pastor the assistance he/she may require to help the Veteran: Deborah Grassman's website on soul injury: www.soulinjury.org; the National Center for PTSD (NC-PTSD) website: www.ptsd.va.gov; the Department of Defense Center of Excellence (DCoE) for

Psychological Health and Traumatic Brain Injury website: http://dcoe.mil; and the HealthCare Chaplaincy Network's Chaplain Care for Veterans website: http://www.chaplaincareforveterans.org/.

Future Research

Additional research needs to be conducted on a larger scale, with both sexes, on those with co-morbid diagnoses of SUD and PTSD. This is something I would like to do. In the interim, I would like to present to the local pastor, minister, chaplain, and clergy that there are ways to reach the Veteran, and that though they are on the front line, they are not alone. I also want our chaplains to have tools to empower the local pastor. On that note, I summarized the salient points of this paper and presented a webinar to the National VA Chaplains in April 2015, so that they would feel empowered to contact the local pastor and share resources.

There is a new scale, the Killing Combat Scale from the National Center for PTSD (NCPTSD). It would be interesting to see the Burns PTSD scale and the PCL-5 instrument applied to all research subjects. And yet, this small sample showed that recovery from PTSD without a faith component may not lead to a complete recovery. When a spiritual injury is present, recovery without a faith component may not even be possible. My experience with SUD Veterans suggests that while the AA program can be navigated without a spiritual component, relapse will usually occur. However, when a strong spiritual component is part of the treatment of people with PTSD, then healing of spiritual injury becomes much more likely.

APPENDIX A

Informed Consent

To be read:

"My name is Scott Jimenez. I am doing a research project for my Doctor of Ministry degree. I am interested in role of spirituality on PTSD and substance abuse. I would like to interview you. If you would give me your permission in the form of a written consent, I will give you a copy of the written consent, which I am reading to you now. Any information that you provide will be held in strict confidence. By participating in this interview, you are giving me consent to anonymously quote you. In order for me to accurately represent your answers, I would like to write down your answers. Later I will give you a draft of this interview so you can check, and if necessary, correct, the content for accuracy. Do you agree to this? "

Name:

_____ _____

(Please print your name) (Please sign your name)

Date: _____ Age: _____ Sex: _____

Conflict/Campaign: _____

APPENDIX B

Burns PTSD Scale

Name: _____ Today's Date: _____

Post-Traumatic Stress Disorder*

Instructions. Use checks (✓) to indicate how much you have experienced each symptom in the past week, including today. **Please answer all the items.**

	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
Category A: Exposure to a Traumatic Event					
1. Have you experienced or witnessed a traumatic event such as death, serious injury, or a threat to your life or someone else's?					
2. Did you feel intensely afraid, helpless or horrified when this event occurred?					
Category B: Persistent Memories					
3. Do upsetting memories of the traumatic event come into your mind over and over?					
4. Do you have upsetting dreams about the traumatic event?					
5. Do you have flashbacks and feel like the event is happening again?					
6. Do you get upset when you think about the event or when you're reminded of it?					
7. Do you have strong physical sensations, such as increased heart rate or sweating, when you're reminded about the event?					
Category C: Avoidance					
8. Do you avoid thinking or talking about the event?					
9. Do you avoid people, things, or places that remind you of the event?					
10. Are there parts of the event you can't recall?					
11. Have you lost interest in life?					
12. Do you often feel isolated or alienated from other people?					
13. Do you feel numb or unable to experience love, pleasure and happiness?					
14. Do you often feel like you have no future?					
Category D: Agitation and Arousal					
15. Do you have trouble sleeping?					
16. Do you get irritable or have angry outbursts?					
17. Do you have trouble concentrating?					
18. Are you always on the lookout to make sure you don't experience the event again?					
19. Do you get startled easily?					
Category E: Distress					
20. How much do your reactions to this event interfere with your life?					

Category F: Duration

How long have you experienced these kinds of symptoms? If unsure, just estimate.		
	Years	Months

Use checks (✓) to indicate the types of traumatic event(s) you experienced, with the dates.

Traumatic Event	(✓)	Date	Traumatic Event	(✓)	Date
Accident			War trauma		
Natural disaster			Physical assault		
Sexual assault			Torture		
Being in prison			Serious illness		
Other event (describe):					

How to Score the 20-Item PTSD Scale*

Many symptoms on this scale are ***not*** specific to PTSD, and are often observed in other Axis I or Axis II disorders. I've listed these non-specific symptoms in the following table.

Keep this in mind when you interpret the scores on the test. For example, a severely depressed individual could easily score 24 on this test, and still have no absolutely ***no*** history or symptoms suggesting PTSD. Someone who is depressed, anxious and angry could score a 36 or higher, and still have no specific symptoms of PTSD.

Disorder	Scale items
Depression	11, 12, 13, 14, 15, 17, 20
Anxiety	12, 15, 17, 19, 20
Anger, relationship problems, mania, or personality disorders (such as BPD)	12, 13, 16, 20

Why is this? Is there something wrong with this PTSD test? Yes there is.

The test is modeled after the DSM-IV Diagnostic Criteria for PTSD and is intended to assist you in screening for this disorder. However, the DSM-IV criteria contain approximately 11 symptoms that are reasonably specific to PTSD and 9 symptoms that are rather non-specific, as you've just seen. Any test that maps onto these criteria will necessarily be flawed, because the DSM-IV criteria for PTSD are flawed.

The grouping categories don't always make much sense, either, and they would not hold up in a factor analysis. For example, item 7 seems to belong in category D, since it reflects agitation. However, DSM-IV places it in the Persistent Memories category, and that's why you'll find it there.

You will find many other inconsistencies if you examine the test critically. However, the goal was not to create the finest possible PTSD test, but rather to create a user-friendly test that will make it easy for you to assess the DSM-IV criteria quickly and accurately.

Score	Interpretation	Comment
0 – 2	Few or no symptoms of PTSD	Nine of the 20 test items assess symptoms of depression, anxiety, and anger, and are not specific to PTSD. Scores in this range may result from other disorders. The non-specific symptoms may inflate the total score.
3 – 5	Few, if any, symptoms of PTSD	
6 – 10	Borderline symptoms of PTSD	
11 – 20	Mild symptoms of PTSD	
21 – 40	Moderate symptoms of PTSD	
41 – 60	Severe symptoms of PTSD	Scores this high are likely to be due to PTSD.
61 – 80	Extreme symptoms of PTSD	

APPENDIX C

PCL-5 PTSD Checklist

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

The PCL can be scored in several ways:

•A total symptom severity score (range = 17-85) can be obtained by summing the scores from each of the 17 items that have response options ranging from 1 to 5.

•The gold standard for diagnosing PTSD is a structured clinical interview such as the Clinician-Administered PTSD Scale (CAPS). When necessary, the PCL can be scored to provide a presumptive diagnosis. This has been done in three ways:

(1) determine whether an individual meets DSM-IV symptom criteria as defined by at least 1 B item (questions 1-5), 3 C items (questions 6-12), and at least 2 D items (questions 13-17). Symptoms rated as "Moderately" or above (responses 3 through 5 on individual items) are counted as present.
(2) determine whether the total severity score exceeds a given normative threshold
(3) combine methods (1) and (2) to ensure that an individual meets both the symptom pattern and severity threshold.
Choosing a cut-point score
Factors to be considered when choosing a PCL cut-point score include:

• The goal of the assessment: A lower cut-point is considered when screening for PTSD or when it is desirable to maximize detection of possible cases. A higher cut-point is considered when informing diagnosis or to minimize false positives.

•The prevalence of PTSD in the target setting: Generally, the lower the prevalence of PTSD in a given setting, the lower the optimal cut-point. In settings with expected high rates of PTSD, such as specialty mental health clinics, consider a higher cut-point. In settings with expected low rates of PTSD, such as primary care clinics or circumstances in which patients are reluctant to disclose mental health problems, consider a lower cut-point.

Below are suggested cut-point ranges based on prevalence and setting characteristics. Consider scores on the low end of the range if the goal is to screen for PTSD. Consider scores on the high end of the range if the goal is to aid in diagnosis of PTSD.

Suggested PCL cut-point scores

Estimated Prevalence of PTSD	Suggested PCL Cut-Point Scores
Below 15% (Civilian primary care, Department of Defense screening)	30-35
16-39% (VA primary care, specialized medical clinics such as TBI or pain)	36-44
Above 40% (Specialty mental health clinic)	45-50

Note. These recommendations are general and approximate, and are not intended to be used for legal or policy purposes. Research is needed to establish optimal cut-point scores for a specific application.

Measuring change

Good clinical practice often involves monitoring patient progress. Evidence suggests that a 5-10 point change is reliable (i.e., not due to chance) and a 10-20 point change is clinically meaningful (Monson et al., 2008). Therefore, we recommend using 5 points as a minimum threshold for determining whether an individual has responded to treatment and 10 points as a minimum threshold for determining whether the improvement is clinically meaningful.

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