

When They Come Home: Posttraumatic Stress, Moral Injury, and Spiritual Consequences for Veterans

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Throughout recorded history, it is clear that civilization has known that war, whether won or lost, has profound effects on those who participate and on society at large. Though public policy makers and even religious leaders may from a distance defend a particular war as a “Just War,” for many soldiers, sailors, and marines confronted directly by horrors unimagined, war may be experienced as anything but just. These service personnel leave the field of battle forever changed by their experiences.

While 1980 marked the formal introduction of posttraumatic stress disorder (PTSD) into psychiatry’s diagnostic system for mental disorders, recognition of the syndrome presently described as PTSD originated much

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earlier. Since the civil war, various terms have been used to describe the personal impact of war zone exposure: "soldiers heart," "war neurosis," and "shell shock," are among the terms utilized in this country during in the last two centuries.

COMBAT STRESS

In a chapter entitled "The Stressors of War," Capt. William Nash describes in detail some of the hardships encountered by deployed troops.¹ The war zone environment inflicts a wide variety of hardships and stressors upon deployed military personnel. In Iraq/Afghanistan, there are a variety of extreme physical stressors that make life difficult for soldiers and Marines. These include extreme temperatures encountered while wearing/carrying heavy equipment, dehydration and wetness, dust, dirt and mud, explosions and other loud noises, noxious fumes and disturbing smells, hunger and thirst, and illness and injury. These experiences combine to make day-to-day life in the war zone difficult and even painful.

There are also emotional stressors that can take a severe toll on well-being. These include things like exposure to the loss of friends through injury or death, fear, uncertainty, and helplessness, horror at exposure to human carnage, as well as shame and guilt sometimes associated with mistakes occurring in the field or with killing itself. There are also social/relational stressors, including things like isolation from family and friends resulting in loneliness, and lack of privacy and personal space associated with always being surrounded by other military personnel. Cognitive stressors would be those issues that overwhelm the mind and cause distress and rumination. This can include things like having too much or too little information, feelings of ambiguity about one's role or mission or about changing or confusing rules of engagement with the enemy. Boredom and monotony can fill one's mind during slack times giving personnel opportunity to dwell and reflect on those issues about deployment that don't make sense. These and other war zone experiences can result in changes in beliefs and expectations about how the world "should" work. This can ultimately result in spiritual confusion, disillusionment, and loss of faith. Though all the experiences mentioned above constitute "combat stress," and make a serious impact on the lives

and functioning of deployed military personnel, many would not rise to the level that clinicians/researchers would consider “traumatic stress.”

WHAT IS A TRAUMATIC STRESSOR?

Mental health professionals’ definition of “trauma” is distinctive and more specific than lay definitions and use of the term. In the psychiatric world, a traumatic event must encompass life threat—exposure to death or serious injury—experienced directly or witnessed as it happened to someone else. This intense experience is usually accompanied by strong emotional reactions, including fear, helplessness, and horror.² Perceived inability to control the situation (i.e., feeling powerless or out of control) or suddenness and unpredictability can add to the intensity of the traumatic experience.

Traumatic events (i.e., events involving serious life-threat or physical injury) can be arranged in three main groups. One group includes natural disasters and other events sometimes called “acts of God.” By this, we mean terrible, life-threatening occurrences that are not brought about directly by human beings. Floods, tornadoes, earthquakes, and hurricanes all fall into this category. A second type of traumas is those events caused unintentionally through human involvement. Experiences such as car accidents, falls, drowning, and structural collapses fall into this group. Often these events involve some human lapse of concentration, carelessness, or neglect that results in serious injury or life threat, or risk thereof. Finally, there is a group of human-caused traumas, where the event occurs, deliberately. Muggings, assaults, rape, child abuse, domestic violence, and terrorist attacks all fall within this group. War zone traumatic experiences often include events from all three groups, although most frequent war-related events are human-caused.

POSTTRAUMATIC STRESS DISORDER

PTSD refers to a particular array of symptoms that follow exposure to a “traumatic event.” These symptoms may last for an extended period of time—even many years. In psychiatric terms, a set of symptoms becomes a “disorder” at the point when the symptoms cause significant impairment in important areas of an individual’s life function (i.e., work, relationships, school). There are three clusters of symptoms that define PTSD.

First, “re-experiencing” symptoms consists of ways in which the disturbing memory of the trauma event comes back—sometimes overwhelming the survivor’s ability to control it. To a large degree, PTSD can be represented as a disorder of intense remembering, where traumatic events return unbidden to survivors along with the strong emotional reactions present at the time of the trauma. Symptoms included in this cluster include nightmares of the event and intrusive memories or flashbacks. Some of these are “cued” or “triggered” by everyday situations or by people that remind the survivor in some way of the trauma. These memories are often accompanied by strong emotional or even physical reactions that are disturbing.

The second cluster of symptoms is “avoidant/numbing” symptoms. These consist of ways in which the survivor attempts to not have the re-experiencing symptoms. This includes avoiding situations, people, conversations that remind one of the trauma. Loss of interest in once enjoyed activities, feeling distant or cut-off from others, feeling shutdown or “numb” emotionally are all characteristic of this cluster of symptoms.

The third symptom cluster is “hyper-arousal” symptoms. A key symptom in this cluster is hypervigilance, i.e., a constant need to scan one’s environment looking for danger. Because hypervigilance takes a great deal of cognitive resources, other symptoms in the cluster include difficulty concentrating, difficulty sleeping, irritability and anger, and exaggerated startle response. In a sense this cluster is comprised of the human body’s attempt to prevent recurrence of re-experiencing symptoms and ultimately a repeat of the actual trauma.

Primary questions that persist related to PTSD are: Who is most likely to develop it? And why does one person develop it when others exposed to the same trauma do not? Much research activity is ongoing to identify risk and resiliency factors that either increase risk for developing PTSD, or promote resiliency from it. One of the most consistent research findings is that there is a “dose-response” relationship between trauma exposure and risk of developing PTSD. In other words, the more intense the experience of trauma (i.e., severity, duration, and frequency), the greater the likelihood is that an individual will develop PTSD. As is true with other types of trauma, this linear relationship between intensity of trauma exposure and likelihood of developing PTSD has been seen in most studies of the war in Iraq/Afghanistan as well.³

Beyond trauma severity, a number of other key risk and resilience factors have been identified.⁴ Major environmental factors and pre-trauma experiences—such as childhood abuse or other aversive childhood experiences, prior trauma, a family or personal history of psychiatric problems, lack of social support, and current life stressors—have been linked to increased risk of PTSD. Demographic factors—younger age, female gender, lower socioeconomic status, less education, and lower intelligence—have also been associated with increased risk for PTSD. There are even potential biological factors that might place individuals at increased risk for PTSD. Brain imaging studies conducted after trauma have shown structural differences in the brains of groups of individuals with PTSD, compared to other groups of individuals without PTSD.⁵ It is not clear at present, whether those differences are indicators of pre-trauma biological differences, or whether these differences are indicative of changes in the brain that occurred as a consequence of the traumatic event.

Issues, such as how widely PTSD is experienced and what percentage of exposed individuals will ultimately develop PTSD, can be controversial, and even politically tinged. The best research studies for answering questions about the prevalence of a disorder are epidemiological studies that sample an entire population in some objectively representative way. In the Vietnam era, the most familiar epidemiological study published regarding PTSD is the National Vietnam Veterans Readjustment Study (NVVRS).⁶ The study indicated that 30.9 percent of those who served in Vietnam theater had experienced war zone related PTSD during their lifetime, and that 15.2 percent currently had PTSD at the time the study was conducted. Controversy over the accuracy of the published results from the NVVRS study continues even today, nearly twenty years after publication. A recent re-analysis of the NVVRS dataset utilizing revised current PTSD criteria suggested that PTSD rates for the NVVRS may be somewhat lower.⁷ Regarding the war in Iraq/Afghanistan, early data suggest that approximately 19.1 percent of returning Iraq veterans struggle with mental health related issues, and that 9.8 percent screened positive for PTSD.⁸ Another recent study suggests that these estimates will probably increase due to new cases with delayed onset of symptoms.⁹ Regardless of the exact number, it seems clear from a large body of research that many veterans will be affected significantly by mental health issues upon return from de-ployment.

THE PRESENT WAR

For many reasons, the current war likely provokes more frequent and varied emotional and spiritual reactions than previous wars. This war is being conducted by an all-volunteer military with extensive use of National Guard and military reserve troops. Among personnel in the present war, greater variability in age, gender, and avenue of deployment (reserves or National Guard) exist than in previous wars. Because there is no military draft, experience levels of troops in the war zone may have been somewhat higher. In the current conflict, repeated deployments of uncertain duration have created significant stress. This is particularly true for reservists and National Guard troops, who must leave careers and businesses behind, and for whom supportive resources and financial security may be lacking upon return home. Homecoming experiences may be another source of differential impact for returnees from the current war. Though there is active and vocal opposition to the current war in some segments of the United States and even more largely abroad, there seems to be awareness, even among those opposing the war, of mistakes made in previous wars. Even those in opposition seem to be making active attempts to express support and concern for returning personnel—something that was not true for returning Vietnam veterans.

Trauma exposure is another area of difference from experiences in previous wars, which may contribute to differential emotional and spiritual impact. Aside from initial battles in the first weeks of the war and sporadic intensive battles within constrained geographic areas (e.g., Al Fallujah), many of the life-threatening experiences individuals face in the current conflict occur randomly and without warning. Many deaths have occurred from improvised explosive devices, rocket-propelled grenades, and suicide bomb blasts. As a result, those who, in previous wars, might have been considered noncombatants (e.g., truck drivers) are now subject to high risk of traumatic exposure and injury.

MORAL INJURY

William Nash, a senior U.S. Navy psychiatrist has written:

War is a clash of opposing human wills, fueled by emotion, and influenced as much by mental and moral forces as by technology and material factors. It is seldom the physical destruction of people or

equipment that brings victory, but destruction of adversary's will to go on fighting because of the bombs, bullets, and other hardships they endure. Combat stressors are weapons whose targets are the hearts and minds of individual opposing warriors.¹⁰

In order to inflict suffering and win the battle of human will, warriors must become callous to the pain and horror they wield. In a guerrilla war, where insurgents hide within the civilian population, that callousness can begin to extend to everyone. Through military training, and then through exposure to horrific events for many months across multiple deployments, combatants may be hardened in a way that can be very difficult to reverse when they return home. Even though conscience, and even perhaps morality, can be pushed aside for a time in the midst of battle to ensure personal survival and protect one's friends and allies, when the war finally ends and reflection begins, soldiers may find they've been morally injured through their experiences and actions.

For many years, clinicians, researchers, and chaplains have recognized that some individuals participating in combat develop problems and symptoms that extend even beyond the diagnostic criteria for PTSD.¹¹ Combat is uniquely an activity where behaviors that are proscribed in other contexts (e.g., killing) are sanctioned and even celebrated when performed in accord with rules of engagement, and validly punished when those rules are violated. Interestingly, the PTSD criteria that define traumatic events does not encompass the infliction of trauma within its definition. Some theorists have suggested that killing in combat may have inherent emotional and psychological consequences that might better fit what one could call "moral injury."¹²

If an injury is defined as "damage or harm done to or suffered by a person," then a moral injury could be construed as damage or harm received to one's moral center as a result of things experienced, seen, and done in the war zone. Some traumatic war zone experiences have the power to damage an individual's view of self as worthwhile human beings, and leave the individual shackled with a distorted view of self and their enemies that is harmful to the individual's life function after leaving the war zone. We have developed a working conceptual definition of moral injury as follows: "Disruption in an individual's confidence and expectations about their own or others' motivation or capacity to behave in a just and ethical manner brought about by bearing witness to perceived immoral

acts, failure to stop such actions, or perpetration of immoral acts, in particular actions that are inhumane, cruel, depraved, or violent, bringing about pain and suffering of others or their death."¹³ Changes to a person's sense of self occur on a broad spectrum and may be seen as a diminished self-worth at the mild end of the spectrum to seeing oneself as a pariah—unworthy of even living in the midst of civilized society at the most extreme end. Oftentimes social isolation ensues in an attempt not to inflict oneself upon others.

The risk for moral injury may be particularly high in conflicts where enemy combatants are embedded among civilians and not easily distinguishable from them. Moral injury is associated with inner turmoil, shame, concealment, and withdrawal. The latter two problems, in particular, may serve to entrench the negative impact of moral conflict because service members can't get feedback from others that might correct distorted self-appraisals.

These disruptions in moral directedness and moral expectancies may lead to a number of symptoms and difficulties, many of which are documented among combat veterans with PTSD: (1) negative changes in ethical attitudes and behavior;¹⁴ (2) change in or loss of spirituality, including negative attributions about God;¹⁵ (3) guilt, shame, and alienation;¹⁶ (4) anhedonia and dysphoria; (5) reduced trust in others and in social and cultural contracts; (6) aggressive behaviors; and (7) poor self-care or self-harm. These are additional problems that are not captured by the PTSD diagnosis but are frequently reported by combat veterans under clinical care.

Combat situations, particularly in war theaters where one is fighting insurgent forces not easily distinguished from civilians, compel service personnel to make quick decisions and take actions in ambiguous situations. These actions may result in deaths, both intentional and unintentional, of enemy fighters, civilians (including women and children), and even friendly forces. Sometimes co-occurring with these decisions and actions are powerful emotions of grief, loss, rage, and hatred that stem from previous experiences in the war zone. Even in situations where the "correct" action or decision was made, personnel can later come to question or doubt the appropriateness of their action or decision. Such second-guessing may lead them down a path of harsh judgment about their own character and hopelessness about the very nature of humankind.

A recent survey of service personnel in the war zone illustrates that moral choices and ethical decision-making may be influenced by the presence of strong emotions, such as anger or loss, and by the presence of combat stress injury already experienced. The results of this survey indicated that a substantial percentage (approximately 10 percent) of soldiers and marines reported "mistreating non-combatants (i.e., damaged/destroyed Iraqi property when not necessary or hit/kicked a non-combatant when not necessary)." Data also indicate that personnel with strong anger, high levels of combat trauma exposure, or who had a mental health problem were twice as likely to report having mistreated non-combatants. The number of deployments and length of deployment were also relevant. Those deployed multiple times were more likely to develop PTSD, and longer deployment length was related to more marital and other mental health problems.¹⁷ Some of these findings may be early indicators of moral injuries that may endure after return from the war zone.

TRAUMA, PTSD, AND SPIRITUALITY

It is becoming increasingly clear that trauma may affect a person's spirituality in two directions, serving to enhance or diminish it.¹⁸ Additionally, there is evidence that spirituality may be associated with either the improvement or worsening of the course of PTSD symptoms. On the positive side, spirituality may help combat veterans achieve post traumatic growth that could lead to benefits, such as increased resilience in the face of future life challenges, increased meaning or purpose in life, and strengthened capacity to utilize positive coping resources amid crises.¹⁹ However, surviving trauma may also be associated with a shift to more negative beliefs about the safety, goodness, and meaningfulness of the world,²⁰ negative views of one's relationship with God/deity (i.e., beliefs that God is punishing me, or has abandoned me),²¹ loss of core spiritual values, and estrangement from or questioning of one's spiritual identity.²² Additionally, several authors have suggested that unhealthy aspects of spirituality might actually lead to worse clinical outcomes.²³

An early study found that many military veterans reported increased religious coping and attempts to assign meaning to war zone events.²⁴ Additionally, a study from a residential PTSD treatment program found strong religious/spiritual distress (i.e., abandoning faith in the war zone, difficulty

reconciling war zone events with faith) in a high percentage of military veterans.²⁵ To date, various dimensions of spirituality and related clinical outcomes among veterans treated for PTSD have not been fully examined.

Several more recent studies have identified both positive and negative associations between spirituality and war zone trauma or related PTSD. Witvliet and colleagues identified two dimensions of spirituality, i.e., lack of forgiveness and religious coping (both positive and negative), which were associated with severity of PTSD and depression in an outpatient sample of veterans treated for PTSD.²⁶ Further, another recent study found significant relationships among types of war zone trauma, loss of religious faith, and increased utilization of Veterans Affairs (VA) mental health services for veterans being treated for PTSD.²⁷ Specific types of war zone experiences (killing others, failure to save the wounded, etc.) were directly and indirectly (mediated by guilt) associated with reduction in comfort derived from religious faith. Both guilt and reduced comfort from religious faith were shown to be associated with increased use of VA services.²⁸

In a recent study of women veterans, those who reported being sexually assaulted (twenty-three percent of the sample) while in the military were found to have poorer overall mental health and higher levels of depression than veterans who did not report being assaulted.²⁹ The study also found that more frequent religious participation was associated with lower depression and higher overall mental health scores among the sexually assaulted women, consistent with a buffering effect for religious participation on mental health.

Taken together, these studies raise several key considerations for professionals interacting with military service personnel returning from combat deployment. First, is the potential that trauma exposure may lead to serious spiritual questioning, sometimes leading to a loss of faith. Spiritual tensions that arise for many combat veterans attempting to come to terms with their war zone experiences may reduce their use of spiritual resources as part of re-entry, and may in turn lead to worsening psychiatric symptoms and higher medical service utilization. Additionally, signs of "negative religious coping" or negative attributions about God (e.g., God has abandoned me, God is persecuting or punishing me) may appear, and these can be associated with more severe PTSD and depression in some veterans. Finally, difficulties with forgiveness and higher levels of hostility or guilt may be associated with more severe problems later on. It is notable

that much of our current knowledge about relationships between trauma and spirituality comes from studies conducted years after those traumatic experiences occurred. It will be important to continue this line of research with individuals returning from the present conflict, soon after their actual combat experiences.

MILITARY CHAPLAINS

Military chaplains have a long and honored history within the U.S. military, dating back even before the Revolutionary War. Chaplains have a unique role in that they are the most frequently sought out, among all the military professional disciplines, by those service personnel struggling with emotional difficulties. As is the case in the general population with clergy, more military personnel with mental health problems seek out chaplains for help than seek out mental health providers. Chaplains are viewed as “safe” listeners, because communication directed toward chaplains can be held confidential and does not have to be reported up the chain of command as those in other disciplines are required to do. Chaplains’ styles of ministry also may make them more readily available. In addition to formal availability through worship services, funerals, hospital work, and counseling, chaplains frequently provide an informal “ministry of presence” by spending time at base camps in informal settings interacting with those they meet.

However, because of close contact with service personnel, and because they are requested specifically during moments of greatest distress, a chaplain’s ministry in a war zone can be particularly difficult and stressful. The chaplain provides support during moments of extreme grief and loss while being affected personally by the same loss or life threat. A recent cover article in *Newsweek* outlined many of the stresses experienced by chaplains in this present war.³⁰ This article provides anecdotal evidence that war zone trauma may affect chaplains in ways similar to other soldiers, including spiritual tension, loss of faith, and PTSD.

THE CLERGY SUPERVISOR’S ROLE

In the course of their work, clergy supervisors may encounter both ordained and non-ordained personnel returning from service in Iraq or Afghan-

istan. There are several ways that supervisors can support successful re-entry of these individuals. An important unresolved issue, in both military circles as well as some elements of our society, concerns stigma associated with needing or seeking mental health services. Whether the concern is being viewed as "crazy" or "weak," many service members are reticent to seek help from the mental-health system. Clergy in general are front-line providers for people struggling with mental health problems. Thus, clergy supervisors have the opportunities to normalize the help-seeking process for all veterans, chaplains, and clergy that they encounter and to model healthy help-seeking themselves.

It is important for clergy supervisors to be aware of the fact that those returning from Iraq and Afghanistan will have unique and individual transition issues whether they have a mental health problem or not. Many experience financial strain, family stress, problems with return to the workplace, difficulty getting needed services, even difficulty simply being around one's children. All of these things can make the transition back home difficult. Many of these transition issues loom even larger for those serving in the reserves or National Guard because fewer supports and services are available for them. Improvements in body armor and medical technology have produced survival rates from war zone injuries that are much higher than in previous wars. Obviously on one hand this is wonderful news. Many of these individuals, however, survived severe injuries and will endure long periods of pain and rehabilitation, often with permanent disability. Record numbers of surviving amputees, burn victims, and individuals with traumatic brain injury have returned home from the war zone. Many of these individuals will need special care, support, and resources for years to come. In addition, some of those wounded physically will also carry the burden of psychiatric problems like PTSD.

Despite the political controversy surrounding the current Iraq war, regardless of personal political persuasions, it is extremely important not to repeat the errors of the past. It is extremely important to separate policy from people. Individual soldiers do not make policy; they simply and honorably carry out the missions assigned to them. Each person returning from the war zone deserves the utmost respect for the hardships and burdens they have borne in our name in the service of their country. Clergy supervisors need to make every effort to communicate that personal support to the returning veterans with whom they come into contact.

People whose lives have been disrupted and changed by their war experiences deserve the respect and support of a caring religious community.

BASIC PRINCIPLES

A helpful set of tools, originally designed to teach basic helping skills to disaster/relief workers in the immediate aftermath of natural disasters, is collectively called "psychological first aid."³¹ A training manual for the use of psychological first aid designed specifically for clergy engaged in post-disaster helping has been recently developed. Though originally designed for use in disasters, the U.S. Navy/Marine Corps has recently elected to use psychological first aid training to enhance the helping skills of chaplains and other health providers in the war zone.

There is now a large body of research literature supporting a number of specific helpful procedures that can be provided by non-mental health providers such as clergy.

(1) *Teach arousal reduction skills.* Traditionally in psychology, examples of these skills are referred to as relaxation training or progressive muscle relaxation. However, there is also empirical support for techniques that arise from a variety of spiritual traditions, such as meditation, mindfulness, breathing exercises derived from various religious traditions, and certain forms of prayer. Re-experiencing symptoms, as well as guilt, sadness, loss, and anger all have potential to produce strong physiological and emotional arousal that can leave a trauma survivor feeling "out of control." Gaining better control over one's physiological arousal can empower survivors to feel more capable of handling situations that arise in the post-trauma environment.

(2) *Reduce social isolation and increase social support.* PTSD and moral injury can lead to profound personal disconnection in survivors of trauma. This disconnection often results in social isolation that, in turn, may result in lack of access to available support and may fuel increasing levels of cognitive distortion due to lack of feedback from friends, family, and others. The lack of corrective information about the way the survivor is thinking about the traumatic event can lead to increasingly difficult and problematic behaviors. Social support provides both emotional as well as instrumental support needed following traumatic experience. Spiritual

communities can be healthy, supportive options, though engagement with any community that fosters healthy living can be very useful.

(3) *Behavioral activation*. This simply means increasing a person's level of physical activity and involvement in pleasurable activities. There is substantial evidence of a strong association between physical activity and improvement in depression that is on par with the results of both psychiatric medication and psychotherapy.³² Though the exact biological and/or psychological mechanisms through which physical activity improves mood are not entirely clear, the evidence for the effect is quite strong. Physical activity and active engagement in pleasant activities with other people provide less available time for harmful rumination about trauma and may help re-create an individual's sense of purpose and meaning. In relationship to PTSD, these activities may lead to a reduction in "numbing" symptoms that are somewhat overlapped with symptoms of depression. It may lead to the recovery of positive emotions, such as love or happiness, that are frequently reported as being lost by trauma survivors.

(4) *Address distorted beliefs and thoughts about trauma*. Cognitive restructuring is an important component of several empirically supported psychological treatments for both guilt and anger. Distorted perceptions about one's own and others' behavior in the midst of trauma can produce strong levels of both these emotions in trauma survivors. Frequently there is a need to sort through both exaggeration and minimization in order to come to a clear understanding of what actually happened. By their very nature, life-threatening traumatic events are things that are "not supposed to happen." Many people believe the world they grow up in is "safe." When the adaptive illusion of safety is damaged or destroyed in the midst of trauma, answering the questions of why the event happened and who was responsible often become an integral part of regaining a sense of agency and control. However, people do make mistakes, bad judgments, and sometimes act on impulse fueled by strong emotion. Not all feelings of blame or guilt are distorted. There may be a role for forgiveness in the context of trauma once clarity is achieved about what actually happened. For some individuals, there may be religious "baggage" attached to the word "forgiveness." For these individuals, there may be other more useful ways of talking about the same process, such as "letting go," "moving forward," or "getting unstuck."

(5) *Help the veteran to diminish the intensity of re-experiencing symptoms.* There are several empirically supported cognitive-behaviorally-based treatments designed to help reduce intensity of re-experiencing. Most of these treatments use an exposure model designed to allow fear and anxiety to “extinguish” through multiple retellings of the traumatic experience. Because these treatments tend to be quite intense both for client and therapist, in most situations it is best to refer clients to experienced mental health providers for this type of treatment. Cognitive Processing Therapy and Prolonged Exposure treatment are both effective treatments being used by the VA system nationally to meet the growing needs of veterans for help in this area.³³

(6) *Help the veteran reconstruct his/her moral compass.* This is an arena where clergy and chaplains are uniquely trained and can be helpful if they are comfortable being guided by the needs of the veteran. A number of existential or spiritual issues arise among trauma survivors. As mentioned earlier, the question of why an experience happened frequently becomes prominent. Historically, philosophers and theologians have called this question “theodicy” or the “problem of evil.” Giving survivors permission to ask these sorts of questions and to wrestle toward their own answers can be part of the healing process that can lead a veteran in the direction of post traumatic growth. Survival after trauma and return to everyday life can leave a veteran uncertain about where to go next. Basic values questions—“What do I care about? What do I want my life to be about?”—can loom large. Meaning in life, which may have been lost to some degree, may need to be rediscovered. Social isolation can leave an individual wondering, “Who do I matter to?” Some veterans have found meaning by being meaningful to others and have taken on involvement in service activities as volunteers. Finally for those whose spirituality has been lost or damaged, reconnecting in a new way with some form of healthy personal spirituality can be a useful and healing endeavor.

VETERAN’S SPECIAL NEEDS

Clergy supervisors, as they live out their various roles as models, educators, consultants, and direct providers of pastoral care, have powerful opportunities to influence and shape the responses of religious communities to the needs of returning veterans. We offer several key suggestions: (1)

Increase personal contact with veterans. Many veterans struggling with spiritual questions may not directly seek support. Increased contact will provide more opportunities for healing conversations to begin. (2) Instruct colleagues, parishes, and veteran families about the consequences of trauma and war and help to open up dialog across groups. (3) Be aware of the variety of related family stresses, including the potential for family violence and harmful substance use. Continue to inquire, check-in, and follow-up with veterans and their families as to how things are going and help facilitate needed supports. (4) Help provide non-judgmental healing environments with strong social support for veterans and an affirming, welcoming community of faith. Consider worship and other liturgical elements that acknowledge and celebrate veterans' service, their safe return, and sacrifices made by veterans and their families.

Noted theologian Mirolav Volf has written extensively on the ambiguity of memory for traumatic events on both the individual and societal level.³⁴ He notes that memory can serve a destructive role by maintaining desires for revenge and retribution, or it can serve a "redemptive" role that facilitates peace and reconciliation. Helping returning military veterans move beyond their war experiences in directions that lead to growth, meaning, and increased connection should be at the heart of all our ministry efforts.

NOTES

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